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Review article

Transforming disability assessment in Albania: progress and challenges of the biopsychosocial model

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Abstract
Introduction: Disability assessment in Albania has traditionally relied on a medical model that conceptualises disability as a personal deficit arising from individual impairment. This model has been widely criticised for its stigmatising nature, inefficiency, and limited capacity to improve quality of life for persons with disabilities (PwDs). In 2019, Albania initiated a policy shift towards the biopsychosocial model, which recognises disability as the outcome of complex interactions among biological, social, and psychological factors.
Aim: This article reviews the progress of the biopsychosocial model's implementation in Albania since its inception, with particular emphasis on structural barriers and facilitating factors.
Methods: A literature review approach was adopted to synthesise legislative, administrative, and academic evidence on the biopsychosocial model's implementation in Albania between 2017 and May 2025.
Results: 37 multidisciplinary assessment teams have been established to provide services to PwDs. Financial assistance mechanisms have been operationalised with some success; however, the integration of health and social services remains a critical challenge. Key issues include limited services availability and the lack of a coherent referral system to connect individuals with available services. These shortcomings significantly limit the model's potential to enhance the well-being of PwDs.
Conclusion: This policy shift underscores the need for a multidisciplinary and holistic approach that enables context-sensitive assessments of individuals' needs. The article concludes with evidence-based recommendations to address these gaps, calling for a coordinated, multisectoral strategy aligned with the biopsychosocial framework to strengthen disability assessment and service delivery in Albania.

Keywords: Biopsychosocial model; Disability assessment; ICF; Integrated healthcare and social services; Multidisciplinary teams

Introduction

Disability assessment and management have undergone significant conceptual and practical evolution over time. The earliest framework – the medical model – conceptualised disability as a biological problem and a direct consequence of an individual's impairment (Brinkman et al., 2022; Dan, 2021; Slorach, 2024; Sulaiman et al., 2021). In this framework, medical practitioners served as the principal assessors, concentrating on bodily structures and functional abilities (ASET, 2024; Tedeschi and Limeri, 2024).

Conversely, the social model of disability, first articulated by Oliver (1983), shifted attention from an individual's impairment to the societal and structural barriers that restrict participation (Adam and Koutsoklenis, 2023; Beck, 2024). The social model emphasised prejudice, discrimination, and policy shortcomings as the main causes of disability, highlighting the need for systemic reforms that promote equity, accessibility, and inclusion (Costantino et al., 2022; Davies and Soni, 2025; Robertson and Jaswal, 2024).

While both models advanced the debate, each remains reductionist when applied in isolation. To address these limitations, Engel (1977) proposed the biopsychosocial model, which integrates biological, psychological, and social dimensions in understanding health and functioning. It positions disability within an interconnected system encompassing emotional states, cognitive processes, socioeconomic status, and environmental factors (Bolton, 2023; Dan, 2024; Lutte et al., 2024).

Although Engel initially laid the conceptual foundations for the biopsychosocial model, its application in disability assessment was formalised by the World Health Organization (WHO) in 2001 with the development of the International Classification of Functioning, Disability and Health (ICF). Unlike traditional disease-based classifications, ICF redirected disability assessment towards functioning and contextual factors, providing a holistic framework that has been increasingly adopted in health and social policy worldwide (Clanchy et al., 2022; WHO, 2001).

Following these global developments, Albania initiated a reform on its disability assessment system in 2019, adopting

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a biopsychosocial approach in accordance with the United Nations Convention on the Rights of Persons with Disabilities (UN, 2006) and the Albanian government's strategic priorities on disability rights and inclusion. Initially piloted in two administrative units in Tirana in 2017, the model's national rollout began in November 2019 in Tirana district (MSHMS, 2019). By 2021, the biopsychosocial model had been extended to Durrës and Elbasan, and by the end of 2022, it was implemented across all remaining districts, achieving full national coverage (SHSSH, 2023).

