Albania's potential accession to the European Union: A gain for the Albanian public health?

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Abstract

Of the three potential EU candidate countries—Albania, Bosnia and Herzegovina, and Kosovo—only Albania has already formally applied for EU membership. At the same time, considering key health and healthcare indicators, Albania appears to score worst of all South-Eastern European (SEE) acceding, candidate and potential candidate countries. Therefore, this article intends to assess to what extent Albanian public health could benefit from its country's process towards EU accession. The EU accession process might best be understood through the notion of conditionality, implying that (potential) accession countries have to meet the EU's accession requirements—as set out in the so-called *acquis communautaire*—in order to become official candidate and eventually member. For public health, these requirements relate to general health conditions in the country, financing of the health system, and efficiency of healthcare delivery. It can be argued then that Albanian public health is most likely to benefit from the EU accession process by being encouraged to meet these *acquis* requirements. So far, however, only moderate progress can be witnessed. Some progress has been made with regard to communicable disease control, while main areas of concern remain tobacco use control, health inequalities and the financing of the Albanian health system. On the other hand, progress does look promising, certainly when taking into account that Albania had the worst starting position in terms of public health of all the SEE acceding, candidate and potential candidate countries. The aftermath of the 2013 Albanian parliamentary elections will be a crucial test for granting the official EU candidate status to Albania, a development that could spur progress in Albanian public health even further.

Keywords: Albanian public health, European Union, potential EU membership candidacy.

Introduction

In the spring 2013 edition of the Albanian Medical Journal, Ulrich Laaser argues that: *"for the countries of South-Eastern Europe it seems that the 2010s offer a quite straightforward highway for improving population health remarkably. The stage is set - it is up to the public health professionals in Albania and the government to take the chances"* (1). Laaser hereby explicitly makes the connection to Albania's prospect of EU accession, by commenting that "Albania has been forced to follow a long and winding road from the Ottoman Empire through war and dictatorship to the open horizon of today with the perspective of accession to the European Union" (1). It is the latter point—more specifically Albania's process towards EU membership candidacy—and its specific relation to public health, that shall be further scrutinised in this article.

Indeed, the next EU enlargement will most likely primarily consist of South-Eastern European (SEE) countries, apart from Iceland and Turkey. However, apart from the acceding country Croatia—which has become an EU member state as of the first of July 2013—and the candidate countries, the former Yugoslav Republic of Macedonia, Montenegro and Serbia, there is another group of countries in the Western Balkans—including Albania—that do not yet have the official candidate status. The other potential candidates are Bosnia and Herzegovina and Kosovo. Interesting about the Albanian situation is that although Albania is the only one of the three potential candidate countries that has already submitted its formal application for EU membership, when looking at several key health and healthcare indicators, Albania actually scores worst of all SEE acceding, candidate and potential candidate countries (2). At first glance, the coexistence of these two extremes may seem contradictory, yet, thereby triggering research interest in this particular case.

The accession (Copenhagen) criteria that (potential) candidate countries are faced with consist amongst others of adopting and implementing the EU's *acquis communautaire*. Of the current 35 *acquis* chapter, particularly chapter 19 on social policy and chapter 28 on consumer and health protection, appear to be most and directly relevant to public health. However, one should well be aware of the fact that almost all other *acquis* chapters have implications for public health as well. The first three chapters of the *acquis*—on the free movement of goods, workers and services—could for example relate to, respectively, pharmaceuticals, health care professionals and patient mobility (3).

Against this background, this article aims to answer the following research question: "To what extent is Albanian public health likely to benefit from Albania's process towards EU accession?" Although the concept of public health has many different definitions, the one proposed by the WHO is the most prevailing: "Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole" (4). Looking at chapter 28 of the *acquis communautaire*, public health can then be operationalized by subdividing the concept into concrete topics such as healthcare services (including e-health), tobacco control, communicable diseases, patients' rights in cross-border healthcare, drug abuse prevention, health inequalities and alcohol-related harm (5).

Conceptual framework

The EU accession process might best be understood through the notion of conditionality, as proposed by Schimmelfennig and Sedelmeier (6). Specifically looking at public health, this notion basically implies that the accession countries have to transfer the health-related rules as set out in the *acquis*—most notably in chapter 28—into their national legislation in order to be eligible for EU membership (6). However, although the notion of conditionality illuminates the end goal (rule transfer), it does not explain the conditions under which this rule transfer occurs.

