journal homepage: http://kont.zsf.jcu.cz
DOI: 10.32725/kont.2024.050

KONTAKT / Journal of nursing and social sciences related to health and illness

Original research article

Access to healthcare services among vulnerable groups in Albania: unveiling barriers and proposing solutions

Emanuela Ismaili, Rudina Rama *, Edmond Dragoti

University of Tirana, Faculty of Social Science, Tirana, Albania

Abstract
This study examines the challenges vulnerable populations in Albania face in accessing healthcare, focusing on structural, access-related, and socio-cultural barriers. Using a qualitative approach, it involved 13 focus group discussions (FGDs) with 118 participants from diverse backgrounds, including individuals with disabilities and members of the Roma and Egyptian communities. Data were collected between 2019 and 2020 as part of the "Health Vulnerability Study in Albania", commissioned by the "Health for All Project" (HAP) and approved by the Albanian Committee of Medical Ethics. Oral consent was obtained, and discussions were recorded to explore participants' experiences and perspectives in-depth.

Key findings highlight limited healthcare infrastructure, negative perceptions of the health insurance system, and discrimination, which erode trust in healthcare providers. Vulnerable groups included socio-economically disadvantaged individuals, older adults, the LGBT community, and women facing domestic violence or unemployment. The study calls for reforms in healthcare infrastructure, health insurance, and cultural competence training for providers to address disparities.

Keywords: Acceptability of healthcare; Discrimination; Healthcare access; Structural barriers; Vulnerable populationss

Introduction

Access to healthcare continues to be a significant barrier to achieving the Sustainable Development Goals (SDGs) in many low- and middle-income countries (LMICs), including Albania. Improving access to quality healthcare, particularly for vulnerable populations, is a priority for stakeholders working towards the SDGs (Acquah-Hagan et al., 2021). Access to healthcare is an important goal, but there are concerns that some vulnerable groups in the population have poorer access than others. Various studies have highlighted that access to healthcare for vulnerable groups is influenced by a multitude of factors that are generally consistent across countries (Corscadden et al., 2018). These individuals often face disadvantages when pursuing services, characterized by delayed seeking for help, challenges in effective communication of their health issues, and issues such as obesity or smoking that might lead to unfavorable judgments regarding their suitability for certain forms of care. Additionally, systemic constraints, including insufficient capacity, further compound the difficulties these groups encounter in meeting their healthcare needs.

Healthcare provision in Albania has undergone significant transformations since the fall of communism in the early 1990s. Despite notable improvements, the system still faces numerous challenges that affect the quality and accessibility of healthcare services. Albania's healthcare system transitioned from a centralized, state-controlled system under communism to a more decentralized model post-1990. This transition aimed to increase efficiency and improve service delivery.

The healthcare system in Albania is organized into primary, secondary, and tertiary levels of care. Primary healthcare services are provided through a network of health centers and family doctors, which serve as the first point of contact for most patients. Secondary and tertiary care services are offered by hospitals and specialized institutions, primarily located in urban areas (World Health Organization, 2018).

Despite this structured approach, significant disparities in access and quality of care exist between urban and rural areas. Rural regions often lack healthcare facilities and professionals, leading to substantial health inequities.

Albania has made notable progress in improving health indicators such as life expectancy and infant mortality rates. The average life expectancy in Albania increased to 78 years in 2019, while infant mortality rates have significantly decreased over the past decades (World Bank, 2020). However, these improvements obscure underlying issues, such as the high prevalence of non-communicable diseases (NCDs), which account for over 90% of all deaths (Institute for Health Metrics and Evaluation, 2020).

The healthcare infrastructure in Albania is aging and often inadequate to meet the growing needs of the population. Many facilities lack modern equipment and essential supplies, hampering the quality of care (European Commission, 2023).

* **Corresponding author:** Rudina Rama, University of Tirana, Faculty of Social Science, 8RC3+MGV, Bulevardi Gjergj Fishta, Tirana, Albania; e-mail: rudina.rama@unitir.edu.al
http://doi.org/10.32725/kont.2024.050
Submitted: 2024-02-12 • Accepted: 2024-09-23 • Prepublished online: 2024-11-01
KONTAKT 26/4: 369–375 • EISSN 1804-7122 • ISSN 1212-4117

As in many countries, Albania faces a significant shortage of skilled healthcare workers. This shortage is exacerbated by the migration of medical personnel to other countries in search of better opportunities, leading to a "brain drain" (Yakubu et al., 2022).