Objective of this article: This article reviews the progress of the model's implementation in Albania since its inception, with particular emphasis on structural barriers and facilitating factors. By synthesising relevant international literature, administrative data, and national reports, this article contributes to the limited but expanding body of literature on disability reforms in Southeast Europe. Albania's experience is contextualised within the wider literature on ICF-based assessment, providing policymakers and practitioners with evidence-based insights for strengthening disability assessment and inclusion models. Given the scarcity of documented case studies in the region, Albania's case offers a meaningful example of an ICF-aligned reform for neighbouring countries undertaking similar initiatives.

Materials and methods

This article adopts a literature review approach to synthesise legislative, administrative, and academic insights on the biopsychosocial model's implementation in Albania between 2017 and May 2025. Literature research was carried out across multiple databases, including PubMed, ResearchGate, BMC, ScienceDirect, Frontiers, Scopus, and Google Scholar. The search was conducted using keyword combinations such as: "ICF implementation" and "disability assessment Albania"; "biopsychosocial model" and "disability assessment processes"; "integrated services" and "disability assessment".

Given the complex nature of the reform and the limited availability of structured academic literature specific to the Albanian context, grey literature was included. This comprised official documents from the Ministry of Health and Social Protection and Council of Ministers; annual reports and statistical data from the State Social Service; technical reports from international organisations, and advocacy and monitoring reports produced by national NGOs working in the field of disability.

Grey literature and other articles (in English and Albanian) were retained if they were issued by recognised institutions or peer-reviewed journals, covered the period 2017–2025, and contained verifiable statistics or descriptions of reform processes, model application and integrated services provision. Exclusion criteria ruled out documents lacking data or policy relevance, as well as materials that merely duplicated statistical datasets without providing additional analysis. Applying these criteria, 61 references were retained for the final review, of which 44 were peer-reviewed publications and 17 were grey literature sources. Quality appraisal of grey literature was conducted by considering the issuing body's credibility, the transparency of data sources and methods, and the consistency of figures (with priority given to the most recent reports). For peer-reviewed studies, quality was assumed through the journals' standard editorial and peer-review processes.

The biopsychosocial model in Albania: innovations that enhance equity and quality of life of persons with disabilities

A people-centred and innovative approach to disability assessment

A defining characteristic of the biopsychosocial model is its people-centred and participatory approach to health and disability assessment. Unlike the traditional medical model, which relied solely on clinical records and professional judgement (K.M., 2020), the biopsychosocial model emphasises the active involvement of individuals in the assessment process (Kasongo et al., 2024; Kim et al., 2025; Sykes et al., 2021). Individuals are no longer passive recipients of diagnoses but become active participants in articulating their own health conditions and related challenges (Australian Interest Group, 2022; Forde et al., 2022). This participatory process is facilitated through a structured interview conducted by the multidisciplinary assessment team, during which individuals describe how their health condition affects various aspects of daily life, including self-care, mobility, domestic responsibilities, and social interactions (Forde et al., 2022; Saleeby, 2025; WHO, 2001). These self-reported experiences are evaluated alongside objective medical data, including referral forms completed by healthcare practitioners (MSHMS, 2019). This integrated assessment allows for a more holistic understanding of the individual's functional capacity and lived experience.

The biopsychosocial model also introduces improvements in efficiency. According to the Ministry of Health and Social Protection (MSHMS, 2019), the entire assessment process is intended to be completed within 30 days of the application's submission. Even in cases of appeal, the Multidisciplinary Complaint Review Team is expected to issue a decision within 30 days of receiving the complaint (Observatori për të Drejtat e Fëmijëve dhe të Rinjve, 2021). Nevertheless, the timeliness of complaint resolution may be affected by the volume of cases and the daily workload of the teams, suggesting room for further efficiency monitoring and adjustment.

