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FINAL REPORT

"IMPROVING PUBLIC EXPENDITURE EFFECTIVENESS IN HEALTH SECTOR

(Case of Albania)"

Submitted

By

2A Consortium

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Dear Friends and Colleagues,

This draft project report shows the current status of 2A (ACER and ASET consortium) work during the implementation of the project entitled: ***"Improving Public Expenditure Effectiveness in Health Sector (Case of Albania)".*** The document reflects the intensive efforts and activities of 2A staff over the last six months, but it will be finalized especially during The Brookings Institution workshop, which will be held on 16 - 19 June 2008. In addition, the report reflects also the main conclusions of the several papers and reports done recently on health sector development in Albania, including 2008 Annual Review of Health Sector performance in Albania (unpublished).

Through the upcoming workshop ACER is expecting an open and professional debate for all civil society organizations involved in the project, in order to reflect over strengths and weaknesses, advantages and disadvantages, achievements, successes and future challenges of the PETS in specific countries.

The ACER expresses its gratitude to The Brookings Institution who contributed directly to strengthening and making ACER and ASET a capable Albanian consortium that operates successfully in the field of budget monitoring and increase of its transparency and accountability. In addition, this report will represent a significant contribution to the future project and activities to be carried out by us, as well as to the mass-media communication with the broad public, in order to improve budget planning and its expenditure effectiveness.

ACER welcomes all comments and suggestions, which hopefully will make the consortium even more successful in achieving its objectives for the benefit of the Albanian society and communities.

Dr. Zef Preci,

Executive Director of ACER
Project Lead Partner

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ACER also thanks the directors and the personnel of health public institutions involved in the implementation of the PETS project for their precious contribution in acknowledging problems, providing experience and valid suggestions to improve the efficiency of health sector in Albania.

Finally, ACER expresses its gratitude to Prof. Fatmir Memaj, President of ASET and its staff, for the step-by-step support in the process of the project's design and its successful implementation.

Abbreviations and Acronyms

ABC	Activity based costing
ACER	The Albanian Center for Economic Research
ASET	Albanian Socio-Economic Think Tank
CIA	Central Intelligence Agency (US government)
CSP	Committee of Strategic Plan
Gini	Coefficient
GSBI	The Groups for Strategy, Budget and Integration
GSBI	The Groups for Strategy, Budget and Integration
HII	Health Insurance Institute
HTMP	The Head of Team of Management Programme
IHCI	Institute of Health Care Insurances
IMF	International Monetary Fund
INSTAT	The Albanian Institute of Statistics
IPH	Institute of Public Health
IPS	Integrated planning System
MBP	Middle-Terms Budget
MoF	Ministry of Finance
MOH	Ministry of Health
MTEF	Medium Term of Expenditures of Framework
OECD	Organization for Economic Cooperation & Development
PETS	Public Expenditure Tracking Survey
PHC	Primary health care centers
SII	Social Insurance Institute
SPSS	The statistical processing software
USAID	United States Agency for International Development
WHO	World Health Organization

1. ABSTRACT OF THE STUDY

1.1. Main assumptions

The role of the Albanian Budget project reflects, in part, the recent dramatic transformation of the Albanian society: the decentralization process. One key element of this process is the finances decentralization. This process is taking place accompanied by a variety of problems and deficiencies that partly give way to public funds leakages.

Some of the problems encountered from the Central Government Budget are as follows:

a) Rather than being a function of specific policies and programs, budget allocations largely follow historical trends;

b) Despite some recent efforts to institute participatory processes around budget formulation, the budget itself remains the business of a handful of experts. There is little interaction with local governments and the entire process remains opaque and highly discretionary. Not to mention here the fact that planning and implementing are kept as two separated processes not necessary linked with each other.

c) Although on the face of it, appears as though public investments match priorities set in the sectorial and national strategies, in fact political rather than economic and social considerations come into the fore play which leads to severe deformations and neglect for the real needs in the country. This makes Health Care services operate under a visible shortage of financing.

As so, the need to strengthen monitoring and evaluation systems of Government activities is imperative.

On the other side, the decentralization process means more stakeholders included in the budgeting process, which by no means can be achieved by the transparency of the process, and the increase knowledge and consciousness within the civil society groups and citizens. The civil society supervision and involvement in this process will be a crucial counterweight and instrumental in improving governance. Part of this picture, is the Health Service which is the focus of this study.

Since the beginning of the transition managers of the health services have been facing challenges to reform both the organizational and the operational aspects of the health systems, due mainly to the reduction of resources assigned not only to the health sector but also to all other social policies, as well. Add to this, the uncontrollable increase of the expenses with medical care and the changes in the demographic and

epidemiological profile of the populations. As a consequence, the search for more equitable alternatives that can ensure a better provision of high quality services have become peremptory, given the increasing social inequalities.

Besides focusing on re-establishing service delivery, the government attempted to overcome the health system weaknesses through several reform processes. Those different reforms pursued changes in the financing system, a reduction of the excess capacity of the provision network, some decentralization and the introduction of some private initiative in the delivery of health care. However, the reforms only had a partial impact and the progress has been limited, with little or no major improvements perceived by the population. Diagnostic and curative health service is organized in three levels: primary health service, secondary and tertiary hospital services. It is equally important for both, the private sector, and the public sector.

Albania has a national scheme of social insurance that is not consolidated and with a lot of shortages. As far as the public service is supposed to be covered partly by the funds coming from this scheme, its efficiency is of vital importance.

In general, it can be concluded that there are many problems with managing the financial resources in the Health services in Albania.

The main goal of this project is the improvement of the effectiveness of the allocation and use of the public budget in the Albanian primary health sector through monitoring and analyzing the expenditure with the appropriate institutions. To the extent possible it will be educated and enabled the civic groups working in the health sector to exercise their role of pressuring the Government of Albania in misusing the public expenditures and to better allocate them in order to have a better service provision.

1.2. Project objectives

Overall analytical project objectives are the following:

- Contribute to de-mystification of the technicalities of budget readings and increase transparency of legislative and procedural steps leading to budget formulation in the health sector.

- Administration of an assessment on the budget expenditures for 53 primary health care centers, hospital services and local government units, and preparing the proper recommendation with regard to policy changes and asking for a more transparent process.

- Increased government transparency and accountability through launching of a comprehensive report. The utilization of civil society

and media organizations existing network to establish permanent monitoring mechanisms to disseminate the main findings of Public Expenditure Tracking Survey.

- Compiling the resulting data gathered and analysis by the 2A experts' team to build a set of benchmarks of public expenditure effectiveness in health sector that can be used later by TAP. Preparation of a comprehensive report with findings and recommendations and the dissemination of the results to the proper institutions.

1.3. Main hypothesis:

A sizeable share of the funds intended for health care services/facilities do not reach their intended destination.

As the service quality is deteriorating and the reporting of illegal payment for the services is increasing, we can assume there is corruption that accompanies the mismanagement of the sector, at all levels. There is no transparency in financing the Health Sector in Albania.

We can also assume that there is no harmony in operation of different levels of the Health Care System. Public investment priorities in the Health Sector do not match sector and national strategies. They do not consider economic and social trends, but mostly the political interests.

1.4. Key issues to be addressed

- There is a mystification of the technicalities of budget readings that harms the transparency of legislative and procedural budget formulation in health sector.

- The role of the Local Government as a partner in the primary health service has declined. Their health budget is insignificant.

- Budget allocation follows historical trends, without considering specific programs and policies. Local Government is not considered as a partner.

- There is a bad time allocation of funds in the health sector that lowers the effectiveness of the service.

- Policy changes are needed to make the process more transparent.

- The monitoring mechanisms need to be enhanced, and become permanent.

- There is not a body of knowledge within the civil society groups, to make them capable of active participating in the process of planning and monitoring expenditures.

- A set of benchmarks of public expenditure would contribute to increase the consciousness of all the stakeholders.