For better explaining these underlying conditions of rule transfer, two competing theories can be applied. On the one hand, the theory of convergence, which implies that in moving towards certain health-related goals, the health(care) systems of the accession countries converge to the norm of the existing countries' systems, which are thus considered as superior (7). On the other hand, the theory of institutional diversity, which focuses on the notion of path dependency, implying that accession countries follow different roads towards the end

goal, depending amongst others on their specific cultural norms and values and on their starting point (which is the state of their inherited health(care) system) (7). This article applies the latter theory as a fundament for further discussion. In the field of public health the EU is not characterised by a clear harmonisation, as health is still a shared competence between the EU and the member states and because the health systems of the different member states are still highly divergent. It would therefore be inappropriate to speak of a 'convergence' of (potential) candidate states' health systems towards a 'European' standard. Although certain common goals are pursued (e.g. through the requirements laid down in the *acquis*), the way these goals are pursued differ highly between (potential) candidate countries. The degree to which public health in a (potential) candidate country can benefit from its process towards EU accession can be assessed by applying a conceptual framework adapted from a model proposed by Dubois & McKee (7). In their analysis of the former accession process of the Central and Eastern European (CEE) countries that became EU member in 2004 and 2007, Dubois and McKee identified several public health challenges that were shared by the majority of these countries. Although these CEE countries share a common communist history followed by a transitional period towards a free market system, it is argued here that—following the line of reasoning of the institutional diversity theory—the existence of a common history or identity is not a prerequisite for the application of this framework. Therefore, the common challenges as identified by Dubois and McKee may well be applicable to Albania as well. The conceptual framework departs from the free movement of goods, services and workers—inherent to the internal market—and considers issues of protecting and improving public health mainly as preconditions for the proper functioning of this internal market. This has to do with the limited competence that the EU has with regard to the protection and improvement of public health. Article 168 of the TFEU, which is the article providing the main legal base for public health action in the EU, stipulates it as follows: "A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities" (8). However, the Article in itself is not a justification for Union action. These preconditions, which are included as concrete accession requirements in the *acquis communautaire*—particularly in chapter 28—are considered nevertheless as being of benefit to the public health of both the (potential) candidate country as well as of the EU at large. In the conceptual model these requirements are divided into three categories, encompassing the general health conditions in a country, the financing of the health system, and the efficiency of healthcare delivery. The likelihood of a country to benefit from the process towards EU accession in terms of public health will depend on its ability to tackle these challenges.

Before discussing these three 'precondition' categories, it should be made clear why the focus of this article is not on the internal market movements themselves. On the one hand, one could namely argue that a candidate country's health status and healthcare system might benefit directly from the free movement of goods, services and workers. The pharmaceutical industry might for example choose for the competitive advantage of producing medicines with lower labour costs in a (potentially) acceding country (free movement of goods). Concerning the free movement of services, especially the increased opportunities for reimbursed cross-border patient mobility is a striking example, following the ECJ Kohll and Decker case law and the Patients' Rights Directive that will enter into force as of 25 October 2013. Acceding countries may be in a position of attracting foreign patients, and thus resources, by offering cheaper healthcare services (9). With regard to the free movement of workers, one could argue that (potential) candidate countries are stimulated to improve the quality of their institutes for medical education in order to attract medical students from abroad. On the other hand, one can just as well apply some of the above arguments regarding the different free movements in such a way as to illustrate disadvantages. As argued by Lobato, for example, "medicines sold in acceding countries might be diverted to more lucrative western European markets, so reducing access to them in their original destinations" (10). Moreover, free movement of workers may lead to a situation wherein highly educated health care professionals of

the new EU member state take the opportunity to move to EU countries that provide higher wages (11). This could have negative impacts on the new member state and might indeed undermine the health values of equity, universality, solidarity and access to good quality care as formulated as core health values for the EU (12,13). Apart from these reservations as to the potential health(care) benefits the internal market might provide to a (potential) candidate country, it is difficult to anticipate any future internal market movements in the first place. Instead, it is much more feasible to measure health(care) progress according to concrete operationalized indicators. In the first place, the accession process stimulates candidate countries to pursue a high health status of its populations. Challenges that were common to the former CEE candidate countries in this respect were twofold. First, they suffered from a significantly higher burden of disease than the existing member states. Specific problems included high levels of non-communicable diseases and the re-emergence of communicable diseases such as tuberculosis and syphilis. Next, the CEE candidate countries were faced with ageing populations, particularly due to declining fertility rates, resulting in a changing and growing demand for healthcare (7).