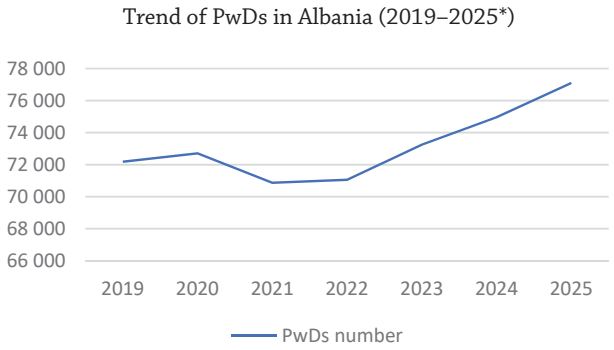
Streamlined application procedure

The new model streamlines the application and assessment procedure. The required medical examinations have been simplified, and notably, hospitalisation in tertiary care facilities is no longer a prerequisite for eligibility (MSHMS, 2019; Taukeni, 2019). Under current legislation, individuals initiate the process through their family doctor, who refers them to a specialist according to the health condition (K.M., 2019). These professionals complete a standardised disability assessment form, providing details of the medical history, ongoing treatment, and the degree of functional limitation in daily activities. These forms, along with specified objective examinations, are sufficient for submitting an application for the biopsychosocial assessment.

Improved geographical accessibility and proximity

Since the adoption of the biopsychosocial model in 2019, there has been a substantial increase in the number of PwDs assessed, continuing through to 2025 (Chart 1).

The trend graph illustrates the changes in the number of PwDs assessed between 2019 and 2025. As shown, the highest recorded increase occurred after the nationwide rollout of the biopsychosocial model in 2022, reflecting expanded assessment coverage and rising demand for disability-related services.



Source: Authors' elaboration based on State Social Service (SSS) statistical data on PwDs 2025, available on SHSSH (2025a).
* The data for 2025 refer to the period up to August 2025.

Chart 1 – Trend graph of PwDs assessed in Albania between 2019–2025

An innovation of the model lies in its emphasis on geographical accessibility and proximity. SHSSH (2022) notes that assessments in Albania are generally conducted in offices located close to the individual's place of residence. In cases where individuals face mobility restrictions, the multidisciplinary team is mandated to carry out home assessments, thereby ensuring that no one is excluded due to physical barriers. To support this approach, 37 multidisciplinary teams have been established and strategically distributed across Albania. The number of assessment offices in each district is proportionate to the local population of PwDs, as shown in Table 1.

A clear demonstration of the commitment to local accessibility is the establishment of the 37th disability office in Tropojë (Kukës District) in July 2023, following the previously excessive travel distances required for residents of Tropojë to reach the assessment office in Kukës (SHSSH, 2024). This development allows multidisciplinary teams to operate closer to service users, thereby enhancing access and reducing administrative burdens. Collectively, these measures underscore the biopsychosocial model's focus on individual engagement, timely assessment, and local accessibility, delivering a more inclusive and responsive system for disability assessment.

Establishment of multidisciplinary assessment teams – social workers role within RMDTs

A key innovation introduced by the biopsychosocial model in Albania is the establishment of multidisciplinary assessment teams, representing a notable shift from the traditional medical model, which relied solely on physicians (MSHMS, 2019). Under the new framework, each Regional Multidisciplinary Team (RMDT) comprises a physician, a social worker, a secretary, and a Head of the Assessment Office, who must hold a degree in either medicine or social work (ILO, 2021; MSHMS, 2019). This composition embodies the model's central principle: that disability arises from the interaction of biological, psychological, and social factors, necessitating an integrated assessment approach (Murniati et al., 2022; Otte et al., 2023; Seyed Alitabar, 2025; Smart, 2023).

Disability assessment is most effective when multidisciplinary teams integrate their respective expertise. Physicians assess the medical condition and the risks associated with the impairment, while social workers assess psychosocial factors, including family support and socio-economic circumstances, and consider how these factors impact the functional limitations of PwDs (Ashcroft et al., 2024). According to the regulations on the functioning of the biopsychosocial model, social workers within the RMDTs assess non-medical information to inform the determination of PwDs functional limitations. They assess rehabilitation opportunities and provide recommendations for services that can facilitate social integration. In addition to service recommendations, social workers liaise with educational institutions, employment services, and other relevant agencies to ensure continuous support for PwDs. Conversely, physicians within RMDTs review medical records and objective examinations and, in collaboration with social workers, conduct interviews to establish functional limitations and determine eligibility for social protection benefits.