- MoH devotes most of its efforts to health care administration rather than to policy and planning.

2 THE IMPLEMENTATION OF PETS IN THE SECTOR OF HEALTH

2.1 Demography, poverty and health indicators

2.1.1 Demography

Albania is situated in the south-western part of the Balkan Peninsula, covering 28,748km², of which 34.8% is comprised of forest, 15% of pasture, 24.3% of agricultural land and 4% of lakes. The landscape is mainly mountainous which cover 76,6% of its territory. The average altitude of Albania is 708 meters, or twice that of Europe.

The 2001 Census put Albania's population at 3,063 million. Based on projections from Census, the population was estimated at 3,134 million in 2005 and is expected to increase to about 3.7 million by 2025. While Albania remains one of the youngest countries in Europe (the average age is 31.7 years old - INSTAT, "Shqiperia ne shifra" 2005 (Albania in Figures) the population's age structure has changed significantly in the past decade. The population below 15 years of age is now decreasing and the population over 65 years is growing faster than the rest of the adult population (the number of people over 65 years of age is expected to double in the next 20 years), but is still characterized by a relatively young population.

Table 1:
Population by sex and five year age groups, 2001 – 2005

Group age	Years				
	2001	**2002**	**2003**	**2004**	**2005**
< 15 years	905,131	889,633	870,531	851,281	831,046
15 - 64 years	1,930,755	1,958,058	1,988,066	2,015,454	2,043,034
> 65 years	227,432	236,458	244,180	252,808	260,902
Total	3,063,318	3,084,149	3,102,777	3,119,543	3,134,982

Source: *INSTAT*

Albania's demographic profile is characterized by three main phenomena:

- large internal and external migratory waves
- improving mortality rates
- declining fertility rates

The Albanian population is still predominantly rural population. As such, about 55% of the population lives in rural areas, based on INSTAT data. As regards, having 55% of its population living in rural areas (2004 year), Albania has one of the highest rural population shares in Europe and the highest in the Balkans. Over the past 15 years, about 20 percent of adults have moved internally. This means that about 450,000 individuals currently reside in a place different from where they were in 1990 (World Bank Report: Albania-A Poverty Assessment, December 3, 2007)**.** In the circumstances of severe economic crisis, migration from the rural areas has resulted in weakening the village social structures and chaotic life of the city, while putting pressure on the social and physical infrastructure. Therefore, health and social services, infrastructures have only a modest added capacity, so the quality and delivery of those services throughout Albania is deteriorating (although this is more obvious in rural areas). However, the urban population has grown rapidly, from about 35.8 percent in 1989 to 45 percent in 2004. Only the Tirana region now accounts about one-fifth of the total population. The external migratory is being estimated -4.41 migrant(s)/1,000 populations in 2008 (CIA-The World Fact book).

Population growth and fertility rates have been falling, but Albania still has one of the highest fertility rates in Europe**.** The population growth rate has been declining steadily, from above 3 percent in the 1960s, to slightly over 2 percent between 1970 and 1990, and to about 0.538% (CIA-The world fact book) since then. Due to migration, the overall population dropped by over 200,000 between 1990 and 2005.

Table 2: Fertility Rate in Albania and Neighboring Countries (2000-2005)

Country	**2000**	**2003**	**2005**
Albania	2.4	2.0	1.78
Bosnia and Herzegovina	n.a	1.3	1.19
Croatia	1.39	1.33	1.42
Greece	1.32	1.28	1.34
Romania	1.3	1.3	1.32
Serbia and Montenegro	1.4	1.6	1.5
Slovenia	1.6	1.2	1.26
FYR Macedonia	1.9	1.75	1.6
Italy	1.26	1.28	1.32

Source: *WHO HFA database*

2.1.2. Poverty

Current GDP per capita in Albania is US$ 2,673 (Source: IMF, World Outlook Database, September 2006), by ranking Albania at the 93-th position from 182 countries.

Table 3: Recent economic indicators 2003-2008

Indicators	2003	2004	2005	2006	2007	2008
GDP (US$bn) (current prices)	5.7	7.3	8.2	9.1	10.6	12
GDP PPP (US$bn)	14.8	15.5	16.9	18.3	19.9	21.5
GDP per capita (US$)	1,835	2,342	2,620	2,892	3,354	3,761
GDP per capita PPP (US$)	4,781	4,981	5,389	5,808	6,290	6,767
Real GDP growth (% change YOY)	5.8	5.7	5.5	5	6	6
Current account balance (US$m)	-296	-292	-545	-535	-877	-991
Current account balance (% GDP)	-5.2	-4	-6.6	-5.9	-8.3	-8.3
Goods & services exports (% GDP)	20.5	22	22.2	25.2	na	na
Inflation (% change YOY)	2.3	2.9	2.4	2.4	2.9	4.2

Source: *Compiled by the Market Information and Analysis Section, DFAT, using the latest data from the ABS, the IMF and various international sources*

Albania's impressive growth performance was accompanied by similarly impressive improvements in living standards. As a result, the real consumption doubled, the extreme and absolute poverty declined sharply, poorer areas narrow the distance between themselves and their neighbors and access to some essential services was improved, though slowly. At the same time, urban growth rates surged much faster than rural growth rates and led to a widening of the urban and rural gaps in welfare. The general decline in poverty was observed in rural as well as urban areas and in all the four agro-ecological regions of the country. However, the majority of the poor people continue to live in rural areas. Differences in the rate of poverty reduction have indicated that time by time the distribution of the poor people living in rural areas has actually increased, not declined. Moreover, the Gini measure of inequality already low, increased modestly and remained around 30 percent. The profile of the poor people shows that the poor are mainly those who live in large households, in rural areas and possess low skills, measured by the levels of education completed.

Table 4: Rates of Poverty Reduction in Rural and Urban Areas 2002 and 2005

Poverty by Rural/ Urban	Years		Change in Poverty	
	2002	2005	No. of Persons	Percent Change
Total population in poverty	813,196	575,659	-237,537	-29.2103
Urban	257,690	151,811	-105,879	-41.08774
Rural	555,506	423,848	-131,658	-23.70055

Source: *World Bank staff estimates using survey data, December 2007*

2.1.3. Health indicators

The health situation highlights problems mainly because of the difficult period of transition, though the main indicators show that the elementary health and hospital services are improving. There are some important indicators, the level of which is comparable with those of developed countries such as: longevity, mortality, chronic morbidity, and others like infantile mortality, maternal mortality and acute contamination morbidity, which are comparable with the levels of developing countries. A positive indicator is the decrease of contamination morbidity and their reduction, which is prevented by the vaccines.

A group of diseases continue to be an increasing indicator such as: breathing apparatus diseases, gastrointestinal, infective, urogenital, blood circulation. The statistics illustrate that in relative terms a high amount of death and diseases in Albania, are a consequence of: smoking, abusing with the alcohol, careless in the street, use of illegal drugs, way of eating, and stress as a new phenomenon of the modern society. The physical inactivity is a risk factor, because it presents a potential problem for the hypertension, coronary heart diseases etc.

Based on statistical data on live births, it is obvious that their number is declining. There are many causes to explain the decline of this index like: high values for migration of fertile population, increase of marriage average age for both men and women, application of family planning methods, etc. Statistical data on mortality, according to gender, indicate that in the total mortality rate, the mortality in man is higher, a ratio 3 to 2 of those of woman.

Life expectancy in Albania is favorable compared to other low and middle income countries**.** Official Albanian statistics show a life expectancy at birth of 75.7 years in 2003 with a female life

expectancy of 76.4 years and a male life expectancy of 71.7 years. The Albanians enjoy the longest life expectancy in the Balkans following by Slovenia, above the average for the entire European region and just 2 years below the average for EU countries. WHO estimates illustrate a completely different picture, with life expectancy in Albania being the lowest in the Balkans, 3 years below the average for the entire European region and 8 years below the average for the EU countries.