The second category concerns the financing of the health system (which is a broad term, encompassing more than merely the healthcare system). Pursuing the creation of a financially sustainable health sector is actually a continuous goal that is being shared by many of the existing EU member states. Especially the current financial crisis necessitates health system reforms in many countries. The challenge for (potential) candidate states might be exacerbated even more, however, due to insufficient healthcare resources as well as to the existence of considerable shadow economies, as was the case with the former CEE countries (7).

A final way of benefitting from EU accession concerns the efficient organization of healthcare delivery. In line with the EU principle of subsidiarity, candidate countries are encouraged to decentralize their healthcare systems for the sake of efficiency. The CEE countries largely inherited hierarchically and centrally organized healthcare systems, lacking incentives to operate efficiently. Challenges therefore encompassed setting up a more pluralistic system of healthcare organizations with a clear division of power between and/ or within these institutions, while at the same time restraining costs and reducing regional inequalities in health and provision of healthcare (7).

Methods

After providing a general framework to assess the extent to which a (potential) candidate country can potentially benefit from the EU accession process in terms of public health, this framework can now be applied to practice. Although the framework was based on experiences learned from the former CEE accession countries, it will here be applied to the current group of potential candidate countries, specifically to Albania. For each of the three categories outlined above, the situation on two reference points will be considered: the situation before officially submitting EU membership application—i.e. 28 April 2009, unless stated otherwise due to data availability—and the current situation. On the basis of the progress made so far, assessments about the progress to be made in the near future can be made. With regard to the latter point it might be worthwhile to take the notion of scenario planning in public health, as proposed by Neiner et al., into account (14). It is namely not about predicting the future, but about illuminating key factors that should be taken into account, in order to imagine how the Albania that we see today will differ from the Albania that would enter the EU.

Discussion

Population health status

Striking with regard to the health status of Albania in 2009—according to the WHO Country Cooperation Strategy—is its rather high life expectancy, despite its rather high rate of infant mortality, low income level, poor status of health services and regular outbreaks of communicable diseases (15). The latter group mainly comprises viral hepatitis, tuberculosis, measles and mumps. Although mortality rates from sexually transmitted diseases—most notably HIV—were low, the WHO considered them as a risk factor due to insufficient health promotion and disease preventive measures in that area. With regard to risk factors for non-

communicable diseases, particularly the use of drugs and tobacco were worrisome and constantly increasing, while the level of alcohol consumption was relatively low (15).

Just like the rest of Europe, also Albania and the rest of the SEE countries face an ageing population. However, as shown by a survey conducted by Mamolo and Scherbov—which is mainly based on Eurostat data—Albania is among the youngest countries in Europe, at least in terms of the proportion of people aged 65+ in population projections from 2007 until 2050 (16). In the Balkan region only Kosovo shows lower proportions of people aged 65+ in such population projections (17). Ylli furthermore captured the health situation of older people quite comprehensively by arguing that: *"demographic trends mixed with a society in economic and political transition raise concerns about increasing needs for care and social inclusion of older people. Moreover, there is a low level of preparation of this society to cope with chronic diseases and long-term care"* (18).

As a reaction to the growing threat of communicable disease outbreaks following the Yugoslav wars and its impact on health systems in the region, some action has already been taken in 2001 which is worth mentioning here. At that time, the South-Eastern European Health network (SEEHN) was created by the SEE countries as discussed in this article, including Romania and Bulgaria, but obviously without Kosovo which was not yet an independent state in 2001. The SEEHN was intended to provide a new and innovative approach towards communicable disease surveillance. In particular, this new approach entailed a focus on cross-border cooperation, in line with EU criteria. The network still exists, and is regarded by many as a good practice in terms of cross-border communicable disease surveillance (19).

Further, the European Commission (DG Enlargement) reports reasonable progress in the field of communicable diseases in its 2012 Progress Report on Albania. A new, more efficient, vaccination system is in the process of implementation, already resulting in an immunisation coverage rate of 95% in 2011. Legislation dealing with the control of hospital infections, as well as legislation dealing with the right to healthcare for HIV infected people and people being at risk for HIV infection, is adopted but not yet implemented (5).