In addition to the RMDTs, the system includes Multidisciplinary Complaint Review Teams, responsible for reassessing cases in which PwDs dispute either the level of benefit award-

Table 1. Distribution of assessment offices in proportion to the number of PwDs in each district

District	No. of PwDs	Estimated Population and PwDs per 1000 %	No. Disability Offices	PwDs per Office (Average no.)	Offices Locations
Tirana	13,309	912,000 (14.6)	6	2,218	5 in Tirana, 1 in Kavaja
Durrës	6,935	290,000 (23.9)	3	2,312	2 in Durrës, 1 in Krujë
Elbasan	13,768	420,000 (32.8)	6	2,295	2 in Elbasan, 1 in Gostima, 1 in Pajova, 1 in Librazhd, 1 in Gramsh
Lezhë	4,703	135,000 (34.8)	3	1,568	2 in Lezhë, 1 in Milot
Berat	3,642	120,000 (30.4)	2	1,821	1 in Berat, 1 in Dimal
Gjirokastër	2,003	62,000 (32.3)	1	2,003	1 in Gjirokastër
Kukës	2,654	73,000 (36.4)	2	1,327	1 in Kukës, 1 in Tropoja
Fier	8,962	310,000 (28.9)	4	2,241	3 in Fier, 1 in Lushnje
Korçë	5,948	200,000 (29.7)	3	1,983	2 in Korçë, 1 in Pogradec
Dibër	3,912	125,000 (31.3)	2	1,956	1 in Dibër, 1 in Mat
Vlorë	4,483	185,000 (24.2)	3	1,494	2 in Vlorë, 1 in Saranda
Shkodër	5,200	200,000 (26.0)	3	1,733	2 in Shkodër, 1 in Puka

Source: Authors' elaboration based on SSS statistical data on PwDs 2025, and INSTAT (2024)

ed or the outright denial of benefits (Observatori për të Drejtat e Fëmijëve dhe të Rinjve, 2021). These teams consist of one physician and two social workers. According to the State Social Service, the first Multidisciplinary Complaint Review Team was established in 2020 (SHSSH, 2021). In response to a significant rise in appeals following the nationwide implementation of biopsychosocial assessments at the end of 2022, two additional Multidisciplinary Complaint Review Teams were set up in 2023 (SHSSH, 2025b).

Enhanced benefits and service integration

A key advantage of the biopsychosocial model over the traditional medical model is its capacity to provide a more differentiated and equitable system of support, combining financial assistance with integrated healthcare and social services (Kim et al., 2025; Waddington and Priestley, 2021). Under the medical model, Albania offered only two levels of financial assistance, with little consideration of the degree of functional impairment or individual needs (ASET, 2024; MSHMS, 2019). By contrast, the biopsychosocial model introduces four distinct levels of financial assistance, determined by the severity of limitations in performing daily activities (ASET, 2024; K.M., 2019; Marotta et al., 2020). This approach promotes greater fairness and responsiveness, ensuring that support levels reflect more accurately an individual's functional capacity (Liu et al., 2025; UNICEF and TDRI, 2022). As MSHMS (2019) notes, under the revised system, individuals with mild limitations are primarily eligible for integrated services, whereas those with moderate to severe limitations receive both financial assistance and access to services.

The implementation of the revised benefit structure has, however, posed challenges. The reclassification of cash entitlements has provoked dissatisfaction among some beneficiaries, particularly those whose benefits were reduced. In 2024, approximately 3,000 complaints were submitted to the Multidisciplinary Complaint Review Teams (SHSSH, 2025c), highlighting the need for clear communication, ongoing support, and transparency in the administration of benefit reforms.