Although health insurance coverage has increased, out-of-pocket expenditures remain high, posing a significant barrier to accessing healthcare for many Albanians. This financial burden is particularly heavy for low-income households (Thomson et al., 2023).

The quality of healthcare services is inconsistent, with issues such as inadequate training of healthcare professionals, lack of adherence to clinical guidelines, and poor patient management practices. These issues contribute to patient dissatisfaction and mistrust in the healthcare system (Saric et al., 2021).

The above challenges multiply the access and the quality of the health services for the vulnerable groups in the country, affecting their overall well-being. The terms 'vulnerability' or 'vulnerable groups' are commonly used, but often with different meanings by various stakeholders and actors involved. The concept of vulnerability is dynamic. Individuals can be more or less at risk of being in a vulnerable situation, depending on the interaction of personal (inborn or acquired), societal, and environmental factors. These factors can either provide or deprive individuals of certain types of resources. Social determinants of vulnerability are also influenced by the political, historical, cultural, and environmental context (World Health Organization, 2021). We considered vulnerable groups who may be more likely to face barriers to access to care as being those participants with chronic conditions, lower income, females, people over 65, LGBTQI community, sex workers, people living with HIV/AIDS, problematic drug users, and Roma and Egyptian communities.

People who belong to potentially vulnerable groups tend to experience significant health challenges and often present a range of complex health needs. Smoothening the progress of access to healthcare involves helping people to command appropriate healthcare resources and to seek care in order to preserve or improve their health. It is worth noting that access is a complex concept. However, four aspects require empirical evaluation. These are availability, affordability, physical accessibility, and acceptability (Levesque et al., 2013).

In Albania, there is little information about the rate of utilization among various vulnerable groups such as people with disabilities, drug users, female, elderly women, etc. Nevertheless, this information is essential as it will help policymakers to know the rate of access to healthcare services among the most marginalized population in the Albania society and respond accordingly. Understanding the factors that influence differences in healthcare access and utilization within vulnerable groups in Albania can also serve as a basis for accurate projection of future healthcare needs. This study therefore aims at assessing the healthcare access differentials among the vulnerable populations and makes this information available to inform policy.

Conceptual module

The study adopts Levesque's framework, which comprises five dimensions of accessibility (approachability, acceptability, availability, affordability, appropriateness) and corresponding abilities of patients and populations to access care (ability to perceive, seek, reach, pay, engage). This comprehensive framework serves as the conceptual foundation for exploring healthcare access among vulnerable groups (Levesque et al., 2013).

Materials and methods

To achieve the study's objectives, qualitative data collection methods were employed, specifically Focus Group Discussions (FGDs). A total of thirteen FGDs were conducted with participants who either had or lacked access to primary healthcare services. These discussions aimed to explore participants' healthcare needs, the barriers they encountered in accessing services, and their perceptions of the quality of primary healthcare. The use of FGDs was chosen for its effectiveness in providing an in-depth exploration of participants' knowledge, attitudes, and practices. This method facilitated rich data collection by encouraging interaction among participants, allowing for time-efficient yet detailed insights into the experiences and factors influencing healthcare access. Data collection occurred between 2019 and 2020.

Sample

Given the fact that this study was based on a qualitative approach, there was no intention to generalize findings rather than explore potential factors that hinder access and quality in the primary health service. Therefore, a deliberate and appropriate sampling was used based on the participants' knowledge and experience on the subject. This sampling method was chosen for researchers to get participants' views on their experiences and standpoints about primary healthcare services. Data was collected by 13 FGs representing the most vulnerable groups in Albanian society regarding their access to healthcare services. Each focus group was composed of 7 to 14 individuals representing the respective vulnerable groups pertinent to the Albanian society. In total, 118 individuals participated in focus group discussions. Focus groups lasted on average about 90 minutes to 120 minutes. All participants were informed beforehand about the study purpose and objectives, as well as their rights, and their oral consent for participation was sought. When participants agreed, the focus group discussions were tape-recorded. Table 1 below presents the distribution of participants in the focus group discussions according to the respective vulnerable groups and place of residence.