In several cases, there is a lack of recent data concerning different indicators, which complex the trends analyses for different phenomenon, as well as the comparing with other countries. On this purpose, in the table below there are data for Comparative Health Expenditure Indicators 2004.

Table 5: Comparative Health Expenditure Indicators, Albania and Comparators, 2004

Countries	Total health expenditure as % of GDP	Total health expenditure, PPP$ per capita	Public sector health expenditure as % of total health expenditure	Public sector expenditure on health as % of total govt. expenditure
Albania	6.7	339	44.1	10
Bosnia and Herzegovina	8.3	603	49.4	9.8
Croatia	7.7	917	81	14.1
Greece	7.9	2179	52.8	10.7
Romania	5.1	433	66.1	11.1
Slovenia	8.7	1815	75.6	13.8
FYR Macedonia	8	471	71	17.1
European Region	7.69	1668.33	68.1	12.59

Source: *WHO database*

Observing the public expenditures data on health (Table 5), it results that Albania is under the level of its neighbors as well as under the average of the European region. However, the health sector is considered as a priority sector in the strategic documents of the Government. Moreover, the expenditures composition generates huge lacks of efficiency. By excluding the percentage of expenditures for health in the total government expenditures (Bosnia Herzegovina follows), also in all the other indicators Albania is under this level. This is a summary conclusion even for the other health indicators related to the weak performance of the health institutions and their standards for services.

An analysis of the Albanian population's health status and the main health challenges is rendered difficult by data limitations. The available data on the population's health status

are scarce and often of questionable reliability. There is a need to establish a reliable health information database, which could help to guide sectoral policy and investment decisions.

2.2. The system of public expenditure distribution in health sector

One of the main objectives of the health policy in Albania is the creation of appropriate opportunities and conditions in order that health services could be use from the population.

Public sector expenditures on health as a share of GDP have risen only slightly in the last 5 years, from about 2.2 percent in 2000 to an expected 2.79 percent in 2008 and remain substantially below European and middle income country averages. Health sector expenditures have increased from a low 7.2 percent of consolidated government spending in 1999 to an expected *9.8* percent in 2008, thus still remaining substantially below of the majority other countries in Europe as well as in the CIS (average 12.1 percent). Although Albania's National Strategy for Development and Integration has singled out health as a priority sector together with education, the budget execution ratio for health has remained substantially below that in most other sectors over the past 5 years. This suggests that over most of the past 5 years, health sector expenditures were not protected when resource constraints called for overall budgetary adjustments. To the extent that the bulk of the adjustments were made on the investment side, the poor budget execution ratio may also partly be due to inefficient capital budget execution by the MOH.

Sectoral funding remains fragmented and financing responsibilities have changed often over the past 5 years. The main source of public sector funding is the state budget, which over the past 5 years has accounted for about 93 percent of public spending on health care while about 7 percent has come from non-budgetary sector employer and employee contributions to health insurance.

The principal public sector financing agents are the MOH (about two-thirds of public spending) and the HII (somewhat over one-quarter). The Ministry of Defense and the local governments (actually the local government doesn’t have any role and responsibility and of course doesn’t expenditure) have each averaged another 3 percent over the past 5 years. The financing responsibilities of local governments in the health sector have frequently changed over the past few years, which at times have led

to uncertainties and irregular resource flows, particularly at the primary care level. Former public sector funding assignations are summarized in Table 6, and current public sector funding assignations are summarized in Table 7. The fragmentation and frequent changes have tended to create uncertainty among providers and patients, leaving ample room for abuse. They have also prevented the introduction of a coherent system of provider payment mechanisms, which could encourage increased efficiency, quality improvements, and coherent provider performance oversight.

Table 6: Public Sector Funding Responsibilities in the Health Sector until 2005

	MOH	MoD	HII	Local Governments
2000-2001	• Salaries of health sector professionals, except general practitioners, PHC staff in Tirana and Durres hospital • operating costs • capital investments	Military hospital	• GP salaries • Prescription drugs • Tirana PHC • Durres hospital	
2002-2003	• Salaries of health sector professionals, except general practitioners, primary care staff in Tirana, & staff of Durres hospitals • operating costs for hospitals, except Durres • capital investments	Military hospital	• GP salaries • Prescription drugs • Tirana PHC Durres hospital	PHC operating costs
2004	• Salaries of health sector professionals, except GPs, PHC staff in Tirana and Durres hospital staff • operating costs for PHC and hospitals, except Tirana PHC and Durres hospital • capital investments	Military hospital	• GP salaries • Prescription drugs • Tirana PHC • Durres hospital • As of mid year also high end diagnostics	
2005	• Salaries of health sector professionals, except GPs, PHC staff in Tirana and Durres hospital staff • operating costs • capital investments in hospitals	Military hospital	• GP salaries • Prescription drugs • Tirana PHC • Durres hospital • high end diagnostics	PHC capital investments via conditional grants from central government

Table 7: Public Sector Funding Responsibilities in the Health Sector 2006-2008

Description of health services	MoH	MoD	HII
Primary Care and Public Health	- Salaries of staff other than GPs, - Operating costs - Investments in primary care facilities - Facilities maintenance		- Salaries of staff other than GPs, - Operating costs - Facilities maintenance
Hospital Care	- All hospital care except Durres and Military hospital	-Military Hospital	- Durres Hospital - 12 high cost tertiary care diagnostics for HI beneficiaries
Prescription Drugs			- Reimbursements forHI beneficiaries

As seen from the table No.7 the financial scheme in the two last years has changed. As such, the Institute of Health Insurances has undertaken more competences as it has had two years before, while the local government units barely have any task and competence in the health service sector. The local power can finance (it's not a legal obligation) for infrastructure, which provides an indirect way to the health service.

Overall, public sector spending has become somewhat more skewed towards hospital spending over the past 5 years. Albania allocates about half of all public sector spending on health to hospital care (compared to an OECD average of 38 percent). The trend over the past 5 years has been a growing share of public spending available to hospital care and prescription of drugs, at the expense of the primary care. Recurrent expenditures for hospital care posted a real growth rate of 26 percent, compared to primary care and public health expenditure growth of 12 percent. The emphasized decline is of concern in an environment in which the population has lost trust in primary care, due to quality concerns and the frequent absence of essential supplies at primary care facilities. A particular concern is also the fact that the budget

execution ratio for non-wage recurrent costs at the primary care level has consistently been below that of hospital care. This has resulted in many primary care facilities while lacking even the most essential supplies to effectively provide care, particularly in rural areas. Therefore, it has contributed to a situation in which much of the population, particularly in rural areas, circumvents primary care facilities in search of better care at higher end facilities. The decrease in emphasis on primary care spending appears to go counter to the Government's stated objective to strengthen the role and performance of primary care to enhance overall cost-effectiveness in the use of limited public sector resources. It also raises questions of how efficiently public sector funds are utilized.

Public sector health spending per capita varies markedly by district and region. Even when Tirana, where the country's tertiary care facilities which serve the entire country are located is excluded, public sector recurrent expenditures on health care per capita vary by a factor of two between Albania, have publicly financed and administered health insurance programs. These programs are based on the concept of social insurance in which citizens are expected to contribute according to their ability to pay, and receive basic health services.

Social insurance contributions (by employers, employees, the self-employed, pensioners, the unemployed and other groups) are the main source of health financing. At the moment they are partly funded through the 3.4% payroll tax, and partly from a yearly general budget transfer. The financing realities in these broader contexts will have to be taken into account when considering alternative ways to finance HII benefits. Contributions for vulnerable groups and funding for special programs (such as public health programs) are made through the general budget.