Beyond financial assistance, the biopsychosocial model enables multidisciplinary assessment teams to recommend integrated healthcare and social services tailored to individual needs. These may include physiotherapy and psychotherapy, assistive devices (e.g., hearing aids, prosthetics), developmental and speech therapy, education-related services, vocational training and employment assistance, as well as community-based, and residential social care services (MSHMS, 2019). This approach reflects a holistic understanding of disability, moving beyond symptom management to promote inclusion, autonomy, and participation in society.

Child assessments and age-differentiated benefits

In the early development of the biopsychosocial model, assessments initially focused on adults, with formal procedures for children introduced five years later (WHO, 2007). Today, the model is applied universally, including to children aged 0–2 years, through the ICF (WHO, 2001) and its child- and youth-specific version (WHO, 2007). The inclusion of children, particularly those under two, is regarded as one of the model's key innovations. As Hebbeler and Spiker (2016) emphasise, "children and adults are not affected in the same way by a given health condition". Consequently, disability assessments and associated benefits must account for these developmental differences, particularly since parents assume primary responsibility for a young child's care and development (Alehagen et al., 2025; Azhar et al., 2019; Damyanov, 2024).

In Albania, children aged 0–2 years were initially excluded from disability assessments during the early implementation of the biopsychosocial model. This exclusion prompted considerable advocacy from parents and organisations representing children with disabilities, beginning in 2018. Their efforts culminated in a policy response in February 2022, when an amended Decision of the Council of Ministers formally incorporated this age group into the assessment process (K.M., 2022). To ensure age-appropriate assessment, a new specialised assessment form was developed for children aged 0–2 years. It considers developmental stages and focuses on functional limitations relevant to infancy and early childhood. It omits domains such as self-care and domestic life, which are not applicable at this age, instead emphasising age-appropriate indicators of functioning to determine eligibility for financial assistance and support services. The integration of early childhood assessment into the national framework represents a critical step towards a more inclusive and developmentally sensitive disability assessment system in Albania.

Gaps and challenges in the implementation of the biopsychosocial model of disability assessment in Albania

Human resource challenges

Implementing a disability assessment system based on the biopsychosocial model requires substantially greater human resources compared with the traditional medical model, due to its reliance on multidisciplinary collaboration and comprehensive evaluation across multiple life domains (Alehagen et al., 2025; UNICEF, 2023). Under Albania's former medical model, disability assessments were centralised and conducted by a limited number of physicians, primarily based in Tirana (K.M., 2020). By contrast, the introduction of the biopsychosocial model necessitated the establishment of 37 multidisciplinary assessment teams nationwide, each comprising a physician and a social worker, totalling 74 professionals across the country.

Human resource constraints remain a significant challenge. A shortage of qualified personnel is a widely recognised barrier to the effective ICF-based assessments (Damyanov, 2024; Hiragami and Macdonald, 2025; Jafri and De Camargo, 2020; Syed et al., 2020). According to the State Social Service Annual Report (2023), in Albania only nine of the 37 (approx. 24%) physicians are engaged full-time within the assessment teams, while the remaining 28 serve as full-time practitioners in public health centres and participate in assessments on a part-time basis. The Multidisciplinary Complaint Review Teams were established by an administrative order of the General Director of the State Social Service, indicating that they do not constitute a permanent, sustainable institutional structure (SHSSH, 2024). Similar to physicians, social workers in the Multidisciplinary Complaint Review Teams work on a part-time basis, as they also hold other functional responsibilities within their institution. This dual workload limits their availability and may compromise the quality and timeliness of assessments.

Integrated services and follow-up mechanisms

Several initiatives have been undertaken to develop and expand integrated healthcare and social services under the biopsychosocial model of disability assessment. A central mechanism in this effort is the Social Fund, a financial instrument established in 2019 to support local authorities in creating new services or expanding existing ones. According to the so-

cial services map in Albania, between 2023 and 2024 a total of 79 new services were developed, 33 of which specifically target PwDs. By 2025, the number of services funded through the Social Fund had reached 36 (SHSSH, 2025b).