Data analysis

Thematic analysis, following Braun and Clarke's six-stage model (Braun and Clarke, 2006), was employed to derive meaningful insights from the qualitative data. Researchers familiarized themselves with the data, transcribed audio recordings, created initial codes, identified potential topics, categorized codes into Levesque's dimensions, revised topics, and interpreted findings. An interpretive approach focused on participants' interpretations, perceptions, and understanding of the discussed topics.

Table 2 presents the themes and subthemes emerging from the focus group discussions involving vulnerable groups.

Limitations

The study encountered several limitations that need consideration for a nuanced interpretation of the findings:

Participants frequently referred to experiences spanning several years, introducing potential recall bias. This temporal inconsistency may impact the accuracy of reported healthcare encounters.

Many participants shared experiences of others, adding complexity to the discernment of individual perspectives. This indirect relay of information might not accurately represent personal encounters with healthcare services.

Table 1. Vulnerable categories included in focus group discussions

No.	Target group	District	Number of participants
1	Vulnerable older people	Tirana	11
2	Women caregivers	Peshkopi	9
3	People with disabilities	Fier	9
4	Vulnerable women	Fier	9
5	People with comorbidities	Vlore	8
6	Roma community	Tirana	10
7	Poor people (including homeless persons)	Vlore	7
8	Poor people	Tirana	8
9	Vulnerable women	Tirana	8
10	Chronic Diseases (AIDS, Hepatitis, Diabetes I)	Tirana	9
11	People with disabilities (paraplegic, tetraplegic, blind people)	Tirana	14
12	Vulnerable rural men	Shkoder	8
13	Poor Roma men (including homeless persons)	Shkoder	8
Total			**118**

Table 2. Themes and subthemes of the focus group discussions

Themes adapted based on Levesque's dimensions	Subthemes
Availability	Health personnel and other human resources Infrastructure and medical equipment Drugs
Accessibility and affordability	Health insurance Waiting time Transportation Out-of-pocket payments
Suitability/Effectiveness	Economy Physician-patient interaction Trust
Acceptability	Fear Faith and credibility Attitudes Prejudices

Some participants held the belief that doctor visits were only necessary for addressing specific illnesses. This perception may influence reported patterns of healthcare utilization, potentially underrepresenting preventive or non-urgent care.

The discussions occasionally veered into experiences with secondary and tertiary healthcare services, deviating from the main focus on primary healthcare. This expansion could dilute the study's intended emphasis.

Language challenges, notably in the Roma community and rural areas, may have introduced variations in understanding and response consistency. This linguistic barrier could impact the accuracy of conveyed experiences.

Results

Availability

In navigating the complex landscape of healthcare access, participants identified structural barriers that collectively hindered availability. These structural barriers encompassed geographical disparities, a shortage of healthcare personnel, challenges in medication accessibility, and deficiencies in organizational aspects of the healthcare system.

Health personnel / Human resources

Participants highlighted a significant obstacle in the form of a shortage of primary healthcare physicians and nurses, particularly in remote rural areas. This scarcity necessitated individuals to embark on arduous journeys, often spanning long hours, to access the healthcare services they required. Notably, the Roma and Egyptian community faced additional barriers related to the lack of identification documents, rendering them unable to receive basic healthcare. In response, this community adopted various strategies, with the prevalent one involving delaying seeking medical attention until conditions reached a critical state, prompting emergency service calls.

Infrastructure and medical equipment

Perceptions regarding healthcare infrastructure and technical capacities were characterized by variability. While some participants acknowledged recent investments in renovating primary healthcare infrastructure and hospital facilities, deficiencies persisted. Lab work and x-ray diagnosis were singled out for criticism, leading individuals to seek services outside their districts, often in the capital or private sector. Participants with disabilities shed light on inappropriate infrastructure conditions, ranging from architectural barriers to violations of privacy, impeding their access to healthcare. Faced with such hindrances, individuals with disabilities reported a preference for private sector services when financially feasible.