A key objective o f the health policy of many countries, including Albania, is to ensure that its population has adequate access to essential health care services and is protected from the impoverishing effects of health expenditures. The Government can substantially influence these objectives with its health finance policy. The mixture of public and private spending, the share of pre-pooled funds versus out-of-pocket spending at the point of service, the mechanisms utilized to allocate public and pooled funds and to pay providers have a direct bearing on the effectiveness and efficiency with which a health care system achieves health outcomes and affords its population safety from the impoverishing effects of health shocks.

General revenues account for over 90 percent of public sector funding, despite a mandatory contributory health insurance system. General revenues have funded about 93 percent of public sector spending over the past five years, while social health insurance contributions from non-budgetary sector employers, employees, farmers and the self-employed have amounted to about 7 percent.

While contributions account for somewhat over half of all HII resources, only about 30 percent of HII funds do not come from general revenues, as a significant share of contributions are those for public sector employees.

In Table No.8 are presented the Public Expenditure on Health by source and Financing Agents during the period 2000-2008. According to this table the financing of the Health sector have increased yearly. As such, in 2008 was doubled in absolute value comparing with 2000 and it has increased progressively as a percentage of GDP. However, in 2008 it results a decrease of financing as a percentage of GDP, although in absolute value it has increased, due to the fact that the increase of health sector is lower compared to the increase of the total budget. The most important financing in the health sector is made from the Ministry of Health. As such, approximately 76% of them are made from the Ministry of Health, 20% from the Institute of Public Health, and 4% from the Ministry of Defense.

In the expenditure structure for the health sector, the expenditures for the investments represent a small weight which has changed from 13% in 2006 to 12% in 2007 and 20% in 2008, but they have been increasing yearly in absolute value. The expenditures for investments among years are made mainly from the interior sources. While the foreign investments have been fluctuating, rising and declining. As such, in 2000 they represtented in total 52% of investments in the health sector, during 2001-2003 37% of investments, 2005-2006 only 18% and in 2008 they are planned to be 44%. It is worthy to mention that the expenditure from the Institute of Public Health incomes have been increasing, rising by 53% in 2008 compared to 2004. Also, the Institute of Public Health intends to improve the financial scheme for the Primary Health Service as a whole. The number of employees in this sector since many years continues to be the same, which evidently shows a lack of structural reforms in the sector.

Table 8: Public Expenditure on Health by source and Financing Agents 2000-2008 (In million leke)

No	Description	2000	2001	2002	2003	2004	2005	2006	2007	Plan 2008
I.	Total of expenditures of Ministry of Health	11,458	12,306	11,840	12,963	15,410	17,721	19,812	23,674	24,409
II.	Total of Expenditures of Health Sector (I+C+D)	11,458	12,306	11,840	12,963	19,312	21,613	23,970	28,713	30,349
	Percent GDP Spent on Health	2.15%	2.08%	1.88%	1.82%	2.57%	2.64%	2.68%	2.85%	2.79%
A.	Operation Expenditures	9,078	10,129	10,725	10,997	11,825	14,918	17,503	21,366	19,568
1	Wages and Social Insurance	4,883	5,164	5,931	5,693	6,634	7,196	7,922	6,436	7,987
2	Goods and Services(operations and maintenance)	2,839	3,252	3,113	3,173	3,936	4,549	4,568	5,369	5,661
3	Subvention	0	0	0	0	0	0	0	0	0
4	Domestic Current Transfers	1,354	1,711	1,673	2,117	1,236	3,147	4,966	5,552	5,867
5	Foreign Current Transfers	2	2	8	14	19	26	47	48	53
6	Others								3,961	
B.	Investment	2,380	2,177	1,115	1,966	3,585	2,803	2,309	2,308	4,841
1	Domestic Financing	1,114	1,350	962	1,407	2,528	2,298	1,810	2,308	2,681
2	Foreign Financing	1,266	827	153	559	1,057	505	499	0	2,160
C.	Ministry of Defense					492	549	461	502	717
D.	Expenditures from Revenues of Health Insurance Institute					3,410	3,343	3,697	4,537	5,223
III.	Number of Employees					21,310	21,300	21,300	21,300	21,300

2.3. Implementation of PETS's questionnaire and sampling methodology, data reliability

2.3.1. Sample design and response rate

Improving Public Expenditure Effectiveness in Health Sector is the first PETS implemented in the health sector in Albania. This study is different from the others because the focus of this study compared to the other is exclusively to assess the leakage of public funds and this can help to assess the efficiency of public spending and the quality and quantity of services. The approach used for this study is different from the others because it uses a wide range of data and information collected through different methods as questionnaires, focus groups and direct observations.

Generally, the other studies on the Albanian health sector are focused on the organizational problems of the health system. The report is innovative and the results of the PETS in Albania are very important because they are based at national level, even the sample is small.

We have conducted the first national based survey in health sector in Albania. All the other studies regarding health sector conducted in Albania have been aimed to analyze the system, or few studies implemented by international organization as USAID have used different types of surveys but not at national base.

The Public Expenditure Tracking Survey (PETS) relied extensively on primary data and secondary data. A wide range of data and information was collected through questionnaires, focus groups and direct observations, to track the flows and use of public expenditures during the period 2005 to 2007.

The sample design of the PETS consisted in a two phase process. In the first phase was elaborated the sample and the second phase consists in the selection of the stakeholders to be interviewed.

The instrument for this assessment was a nation-wide survey of 47 primary health care service, hospital services, and local government units. The survey covered 6 from a total of 12 prefectures by selecting 31 primary health care centers, 6 hospital services and 10 local

government units. Based on the recommendations of Brookings and Results for Development Institutes experts and consultation with other local experts in the field, four different questionnaires for each category were designed to collect information on the flows of funds, the use of funds and the impact as perceived by service providers, at the provincial, district and facility levels in the health sector. At the primary health care centers and hospitals level, the head of the institutions and one person responsible for the financial management provided the information. At the local government units only the head of the institution (mayor or head of commune according to the case) was interviewed. All the 47 institutions were successfully interviewed giving a response rate of 100%.

Random exit interviews were conducted for more than three clients for each institution utilizing primary health care centers and hospitals through another different questionnaire. A total of 124 clients were sampled and 111 were successful interviewed giving a response rate of 89%.

The following criteria have been considered during the selection of the sample:

- *Geographical Distribution*: The country has been first divided into three main regions, North, Central and South, and 2 prefectures have been selected for each region, to ensure national representation. 6 out of 12 Albanian prefectures have been selected: Tirana, Durres, Diber, Shkoder, Berat, and Vlore.
- *Tirana based centers*: Albania's capital enjoys more advantages than the other part of the country, according to its size and population (1/3 of Albania's population lives in Tirana).
- *Demographical data and size of territorial unit*. The six selected prefectures cover 58% of the population, 69% of the total urban population and 47% of the total rural population as it is presented in the table below.