Some progress has also been made with regard to the non-communicable disease risk factors mentioned above, that is, tobacco and drug use. With regard to the former, especially the introduction of a tobacco advertising ban and the development of a strategy for introducing pictorial warnings on tobacco packages are worth mentioning. The number of inspections on the use of tobacco among minors has been increased over the past few years throughout the country. The 'Task Force for Protection of Health from Tobacco and Alcohol Use by Minors' has been responsible for inspections in the capital city Tirana, while the 'State Sanitary Inspectorate' has performed this job in the rest of the country (5). Despite these efforts, the number of fines handed out stays low, most notably because of the intransparent sale of tobacco products on the street. In general, the European Commission concludes that the Law on Health Protection from Tobacco Products has not been adequately implemented yet (5).

With regard to drug prevention, especially the multiannual National Drug Control Strategy adopted in mid-2012 is notable. Second, a National Information Centre for Drugs has been established within the Institute for Public Health. Finally, Albania's first comprehensive drug treatment centre was opened in the beginning of 2012 in a hospital located in Tirana (5).

Financing of the health system

Concerning the macro-economic conditions of the health system, particularly the low spending on healthcare in Albania is striking. As can be seen in Table 1 and Figure 1 in the Appendix, in 2009 Albania even scored lowest of all the SEE accession countries (although figures for Kosovo were not available) and far below the average numbers for the WHO European Region on three different indicators (total health expenditure in PPP$ per capita; total health expenditure as % of gross domestic product (GDP); and public sector health expenditure as % of total health expenditure). In the figures of the year thereafter—which are the most recent data available—these figures did not change significantly (2). These figures are particularly worrisome as a study conducted by Mendola et al.

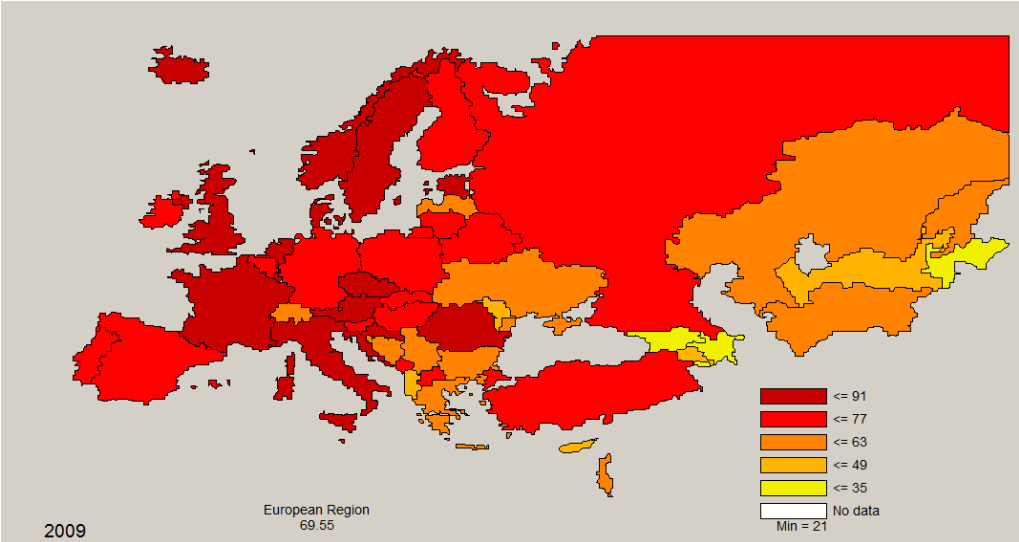
Table 1. Health expenditure in South Eastern European (SEE) acceding, candidate and potential candidate countries, 2009 *(own composition)* (2)

	Total health expenditure (in PPP$ per capita)	Total health expenditure (as % of GDP)	Public sector health expenditure (as % of total health expenditure)
Croatia	1555,72	7,76	84,88
fYRoM	763,44	6,86	66,5
Montenegro	1215,1	9,42	71,3
Serbia	1162,34	10,52	61,86
Albania	**591,48**	**6,88**	**41,18**
Bosnia and Herzegovina	933,78	10,94	61,36
Kosovo	*No data*	*No data*	*No data*
European Region	2209,94	8,44	69,55

shows that of all Western Balkan countries, the impact of government health expenditures on protecting against adverse health events is highest in Albania and Kosovo (20). As an example, a survey conducted among older people (aged 65+) in Albania showed that 66% of them have to rely on some financial support from family members or such sources as renting properties (17,18). Combined with a low availability of jobs in the formal sector, the underdeveloped Albanian welfare system also tends to trigger the informal sector. In Albania, the informal sector is estimated to constitute a third of the total economy (21).