Drugs

A common concern across all focus groups pertained to serious problems associated with shortages in pharmaceutical supplies. Chronically ill participants expressed frustration at the frequent unavailability of the medicines they required. Moreover, discussions unveiled perceived issues with doctors prescribing specific brand names rather than emphasizing chemical compositions. Participants suspected a clandestine collaboration between pharmaceutical interests and doctors' prescription practices, with some suggesting doctors might receive incentives for promoting certain brands. The effec-

tiveness of drugs on the reimbursement list became another contentious issue, with doubts raised about their quality and expiry dates. Affordability was a recurring theme, with participants lamenting the high cost of medicines and adopting various strategies to cope, such as delaying treatment until financial resources allowed.

In the context of HIV/AIDS, a distinct pattern emerged, as individuals with HIV/AIDS primarily sought services at specialized centers concentrated in Tirana. This group encountered challenges in reimbursement due to bureaucratic disconnection from family physicians, exacerbating difficulties for people living with HIV/AIDS.

Access and affordability of health services

Access

Health insurance

Contrary to expectations, attitudes toward the health insurance system were predominantly negative, irrespective of participants' insurance status. While possessing a health card granted the right to a free health center visit, participants voiced dissatisfaction, asserting that many essential services were not covered. Paradoxically, those with health insurance perceived themselves as receiving lower-quality care, facing longer queues, and contending with a more restrictive, bureaucratic system compared to those paying out of pocket. Participants hinted at a perception that physicians paid less attention to insured individuals, fostering a preference for patients without insurance who might be more inclined to make informal payments.

Waiting lists and waiting time

Accessing healthcare was not only a matter of geographical and financial barriers; participants highlighted bureaucratic hurdles within the system. Planning procedures, even for emergencies, necessitated lengthy waiting times, discouraging individuals from seeking timely care. To circumvent these delays, some participants resorted to informal payments or sought services in the private sector. Notably, individuals with disabilities faced similar challenges despite their status, navigating queues and planning systems with difficulties unique to their circumstances.

Transportation

Rural and local populations, particularly those in remote areas, confronted additional challenges related to transportation. Accessing specialized medical services often required extensive travel, imposing burdens of time, cost, and potential job loss. Lack of available transport compounded the issue, especially in rural areas where public transport options were scarce. Participants highlighted the absence of transportation services for bringing sick individuals from towns to cities, further restricting access. The cost of transportation emerged as a significant concern, leading individuals to delay seeking healthcare until conditions worsened or resorting to borrowing money to access necessary services.

Affordability

Financial barriers emerged as a predominant theme in discussions, with participants indicating a reluctance to seek healthcare immediately due to economic constraints. The ability to pay informally (out-of-pocket) was perceived as a facilitator of access to healthcare, surpassing the advantages of health insurance coverage. Participants suggested that informal payments played a crucial role in ensuring better access to healthcare services. They described a nuanced relationship between financial contributions and the quality of care received, particularly emphasizing the impact on hospital services. Despite the presence of social and health insurance, participants noted perceived differences in the quality of medical services, attention, and care based on informal payments, especially within hospital settings.

Effectiveness

Socioeconomic status

The socioeconomic status of individuals played a pivotal role in shaping their healthcare-seeking behavior. Participants described situations where economic factors, such as the need to leave work, compelled them to delay or avoid seeking medical care. This was particularly evident among women with young children or children with disabilities who prioritized their family's needs due to financial and time constraints. Participants perceived that their socioeconomic status influenced the treatment they received, impacting access to healthcare and the overall doctor-patient relationship. Differences in patient communication were frequently reported, with providers often failing to hear patients' concerns or answer their questions adequately.

Patient-doctor interaction

Dissatisfaction with the interaction between patients and medical staff was prominent, especially among urban participants. Communication issues, the way individuals were addressed, and superficial explanations about treatment were common grievances. In scrutinizing the quality of patient-doctor interactions, participants voiced dissatisfaction with the brevity of visits to family doctors and specialists. The limited timeframe, averaging 10 to 15 minutes, was deemed insufficient for doctors to fully address patients' concerns, offer thorough explanations about their conditions, or provide comprehensive guidance on treatment options. This lack of time was perceived as a significant barrier to achieving high-quality, patient-centered care.