Table 9: The population structure on 01.01.2007

Item	Total	Urban	Rural
Albania	3,152,625	1,522,508	1,630,117
6 selected prefectures	1,829,137	1,051,342	777,797
Structure	58%	69.1%	47.7%

Source: Albanian Institute of Statistics

Table 10: Sampling units based on type and location

No.	Public Health Institutions/Fund Users	Number of Survey units	Divided into		Number of questionnaires per institutions	Total number of questionnaires
			Urban	Rural		
I	**PRIMARY HEALTH CARE SERVICE**					
1	Primary Health Care Centers	10	10	0	1	10
2	Polyclinics	7	1	6	1	7
3	Health Posts	14	2	12	1	14
TOTAL PRIMARY HEALTH CARE SERVICE					**3**	**31**
II	**HOSPITAL SERVICE**					
1	Main Tirana University Hospital Center	1	1	0	2	2
2	Regional Hospitals	5	5	0	2	10
TOTAL HOSPITAL SERVICE					**4**	**12**
III	**LOCAL GOVERNMENT UNITS**					
1	Municipalities	2	2	0	1	2
2	Communes	8	0	8	1	8
TOTAL LOCAL GOVERNMENT UNITS					**2**	**10**
IV	**BENEFICIARIES**					
1	Main Tirana University Hospital Center and Regional Hospitals	6	6	0	3	3
2	Regional Hospitals	5	5	0	3	15
3	Primary Health Care Centers	10	10	0	3	30
4	Polyclinics	7	1	6	3	21
5	Health Posts	14	2	12	3	42
TOTAL BENEFICIARIES					**15**	**111**
TOTAL SURVEY					**24**	**164**

2.3.2. Data collection

The survey started on April 21, 2008 and finished on April 29, 2008. Before the implementation of the survey, the three interviewing teams, each of them consisting of 2 interviewers and 1 supervisor, in total 6 interviewers and 3 supervisors have been trained through a one-day intensive training course on issues related to the survey methodology,

specific features of the questionnaire and of specific questions, and specific fieldwork requirements. They have been also trained on how to build confidence to the respondent and how to get sincere and clear answers. The team of interviewers was composed by lecturers of statistic course at Faculty of Economics, University of Tirana and members of 2A Consortium Expert Team. The interviewer team was distributed uniformly to cover 6 prefectures of the country. The interviewer team has received written instructions, Route Administration Sheet, cards and an interviewer report to be filled for each prefecture.

2.3.3. Data processing

Once the questionnaires and the checklists were provided back to the 2A experts' team offices in Tirana, the computer operators entered the data into an Excel database format. The analysis of the typed data has been done through the statistical processing software (SPSS) in a way, that data provided through the survey will be readable in any MS standard package. Different reporting forms (cross-tabulation, correlation, etc) were prepared to interpret the results and draw up the conclusions and relevant recommendations.

2.3.4. Survey instrument

a) Hospitals' questionnaire

This instrument was designed to collect information from the head of the institution and one person responsible from 6 hospitals in the country. Financial management on the amount of resources requested and allocated to their institution, criteria used in resource allocation, efficiency of funds and inputs, number of clients who sought medical care, challenges experienced in provision of primary health care and other issues were analyzed through this questionnaire.

b) Primary health care questionnaire

The primary health care questionnaire was very similar to hospitals' questionnaire and similar information was collected, with few changes in the flow and sources of funds.

c) Municipalities & Communes' questionnaire

This questionnaire was administered to the mayors or the head of communes (according to the case) for a total of 10 interviewers. The information collected was focused on general data on municipality/commune, channel of information on funding, competition procedures for obtaining grants, grant implementation and monitoring.

d) Beneficiaries' questionnaire

The client/beneficiaries' questionnaire was administered to 111 clients from 37 the primary health care service and hospital services. The instruments gathered information on accessibility to medical care, availability of drugs and other inputs, payment for the services (user fees/cost sharing) and the client's perception of the quality of services provided by the health provider.

2.3.5. Data received from each questionnaire

For Hospital's questionnaire:

- Information on budget planning.

The Budget is planned from the central institutions based on the previous budgets without taking into consideration the health institution needs.

- Information for budget execution

The budget for the hospitals in 2008 has increased less than the economic growth rate comparing to the previous year and does not fulfill their needs. Apart this, it results that there are changes of destination during the year. In addition, there are no sanctions for the non-implementation of the planned budget. The major part of the budget, approximately 60% goes for the wages of the hospitals employees. The biggest part of the budget is addressed to payments and operative expenditures and a minor part goes for investments. There is a kind of positive self-evaluation concerning the budget management level of their institutions and a lower evaluation for the other institutions (Ministry of Health, Institute of Public Health, Institute of Health Care Insurances) according to their perceptions. The audit is not accomplished within one year for all hospitals institutions.

- Investments in buildings and equipments

It results that the rapport between the new buildings and reconstructions is in favor of these latest. Despite the insufficiency for medical equipments, a part of them are not working properly. There is a disproportion between the number of rooms per hospital and the number of beds in those (high number of beds in one room), which shows scarcity in the effectiveness to use the hospitals spaces. This results also from the hospital occupancy yearly rates which the respondents do not know and do not calculate it or calculate at small scale. It is ascertained that the hospitals have insufficient toilets, water supply, and electrical energy in quantity and quality.

- Human resources management

It is assert that the number of the specialized doctors is insufficient at the hospitals. The managerial staff changes frequently according to the changes due to political elections. Although the government planned to increase the salaries of the health sector employees in general, the survey showed that they are paid more or less the same as last year. Though, the number of respondents who say that hospitals employees take bribes is small, they assert that the level of bribe is between 300-500 Leke (3.6 – 6$). Despite the dismissals are a result of the lack of discipline at work and due to other reasons, it results that there are also voluntary leaves from health service due to the shift of population toward the central region Tirana-Durres. In addition, if there are qualifications for nurses and assisting staff, there are not trainings for the specialized doctors and experts of budget in these institutions.

For Primary Health Care Institutions' Directors questionnaire:

- Information on budget planning;
- Information on budget implementation;
- Investments in buildings and equipments;
- Human resources management - The majority of the respondents think that the number of the primary health sector employees is insufficient. There are not enough specialized doctors, differently from the number of nurses which is sufficient according to respondents. Also, there is identified the change of the managerial staff approximately once in 4-5 years and the doctors as well. Referring to the level of wages, the employees of Prime Health Care do not feel as the most favored one, compared with employees in other public sectors. These factors and others have increased the mistrust in the Prime Health Care service. The survey clearly shows the existence of dismissal in the health

system. This factor must be analyzed in the light of duty responsibility and migration of population into urban areas. The performances of health sector employees hang on their trainings. The survey finds that about 85% of the respondents have not complete vocational training. The raise of their performance has influenced the engagement of doctors in private centers as owners or as employees.

For Mayor and Head of Municipality and Communes

questionnaire

- General data on municipality, commune;
- Data on the information channel to aply and procedures of application**.**
- Information on the competition method of the competitive grants and competition procedures.
- Information on grant implementation and control of its realization.
- Opinions about the government policy regarding the collaboration between the municipalities, communes and the Ministry of Health.

For beneficiary's questionnaire

- The majority of respondents (51%) pay the social and health insurance contributions compared to 49% who not pay (Fig. 66 Respondents who pay or not social and health insurance contributions).
- The opinion if the service provided is in accordance with the contribution paid by the respondents, 50% of them consider that the service totally deserves what they pay.
- The health system organization is considered by 53% of the respondents that is on the average level. Another relevant category of clients (34%) says that the health system is bad organized and only 7% appreciate that the system is good organized.
- A great part of clients (23%) have not preferred of being visited because the doctor/nurse asked him/her to pay a bribe. A considerable number of clients (27%) consider that service has a low quality and 20% of them believe that the staff is not committed to work.
- The majority of the clients (53%) believe that the quality of the service provided by the medical center/ambulance is on the average level. There are 25% of the clients who consider that the quality is bad and 5% consider that it is very bad.

- The level of changes occurred on the quality of the services in the medical center during the last 3 years, 66% of the clients declare that they have noticed little, very little, or not any changes in the quality of the services.
- It is prevalent the number of respondents (56%) who declare that there were visits out of a row for being visited at a health center.
- The majority of clients consider that the doctor/nurse have not used cleaned gloves & masks (74.7%) and special equipments (79.6%).
- 59% of the clients declare that the medical center/ambulance has not or a less extended heating system.
- There are 53% of the clients who believe that little or very little has changed in the conditions of the equipments and building in the medical center during the last three years.
- Perception among 72% of the clients on the dissemination channel of information (posters, leaflets, others) regarding the diseases and services are that little, very little or nothing has been done to spread the information regarding the diseases and services provided by the medical center/ambulance.
- 61% of the clients have confirmed that have paid money to the doctor/nurse for the visit they made. From the clients who paid money they declare that 43% that they paid because the doctor/nurse made her/him understand to do in that way. 22% of the respondents declare that they have been asked to pay. There are also 35% of the respondents who paid voluntary.
- A wide spread phenomenon is the recommendation of the doctor/nurse to respondents regarding any specific pharmacy to buy the medicines which has been confirmed by 97% of the respondents.