In addition to the Social Fund, efforts have been made to enhance inter-institutional coordination. At the end of 2022, a series of cooperation agreements were signed with key stakeholders, including municipalities and Regional Directorates of Employment and Skills. However, comparable agreements with the Regional Educational Directorates and Compulsory Health Care Insurance Fund have yet to be finalised (ibid).

Although integrated services constitute a core component of the biopsychosocial model, their availability remains a major challenge (ASET, 2024; MSHMS, 2019). At present, service coverage is inadequate at the national level, with the personal assistant service being the only provision consistently accessible across the country (delivered as a cash benefit to the designated assistant). Furthermore, approximately 50% of existing services are provided by non-governmental organisations (NGOs) (Hartley, 2011). Such reliance on NGOs renders service provision both unsustainable in the long term and unevenly distributed geographically. Many municipalities do not offer any services for PwDs, even when such services are explicitly recommended by multidisciplinary teams. Where services do exist, they are predominantly focused on children, with a notable absence of services for individuals over 18 with mental health conditions (SHSSH, 2024).

Another critical barrier is the lack of a formal referral mechanism, which prevents individuals from accessing available services in a systematic and timely manner. For example, although *"the hygiene and sanitation package"* is intended to be part of the support system, it has yet to be implemented due to unresolved issues regarding its costing and whether it will be provided in kind or as a cash benefit (ibid). The policy document on disability reform in Albania stipulates that the hygiene and sanitation package will be delivered in kind through the pharmaceutical network (MSHMS, 2019). Management of this benefit, along with the distribution of assistive devices, is assigned to the Compulsory Health Care Insurance Fund to prevent misuse. At present, however, there is no documented evidence (in either the academic or grey literature on Albania's biopsychosocial model) that the hygiene and sanitation package or assistive devices have been provided in practice. Collectively, these structural and procedural limitations significantly undermine the biopsychosocial model's potential to deliver comprehensive, person-centred care, and they continue to impede improvements in the well-being and social inclusion of PwDs.

Limitations

This review has several limitations that should be acknowledged. First, the body of peer-reviewed literature on disability assessment in Albania is limited. Consequently, a substantial portion of our analysis draws on grey literature (government documents, statistics, reports, etc.), which was essential to capture the details of the disability reform process but may carry institutional biases or reflect political considerations.

Second, the literature reviewed was restricted to publications in Albanian and English, which may have led to the exclusion of relevant studies in other languages or contexts that could have enriched the analysis.

Given that this article relies on a literature review, future research could benefit from including a broader range of sources and possibly primary data to validate and supplement the findings presented here.

Discussion

The findings underscore Albania's transition from a medical model of disability assessment to a biopsychosocial approach, reflecting international human rights principles and aligning with the WHO's ICF classification. This shift mirrors global trends in disability policy while supporting Albania's social inclusion priorities. Consistent with international evidence, the new assessment model in Albania has enhanced fairness in eligibility determination (ASET, 2024; Liu et al., 2025; UNICEF and TDRI, 2022) and begun to integrate cash benefits with services (Kim et al., 2025; Otte et al., 2023; Waddington and Priestley, 2021), thereby contributing to improvements in the quality of life of PwDs. The inclusion of early childhood assessments, including children aged 0–2, places Albania among the countries that are gradually aligning disability assessment procedures with developmental needs across the life course (Alehagen et al., 2025; Azhar et al., 2019; Damyanov, 2024).

Nevertheless, persistent gaps constrain the full realisation of the model's objectives. Human resource shortages, particularly the reliance on part-time physicians and social workers, mirror challenges observed in other countries adopting ICF-based assessments (Hiragami and Macdonald, 2025; Jafri and De Camargo, 2020; Syed et al., 2020). International evidence underscores the pivotal role of social workers in multidisciplinary teams – *conducting psychosocial assessments, making referrals, and coordinating services* (Ashcroft et al., 2024; Hassan et al., 2020; Ramachandran and Das, 2024). Thus, the part-time engagement of key professionals may be impeding the model's full potential. Likewise, the sustainability of Multidisciplinary Complaint Review teams remains uncertain, given their current ad hoc institutional arrangements.