The urban-rural divide in attitudes towards healthcare personnel was evident. Rural participants generally reported positive relations and communication with doctors and nurses in their villages. However, when needing to access services in urban areas, dissatisfaction prevailed, with urban healthcare staff's behavior and attitudes drawing criticism.

Members of vulnerable minorities, specifically the Roma and Egyptian communities, faced discrimination not only in primary care services but also in hospital settings. Instances of perceived hostile behavior led to physical confrontations in some cases, highlighting the intensity of the challenges faced by these communities.

Trust in doctors

Participants' attitudes toward the medical staff's competence revealed a divided perspective. While some believed doctors were capable problem-solvers, the majority felt that the most competent and experienced doctors were concentrated in Tirana. Lack of confidence in certain doctors prompted patients to seek second or third opinions, often receiving conflicting diagnoses. Participants highlighted concerns about doctors not paying sufficient attention during visits, leading to brief interactions where explanations about illnesses, medications, and consequences were lacking. The Roma community claimed they were not physically visited by doctors due to perceived discriminatory and hostile behavior.

The role of a doctor's personality emerged as a significant factor influencing care and attention, transcending socio-eco-

nomic status considerations. Some participants emphasized that good behavior should be a matter of conscience, independent of financial considerations.

Acceptability

Interpersonal level

Acceptability of healthcare services was profoundly influenced by the lack of trust in doctors, fear of negative diagnoses, barriers to medication adherence (including cost and perceived corrupt practices), and financial implications. Participants expressed dissatisfaction with doctors' quick health visits, insufficient information provision, profit-driven motives, and perceived lack of focus on proper care. Negative perceptions of doctors and a distorted doctor-patient relationship were pervasive across focus groups.

Reports of violence involving dissatisfied patients and medical personnel had been covered in the media over the past few decades. Respondents in large cities outside Tirana highlighted a lack of trust and close relationships with family doctors as factors deterring patients from seeking care, potentially leading them to alternative healthcare providers.

Fear and previous experiences

Fear, rooted in attitudes and negative experiences, emerged as a substantial barrier to seeking healthcare. Participants recounted instances of doctors ignoring, shouting, and humiliating patients. Language and communication barriers, including the use of medical jargon, further strained the doctor-patient relationship, fostering misunderstandings.

Discrimination extended beyond socio-economic factors, with the Roma and Egyptian communities expressing heightened feelings of being discriminated against. The fear of financial and emotional stress, coupled with anxiety about life-changing diagnoses, deterred individuals from seeking timely medical care. The complexity of the health system, potential corruption, and the prevalence of bribery created psychological barriers, exacerbating stress and anxiety, even among disabled individuals.

In summary, the acceptability of health services was deeply influenced by interpersonal dynamics, trust issues, fear, negative experiences, and systemic complexities, illustrating the multifaceted nature of barriers within the healthcare landscape.

Discussion

The findings of this study shed light on the intricate challenges faced by vulnerable populations in accessing and utilizing healthcare services in Albania. The study shows that lack of transport, availability of services, inadequate drugs or equipment, and costs are the four major barriers to access. The multifaceted nature of these challenges calls for a nuanced discussion to better understand the implications and potential strategies for improvement. Whist universal approaches to healthcare aim to offer equitable access to all, there are some groups of people who continue to experience barriers in accessing healthcare or fail to access healthcare by conventional means. Targeted or specialized interventions are an effective way of addressing the health needs of vulnerable groups, as they tend to be specifically tailored to the needs of particular groups or particular health needs (e.g., outreach services tackling communicable diseases among homeless populations). Monitoring the health of populations and the services is an effective way of understanding both the needs of the population and gaps in health service provision (e.g., health needs assessments of prisoner health).