3. PRIMARY HEALTH CARE AND PUBLIC EXPENDITURES

3.1 Health facilities and human capacities management and improvement

3.1.1 Health facilities management and improvement

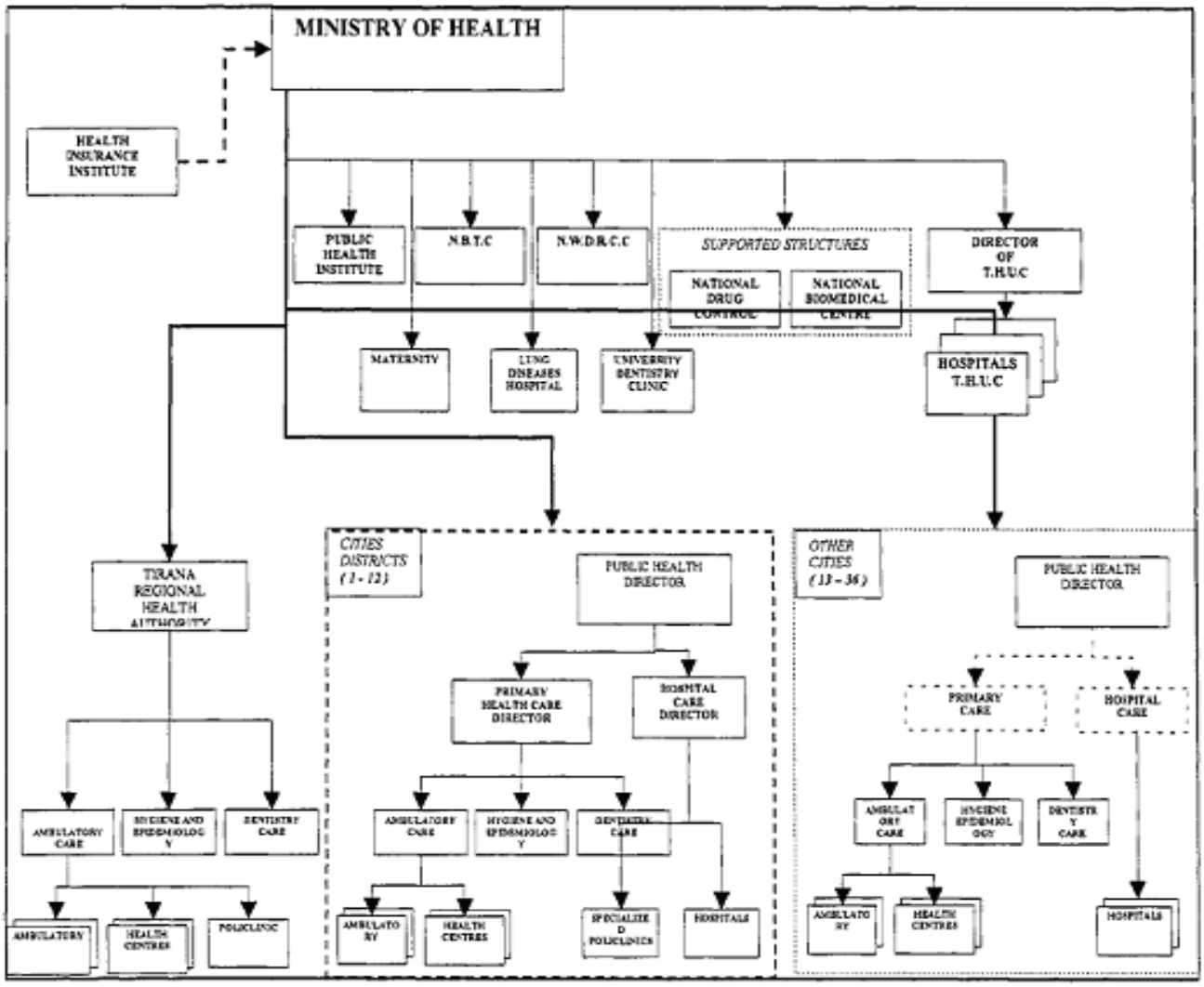
Administratively, Albania is divided into 12 regions including 36 districts, 65 municipalities and 308 communes. The health sector follows the same subdivision on a regional/prefecture and district level. Each prefecture comprises about three districts that are responsible for administering district hospitals, polyclinics and primary health care centers (PHC) through the regional or district public health departments, which are the MOH's local affiliates.

The key public provider is the MOH. Other public ministries (Defense, Education, and Justice) also provide health care services, but their capacities are limited.

The MOH is the main provider of health care in Albania. It provides care through an extensive network of hospitals, polyclinics, and primary health care centers. Specialized services such as obstetrics/gynecology and pediatrics are integrated within the PHC system. The Institute for Public Health (IPH) attached to the MOH, is responsible for health protection (e.g., prevention and control of infectious diseases, national vaccination), and environmental health; it mainly works through the district public health directorates. The directorates are accountable to both the IPH and the MOH.

Local authorities are directly responsible for public health issues such as waste disposal, drinking-water supplies and some forms of environmental protection. Government sanitary inspections are the responsibility of the MOH (See figure 1).

Figure 1: Health System Organization



Currently in Albania are registered 49 public hospitals. Overall, 2422 health facilities were reported in the public sector: health centers in commune level, health centers in the cities, ambulances and policlinics (table 11).

Table 11: Number of health facilities

No	Item	1999	2000	2001	2002	2003	2004	2005	2006
A	Health Centers	567	580	577	571	582	688	671	682
B	Ambulances	1,624	1,505	1,421	1,375	1,501	1,779	1,675	1,690
C	Policlinics	51	50	50	50	50	50	50	50
	Total of PHC	2,242	2,135	2,048	1,996	2,133	2,517	2,396	2,422
D	No. of hospital institutions	51	50	50	50	50	50	50	49
	Total of PH Institutions	2,293	2,185	2,098	2,046	2,183	2,567	2,446	2,471

Source: *INSTAT, 2008*

Health care is supplied by a multitude of public and a limited number of private providers. A total number of 148 health facilities were recorded in the private sector; 8.8% of these private facilities are private not for profit facilities and 91.2% are private for profit facilities. Tirana district reported 88 private health facilities and 49 public health facilities (Service Availability Mapping Albania, 2005-2006).

Table 12: Number of out patients facilities 1999-2006

	Years							
Item	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Population	3049.2	3058.5	3063.3	3084.1	3102.8	3119.5	3135.0	3147.0
Health Centres/100000 inhabitants	18.6	19.0	18.8	18.5	18.8	22.1	21.4	21.7
Ambulances/100000 inhabitants	53.26	49.21	46.39	44.58	48.38	57.03	53.43	53.70
Policlinics/100000 inhabitants	1.67	1.63	1.63	1.62	1.61	1.60	1.59	1.59
Hospitals/100000 inhabitants	1.67	1.63	1.63	1.62	1.61	1.60	1.59	1.56
Health Facilities/100000 inhabitants	75.2	71.4	68.5	66.3	70.4	82.3	78.0	78.5

Source: *INSTAT and survey results*

As resulted from the above table No.12, the number of health centers and ambulances has been increasing thus provided for 100.000 inhabitants and the same indicator has been decreasing concerning the polytechnic and hospitals. This trend is the result of priority policies which continue to be offered to the primary health service. However, from the survey it results that the management and effectiveness of their use is still very low. As such, 63% of directors of the primary health objects asked for the survey purpose , said there are no toilets

divided between men and women (Source: Q-62: "For Primary Health Care Directors of Institutions" questionnaire results).