The uneven development of integrated services in Albania, combined with heavy reliance on NGOs, reflects patterns seen in other low-and middle-income contexts where systemic capacity lags behind policy ambitions (Costantino et al., 2022; Hartley, 2011). Although significant progress has been made through the establishment of the Social Fund, service coverage remains limited. Weak inter-institutional coordination, particularly with education and health authorities, continues to hinder the practical implementation of the biopsychosocial model. The lack of a formal referral mechanism and unresolved issues related to the hygiene and sanitation package further illustrate the gap between policy intent and practice.

In addition to these operational gaps, the reform faces deeper institutional and political obstacles. Albania's decentralised system of social care means that implementation relies on strong engagement and capacity at the municipal level. Some municipalities have been slow or unable to establish the services recommended by assessment teams, reflecting disparities in local resources and highlighting the challenges of decentralisation in executing national reforms. Furthermore, sustaining political will has been essential. Changes introduced by the reform, such as the differentiation of benefit levels (which led to reductions for certain individuals), have encountered resistance from affected beneficiaries. Such dynamics risk slowing or diluting the reform unless there is continued high-level commitment and stakeholder engagement. Overcoming these institutional and political barriers is crucial for fully realising the biopsychosocial model's objectives. For these reasons, Albania's case highlights the need to accompany disability assessment reforms with broader service development, workforce investment, and coordination mechanisms to bridge the implementation gaps between policy and practice.

Policy recommendations

In summary, Albania's biopsychosocial model is still in a post-transitional phase that requires targeted interventions to realise its full potential. To address the remaining implementation gaps, the following actions are recommended:

- Strengthen referral mechanisms and service integration: Develop a formal national referral system to ensure that PwDs can promptly access the services recommended by multidisciplinary assessment teams. All planned support measures (such as the hygiene and sanitation package) should be operationalised with clear guidelines and appropriate funding models, and inter-institutional agreements (particularly with health and education authorities) should be finalised to facilitate integrated service provision.
- Invest in human resources: Strengthen the workforce underpinning the biopsychosocial assessment system. This entails recruiting and retaining full-time physicians and social workers for the Regional Multidisciplinary Teams, providing ongoing training on ICF-based assessment, and institutionalising the Multidisciplinary Complaint Review Teams within the social protection system to ensure their sustainability and authority. Adequate staffing and capacity-building are critical to maintain the quality and timeliness of assessments.
- Support local service provision: Encourage and increase support for local government to develop new services or expand existing social care services tailored to PwDs needs.
- Implement robust monitoring and evaluation: Establish continuous monitoring and evaluation mechanisms to support evidence-based refinement of the disability assessment system. Establish mechanisms to systematically collect and analyse data on assessment outcomes, user satisfaction, etc. This data should inform ongoing improvements and policy adjustments to ensure the system responds to needs and supports inclusion.

Conclusion

The implementation of the biopsychosocial model of disability assessment in Albania represents a significant paradigm shift from the traditional medical model, bringing national policy into alignment with international standards such as the UN Convention on the Rights of Persons with Disabilities and the WHO's ICF framework.

The new model has introduced several important innovations, including the establishment of multidisciplinary assessment teams across the country, the extension of assessments to children under 2 years of age, the introduction of four differentiated levels of financial assistance based on functional limitations, and integrated health and social services as part of the assessment process.

These changes have laid the groundwork for a more holistic, inclusive, and equitable disability assessment system. However, the reform's implementation has also revealed critical structural and operational challenges. Human resource shortages (especially the reliance on part-time professionals), the absence of formal referral mechanism, and insufficient service coverage (particularly for adults with certain needs, such as mental health conditions) continue to undermine the model's full impact. A high volume of appeals regarding benefit level decisions indicates a need for clearer communication with beneficiaries and better support during the transition to the new system, and potentially, policy adjustments.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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