Structural barriers and availability

Many people face barriers that prevent or limit access to needed healthcare services, which may increase the risk of poor health outcomes and health disparities (Institute of Medicine /US/ Committee..., 2003). The scarcity of healthcare professionals and inadequate infrastructure, especially in remote areas, poses a significant barrier to healthcare access. In general, the vulnerable groups identified through various research methods used in this study are in concordance with previous reports from Albania. The reported challenges related to waiting times and transportation, particularly in rural areas, emphasize the importance of improving accessibility. Policymakers should consider measures to reduce waiting times, enhance transportation options, and explore ways to make healthcare more affordable, ensuring that individuals are not compelled to seek alternatives in the private sector due to perceived inadequacies in the public system.

The most vulnerable group, universally identified across all methods employed by the current study (prioritization exercise, quantitative survey, key informants' interviews) and exhibiting many barriers and challenges during focus groups discussion were "older people". This group encompasses many more vulnerable sub-groups as many older individuals also experience the high burden of multi-morbidity, disability, deteriorated mental health, high levels of poverty, low education level, mobility issues, etc., all of which contribute to their distinctly disadvantageous positions in relation to other population groups. The older community is increasing in Albania, with the country experiencing the effects of population ageing, similar to the rest of Europe (INSTAT, 2011). This demographic transition is also reflected in a rapid shift of the disease profile and mortality patterns, a phenomenon referred to as "epidemiological transition".

The study, International Mobility in Ageing, conducted in Tirana, indicates that around 10% of older persons live totally alone (IAMS, 2016). In the current study, lack of home care for elderly people was a major obstacle to access to health care. The reported strategies, such as delaying healthcare until a critical condition or relying on emergency services, highlight the desperate measures individuals take when faced with structural deficiencies. Addressing these issues requires targeted investments in healthcare infrastructure, incentivizing healthcare professionals to work in underserved areas, and developing strategies to ensure essential services are available locally.

Access and affordability

Poverty is a universal risk factor across all vulnerable groups identified in this report and beyond. Indeed, the poorest individuals exhibited worse outcomes on all the indicators of access to health care and health care quality included in the current study. Poverty is deeper among vulnerable groups, and poverty and vulnerability boost each other endlessly.

According to Living Standards Measurement Survey 2012 (INSTAT, 2012), the prevalence of absolute poverty in Albania was 14%, with 3% of the population living in extreme poverty. In 4 regions (Gjirokaster, Berat, Diber, and Tirana), an important association was observed between poverty and distance from the nearest doctor. In some cases, but not in all, this association could be explained by urban rural differences in poverty levels and distribution of health services.

The Albanian Demographic and Health Survey (ADHS) 2018 used another indicator for estimating the distribution of

poverty in the population: relative poverty or the wealth distribution index. It shows that wealth and economic opportunities tend to concentrate in urban areas. Only 5% of households in urban areas are in the lowest wealth quintile, compared to 42% of households in rural areas.

The critical component of financial barriers in the HCAB model is the cost of healthcare (Carrillo et al., 2011). Out-of-pocket medical care costs may lead individuals to delay or forgo needed care (such as doctor visits, dental care, and medications) (Pryor and Gurewich, 2004), and medical debt is common among both insured and uninsured individuals.

Effectiveness of healthcare

The delay in seeking healthcare due to economic factors and concerns about the perceived differential treatment based on socioeconomic status is a critical issue. Interventions should focus on raising awareness about the importance of timely healthcare seeking and addressing the root causes of socioeconomic disparities in healthcare delivery. Additionally, efforts to improve the quality and duration of doctor-patient interactions can enhance the effectiveness of healthcare services.

Acceptability and trust

Trust is a combination of two components; it includes confidence in the other person's skills and competences and their positive intentions. In the case of healthcare services, this means that for a patient to trust the services, they must believe that healthcare professionals have both the ability and the willingness to work in favor of the patient (Calnan and Rowe, 2006; Mahon, 2013). A patient's trust is formed based on their experiences, but trust also affects how they perceive further experiences (Hall et al., 2001). The reported lack of trust in healthcare professionals, especially in urban areas, underscores the need for interventions to rebuild confidence. In addition to the reasons above, distrust in public health care services is caused by a number of mechanisms in society. It is based on a broader concept and discourse on the trustworthiness of public services and local government (Manning and Guerrero, 2013). It cannot, therefore, be solved by only focusing on the issues of quality and staff responsibility, but must be seen as a component of a broader discussion on political and societal trust. However, distrust is not limited to public services alone. Strategies may include initiatives to improve communication, cultural competence training for healthcare professionals, and community engagement to bridge the trust gap. The discriminatory practices faced by vulnerable populations, particularly the Roma and Egyptian communities, demand urgent attention, necessitating anti-discrimination policies and awareness programs within the healthcare system.