Moreover, the directors and the objects go through electrical energy problems. So, 15 from 30 of the respondents confirm that the voltage is on the average and low level (Source: Q-65: For Primary Health Care Institutions Directors questionnaire results). More than half of them testify that the heating is partly or entirely missing in their environments (Source: Q-68: For Primary Health Care Institutions Directors questionnaire results). Whilst, 44% of interviewee directors affirm that the water supplied to the objects is not potable or hardly potable (Source: Q-74: For Primary Health Care Institutions Directors questionnaire results). All the above identified indicators are complex and with human resources management problems, which is reflected also in the activities of the primary health services institutions as shown in table no.13.

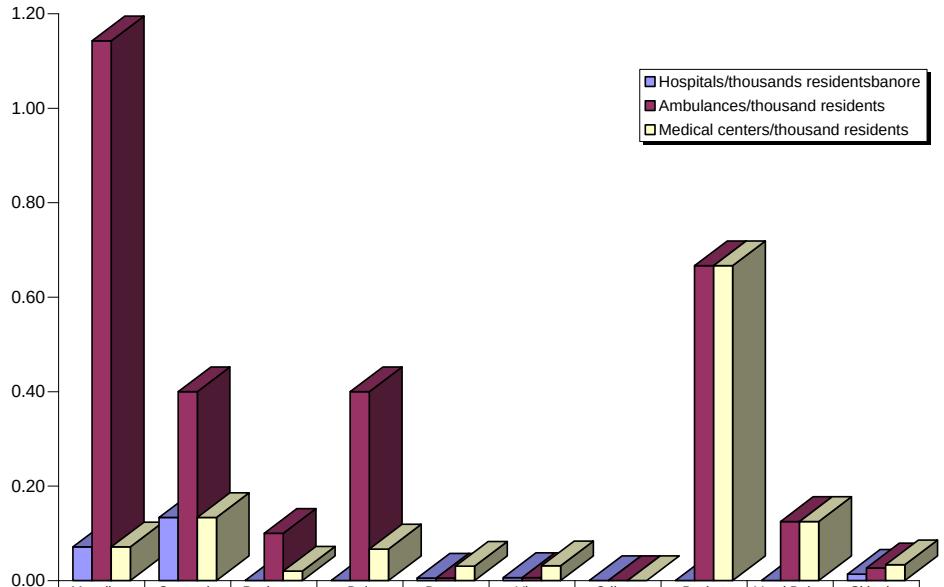
Table 13: Activity of Health Centres, Ambulances and Policlinics for 1999 - 2006

	Years							
Item	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Total visits	5,667,750	5,547,888	5,160,439	4,835,467	5,099,997	5,336,444	4,777,898	4,816,883
Health Centers	567	580	577	571	582	688	671	682
No. of visits in Health Cent.	2,032,662	1,972,990	2,090,901	1,988,450	2,134,027	2,394,249	2,138,505	2,052,777
Visits at home	141,483	129,701	121,462	113,286	99,085	97,856	77,704	78,677
Ambulances	1,624	1,505	1,421	1,375	1,501	1,779	1,675	1,690
No of visits in Ambulances	1,042,697	1,069,752	845,319	726,311	867,338	869,430	616,618	573,376
Visits at home	74,033	64,491	51,628	45,749	223,446	33,585	32,463	31,254
Policlinics	51	50	50	50	50	50	50	50
N0 of visits in policlinics	2,592,391	2,505,146	2,224,219	2,120,706	2,098,632	2,072,765	2,022,775	2,190,730

Source: *Ministry of Health*

Notwithstanding, there are major differences in the distributions of these institutions among municipalities and communes, which according to local units are reflected as below:

Figure 2: Number of hospitals, ambulances, medical centers in Municipality/Communes survey



	Maqellare Commune	Çorovode Municipality	Paskuqan Commune	Dajt Commune	Durres Municipality	Vlore Municipality	Orikum Municipality	Bushat Commune	Vau i Dejes Commune	Shkoder Municipality
Hospitals/thousands residentsbanore	0.07	0.13	0.00	0.00	0.01	0.01	0.00	0.00	0.00	0.01
Ambulances/thousand residents	1.14	0.40	0.10	0.40	0.01	0.01	0.00	0.67	0.13	0.03
Medical centers/thousand residents	0.07	0.13	0.02	0.07	0.03	0.03	0.00	0.67	0.13	0.03

Source: *Q-4: For Mayor and Head of Municipality/Communes questionnaire results*

The same illustration is remarked even from the studies of the World Bank, saying that there are regional variations manifested in the availability and coverage of primary health care facilities. The Central area has about 39 percent of the population and a considerably larger proportion of total PHC facilities (54 percent). Approximately, there are 5,274 people per health center, 2,045 per health post, and 62,638 per polyclinic, resulting in an average catchments area of 1,440 inhabitants per public outpatient facility, with significant inter-regional variations. Compared to WHO recommendations, these catchments areas are relatively small.

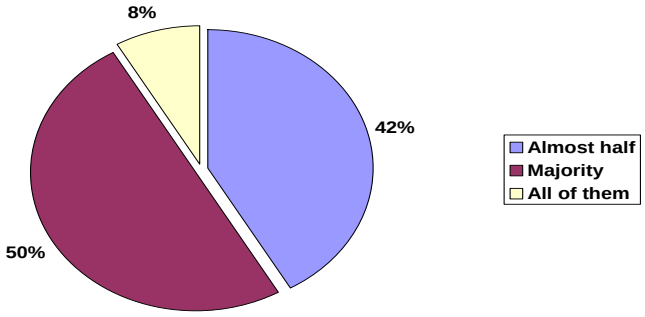
Table 14: Number of Public Hospitals, Public Health Facilities and Hospital Beds for 100.000 inhabitants, comparative with WHO European region, year 2006

Item	Population	Number of Public Hospitals	Hospitals/ 100,000 inhabitants	Public HF	Public HF/ 100,000	Hospital beds	Public Hospital beds/100,000 inhabitants
Total Albania	3,147,261	47.0	1.56	597	19.1	7,767	248.4
WHO European region			4.2		19.1		691.3
WHO Eur A			3.3		19.1		590.1
WHO Eur - B+C			4.5		19.1		711.0

Source: *Service Availability Mapping Albania, 2005-2006*

Referring to table No.14, there are two crucial indicators which reflect the level of hospital service development: hospital beds and hospitals for 100.000 inhabitants are approximately three times lower than the average of the countries in the European region.