The European Commission reports moderate progress in the field of health system financing. Most notable is the implementation of the Law on Compulsory Health Insurance, which intends to improve basic standards of health financing (5). In 2011, the Albanian government agreed on a law aimed at reforming hospital services financing. However, implementation of that law did still not occur (5). In general, financing of the Albanian health system remains insufficient according to the European Commission. Therefore, it recommends Albania to continue, in particular, its efforts in terms of capacity building as well as in terms of implementation and enforcement of health-related legislation. As the European Commission argues, effective implementation and enforcement of such legislation is currently being impeded by the: *"low awareness in the health protection system, both amongst professionals and the public"* (5).

Figure 1. Public sector health expenditure as percentage of total health expenditure (2)



Organization of healthcare delivery

Concerning the organization of the healthcare system, the WHO was very clear in its 2007 Country Cooperation Strategy, by reporting that Albania is characterized by:*"outdated, weak and insufficient public health services"* (15). Healthcare funds are for example divided between the Ministry of Health, the Ministry of Labour and the Health Insurance Fund (15).

The European Commission reports only little progress in the field of healthcare delivery. Positive signs are the reorganisation of the Institute for Public Health, which has lead amongst others to new infrastructures for primary healthcare services. A new training system for public health professionals has been established, which however does not yet comprise EU health legislation. Some progress has been made in the area of e-health: on the one hand, through the fulfilment of a feasibility study; second, the completion of a national e-health strategy is expected soon. Despite these modest achievements, severe shortcomings still exist in Albania's efforts towards decreasing health inequalities, especially with regard to the Roma community in the country. Some concrete action has been taken towards this latter group, such as awareness-raising campaigns on available healthcare services, as well as vaccination and health screening campaigns. However, further efforts are required in order to make healthcare delivery truly accessible for vulnerable groups throughout the country, in particular in the rural regions. These vulnerable groups do not merely encompass the Roma community, but also such groups as adolescents and young adults with HIV or being addicted to drugs (5).

Conclusion

This article has attempted to examine to what extent Albanian public health is likely to benefit from Albania's process towards EU accession. Albanian public health, it was argued, is most likely to benefit from the EU accession process in terms of being encouraged to fulfil the health-related *acquis* requirements. Through the application of a conceptual framework based on the work by Dubois & McKee, and by relying primarily on the Albanian Progress Reports as published by DG Enlargement, an assessment was made of Albania's progress in fulfilling these requirements. In general, these documents only report moderate progress in approximating the *acquis* requirements in the field of public health. Reasonable progress has been made with regard to communicable disease control, while main areas of concern comprise control of tobacco usage, tackling health inequalities and the under-financed state of the Albanian health system in general. The Albanian government will particularly have to pursue undiminished action with regard to public health capacity building and the actual implementation of adopted legislation in line with the *acquis* requirements.

However, this article suffers from a few limitations that might have impeded the depth of its conclusions. First, only the main progress made on some of the most key health(care) indicators has been considered. Second, although the three categories outlined in the conceptual framework (health status, health system financing and healthcare organization) aimed to facilitate a structured discussion on the opportunities as well as the challenges surrounding Albania's process towards EU accession, these categories might give a superficial picture of reality. As a suggestion for further research it is therefore recommended to conduct a similar, and broader, research in cooperation with public health researchers from Albania and the wider Western Balkan region.

In summary, it can be argued that the process towards EU accession certainly has spurred Albania to improve its population's health status, the financial viability of its health system and the efficient organization of its healthcare services. However, one should be aware that other influences spurring such action may be at stake as well, impeding conclusions on the direct causal link between *acquis* requirements and public health progress made. At the same time, it is difficult to distil public health progress from progress in other, more general, fields such as the rule of law and the market economy. On the other hand, the public health progress made so far may be limited, but promising, especially when taking account that Albania might have had the worst starting position in terms of public health when compared to the other SEE acceding, candidate and potential candidate countries (2). The fact that Albania is the only potential candidate country that formally applied for EU membership is also a sign

of its genuine willingness to make progress. The European Commission has declared furthermore that the aftermath of the 2013 Albanian parliamentary elections, that have taken place on the 23rd of June, will be a "crucial test" for granting the official candidate status to Albania (22). Nevertheless, it remains highly doubtful whether the Albanian public health would benefit more from the actual EU accession, rather than from its road towards the EU membership.

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