Fear and psychological barriers

The pervasive fear of negative diagnoses and the psychological stress associated with healthcare interactions highlight the importance of addressing mental health aspects. Integrating mental health support within primary healthcare settings and implementing measures to reduce the stigma associated with seeking medical help can contribute to a more accepting and supportive healthcare environment.

Conclusion

The exploration of healthcare experiences in this study reveals a complex landscape marked by numerous challenges that hinder effective healthcare delivery and patient well-being. The main reasons for the inability to access healthcare services included financial constraints, reluctance to go to the pharmacy, and a lack of trust in the effectiveness of recommendations and prescribed medications. Poor health status/mobility, and the distance to health centers were also important barriers among some groups – such as the disabled, chronically ill, and elderly.

Structural barriers, ranging from the shortage of health personnel in remote areas to deficiencies in medical infrastructure and equipment, contribute to limited accessibility and availability of health services. Medication shortages, informal payments, and doubts about the effectiveness of reimbursed drugs further compound these challenges.

The analysis of access and affordability underscores the inadequacies of the current health insurance system. Despite possessing health insurance, participants expressed dissatisfaction, perceiving those with insurance to receive lower-quality care and face bureaucratic hurdles. Waiting lists, waiting times, and transportation barriers, particularly in rural areas, add additional layers of complexity to accessing healthcare.

Effectiveness of healthcare is compromised by delays in seeking medical attention, influenced by socioeconomic factors and negative perceptions of the healthcare system. The intersection of poverty, age, and ethnicity emerges as limiting factors, leading to delayed or avoided medical care. The brief duration of doctor visits, discriminatory behaviors, and a lack of trust in doctors further impact the effectiveness of healthcare services.

Acceptability of healthcare services is marred by interpersonal conflicts, fear, and negative experiences. Participants report dissatisfaction with doctor-patient interactions, citing quick visits, inadequate information, and profit-driven motives. Discrimination, especially against vulnerable minorities, contributes to physical confrontations and a breakdown of trust. Fear of bad diagnoses, financial implications, and a perceived lack of care drive individuals to avoid seeking medical attention, perpetuating a cycle of delayed or neglected healthcare.

In the studied context, the healthcare landscape is shaped by a web of interconnected challenges, spanning structural, access-related, effectiveness, and acceptability dimensions. Addressing these multifaceted issues requires a comprehensive and integrated approach, involving stakeholders at various levels to enact policy changes, enhance healthcare infrastructure, and foster a culture of trust and empathy within the healthcare system. The findings underscore the need for targeted interventions to bridge gaps in healthcare delivery and improve patient experiences, ultimately working towards a more equitable and accessible healthcare system for all.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

References

1. Acquah-Hagan G, Boateng D, Appiah-Brempong E, Twum P, Amankwa Atta J, Agyel-Baffour P (2021). Access Differentials in Primary Healthcare among Vulnerable Populations in a Health Insurance Setting in Kumasi Metropolis, Ghana: A Cross-Sectional Study. Hindawi Publishing Corporation, 14 p. DOI: 10.1155/2021/9911436.
2. Albania Demographic and Health Survey 2017-18 (ADHS). Tirana, Albania: INSTAT, IPH, and ICF. Available from: https://www.instat.gov.al/en/publications/books/2018/albania-demographic-and-health-survey-2017-2018/

3. Braun V, Clarke V (2006). Using thematic analysis in psychology. Qual Res Psychol 3(2): 77–101. DOI: 10.1191/1478088706qp063oa.
4. Calnan M, Rowe R (2006). Researching trust relations in health care: conceptual and methodological challenges – an introduction. J Health Organ Manag 20(5): 349–358. DOI: 10.1108/14777260610701759.
5. Carrillo JE, Carrillo VA, Perez HR, Salas-Lopez D, Natale-Pereira A, Byron AT (2011). Defining and targeting health care access barriers. J Health Care Poor Underserved 22(2): 562–575. DOI: 10.1353/hpu.2011.0037.
6. European Commission (2023). Albania 2023 Report. Commission Staff Working Document, SWD (2023) 690 final. Accompanying the document Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. 2023 Communication on EU Enlargement policy {COM(2023) 690 final}. Brussels. [online] [cit. 2024-01-22]. Available from: https://op.europa.eu/en/publication-detail/-/publication/8181fd61-7eee-11ee-99ba-01aa75ed71a1/language-en
7. Hall MA, Dugan E, Zheng B, Mishra AK (2001). Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? Milbank Q 79(4): 613–639. DOI: 10.1111/1468-0009.00223.
8. INSTAT (2011). Population and Housing Census 2011. Albania: Insitute of Statistic. [online] cit. 2024-01-22]. Available from: https://www.instat.gov.al/en/themes/censuses/census-of-population-and-housing/publikimet/2011/publications-of-population-and-housing-census-2011/
9. INSTAT (2012). Living Standard Measurement Survey (LSMS). Albania: National Institute of Statistic of Albania. [online] [cit. 2024-01-22]. Available from: https://www.instat.gov.al/en/themes/social-condition/living-standard-measurement-survey-lsms/
10. Institute for Health Metrics and Evaluation (2020). Global Burden of Disease Study 2019 (GBD 2019) Results. Seattle, WA: IHME. [online] [cit. 2024-01-22]. Available from: http://ghdx.healthdata.org/gbd-results-tool
11. Institute of Medicine (US) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care (2003). Unequal treatment: Confronting racial and ethnic disparities in health care. Smedley BD, Stith AY, Nelson AR (Eds). Washington (DC): National Academies Press (US). DOI: 10.17226/12875.
12. International Mobility in Ageing Study (IAMS, 2016). International Mobility in Ageing Study, Albania. [online] [cit. 2024-01-22]. Available from: http://www.imias.ufrn
13. Levesque JF, Harris MF, Russell G (2013). Patient-centered access to health care: conceptualizing access at the interface of health systems and populations. Int J Equity Health 12: 18. DOI: 10.1186/1475-9276-12-18.
14. Mahon A (2013). Relationships in healthcare: trust in transition? In: Llewellyn BS (Ed.), Trust and confidence in government and public services (pp. 185–203). New York: New York: Routledge.
15. Manning N, Guerrero A (2013). Why do politicians reform? Do they know something about the drivers of trust in government? New York: Routledge, pp. 80–120.
16. Pryor C, Gurewich D (2004). Getting care but paying the price: how medical debt leaves many in Massachusetts facing tough choices. The Access Projec.
17. Saric J, Kiefer S, Peshkatari A, Wyss K (2021). Assessing the quality of care at primary health care level in two pilot regions of Albania. Front Public Health 9: 747689. DOI: 10.3389/fpubh.2021.747689.
18. Thomson S, Cylus J, Al Tayara L, Martínez MG, García Ramírez JA, Gregori MS, et al. (2023). Monitoring progress towards universal health coverage in Europe: a descriptive analysis of financial protection in 40 countries. Lancet Reg Health Eur 37: 100826. DOI: 10.1016/j.lanepe.2023.100826.
19. World Bank (2020). World Development Indicators 2020. Washington, DC: World Bank. [online] [cit. 2024-01-22]. Available from: https://data.worldbank.org
20. World Health Organization (2018). Health Systems in Transition: Albania Health System Review. Copenhagen: WHO Regional Office for Europe. [online] [cit. 2024-01-22]. Available from: https://www.euro.who.int/en/countries/albania
21. World Health Organization (2021). Vulnerability and health. [online] [cit. 2024-01-22]. Available from: https://www.who.int/news-room/questions-and-answers/item/vulnerability-and-health
22. Yakubu K, Durbach A, van Waes A, Mabunda SA, Peiris D, Shanthosh J, Joshi R (2022). Governance systems for skilled health worker migration, their public value and competing priorities: an interpretive scoping review. Glob Health Action 15(1): 2013600. DOI: 10.1080/16549716.2021.2013600.