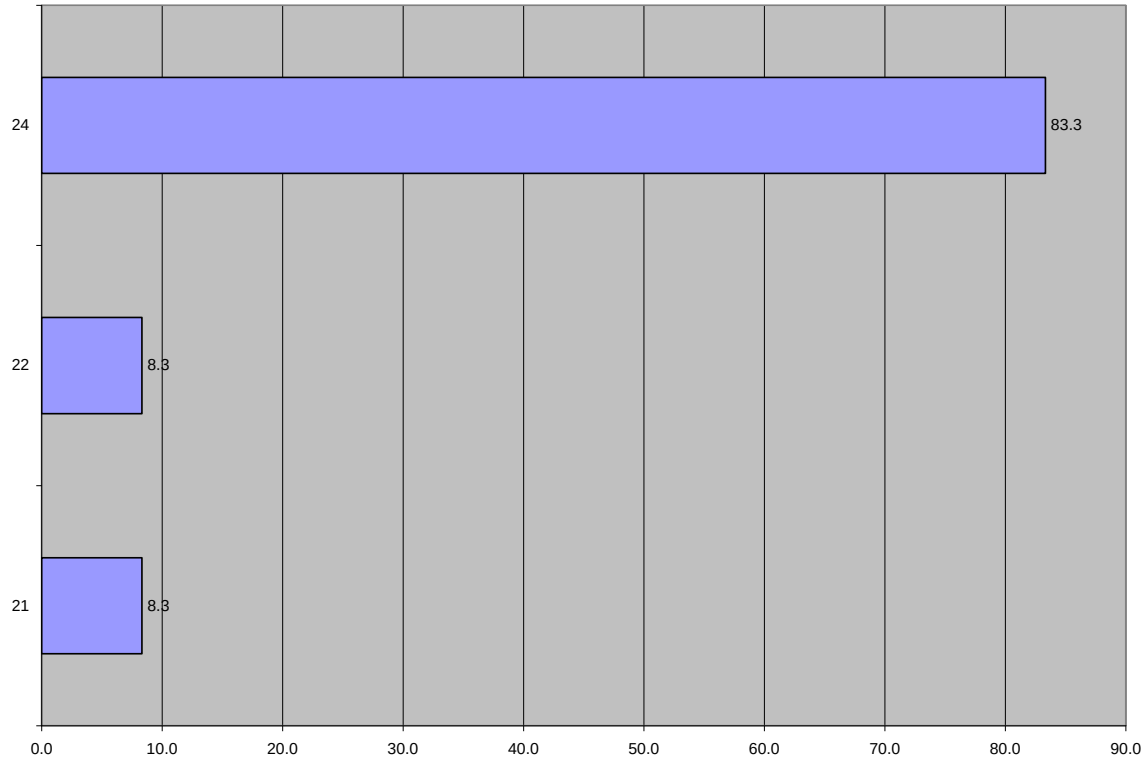
In six observed hospitals resulted that the answer to the question: "Do your equipments function regularly?" – Half of them replied that at maximum half of them are working, which clearly show the low performance of their operations.



Source: *Q-48: For Hospital's Directors questionnaire results*

In addition, 83% of the interviewed hospital directors say that the electrical energy was off for more than 30 minutes. The problems of electrical energy are related even with the voltage where only 42% answered that is good and very good. (Graphic No.23 – hospitals).

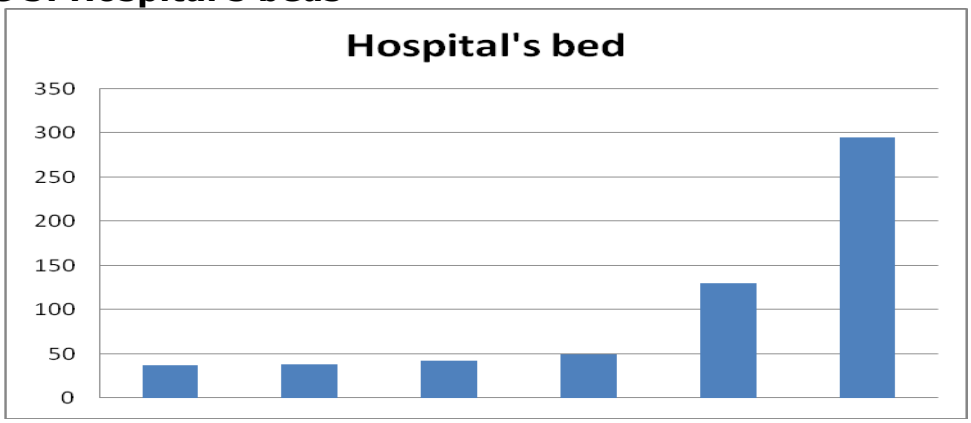
Figure 4: How many days per year the electrical power was interrupted for more than 30 minutes



Source: *Q-64: For Hospital's Directors questionnaire results*

In addition, there are still ongoing problems concerning cleanness at the hospitals, where 16.7% of the interviewed directors answer that this indicator is over the average. (Q-112: For Hospital's Directors questionnaire results).
From the survey it results that 67% of hospitals have not more than 130 rooms and only two of them have 295 of them (Graphic No.5).

Figure 5: Hospital's beds



Source: Q-55: For Hospital's Directors questionnaire results

A large number of small hospitals with low utilization and occupancy rates point to an overall sub-optimal hospital structure**.** Over 60 percent of Albania's hospitals are too small to exploit scale economies in the general acute care hospital setting. Thirty out of 46 hospitals have less than 200 beds. Together, these hospitals account for only one quarter of all hospital admissions. International evidence suggests that acute hospitals with less than 200 beds are too small to provide a full range of acute general hospital functions and achieve scale economies, while hospitals that have more than 600 beds are likely to display diseconomies of scale. Only three hospitals in Albania have more than 500 beds, but these account for about 28 percent of all hospital beds and 30 percent of all admissions.

It is impressive the fact that the respondents do not calculate or calculate at small scale the yearly coefficient of using the hospital beds. Regarding, 25% of the interviewed directors do not know what this coefficient for their hospital is. Whilst, for two of them is 13, for other two is 40.3 and for other three more is 50 and only one is 52. Therefore, there is a significant difference between regions. (Source: Q-57&58: For Hospital's Directors questionnaire results).

Hospital occupancy rates vary considerably across regions, reflecting regional disparities in hospital capacity and varying utilization rates. Six out of ten regions report occupancy rates below 40 percent. Only two regions, Lezhe and Diber in the mountainous area report occupancy rates above 50 percent. These are also the two regions which post the lowest utilization and productivity of primary care with 32 doctors. This suggests that quality of primary care in these regions is of particular concern, by enforcing the population not to ask for care until hospitalization is required. This, in turn, can lead to significantly higher costs, both for the patient and for the health care system. The relatively short ALOS in most regions mirror to some extent the limited hospital capacity to treat less severe case mixes outside Tirana. At the same time, the relatively short ALOS in tertiary care facilities in Tirana suggests that a significant share of cases treated in these facilities may be basic cases, which do not require secondary or tertiary care.

Hospital capacity has continued to increase over the past decade, despite falling admissions and shorter lengths of stay. Growing hospital capacity relative to the population, but falling admission rates and shorter average lengths of stay (ALOS) have led to a 10 percentage point drop in hospital bed occupancy since 1993. Over the past 5 years, the main hospital performance indicators including admission rates, ALOS, bed

occupancy and bed turnover rates have remained on a similar low level, pointing towards inefficiencies in production and idle resources in hospitals. Compared to other European countries, Albanian hospitals report relatively low rates for hospital admissions, surgeries, and bed occupancy.

The problematic of the hospital service including those of human resources management is expressed in the table No.15 of the hospital activities.

Table 15: Activity of Institutions with Beds 1999 - 2006

Activity indicators	Hospitals							
	1999	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Number of hospital institutions	51	50	50	50	50	50	50	49
Number of beds in hospitals	10,207	10,162	9,991	9,724	9,514	9,405	9,284	9,344
Hospitalized persons	257,524	266,381	272,820	269,309	273,891	272,375	272,402	279,791
Persons recovered	256,334	264,450	272,260	267,818	271,307	270,501	271,086	278,262
from rural	116,707	122,781	117,207	117,410	122,544	124,082	115,421	108,379
less than 1 year	14,291	14,149	16,021	16,489	16,789	17,457	15,431	15,824
60 years old	25,896	33,274	26,996	40,131	32,262	42,282	38,197	38,517
Bed ccupancy in days	177.7	179.9	183.2	184.3	186.9	183.6	186.3	185.6
in percentage	48.7	49.3	50.2	50.5	51.2	50.3	51	50.8
Average duration of hospitalization period	7.1	6.9	6.7	6.7	6.6	6.4	6.4	6.2
Bed turn	25.1	26	27.3	27.5	28.5	28.8	29.2	29.8
Number of persons operated on	47,521	51,095	54,255	54,050	55,656	59,005	55,383	56,175
Discordance	1,474	1,335	1,595	1,262	1,477	1,577	2,030	1,933

Source: *Ministry of Health*

3.1.2 Human capacities management at health sector

Analyzing the number of employees from the public and private health sector, it results that in 2004 this reached the highest percentage (3%) and in 2006 the number goes to 25 thousands persons in total.

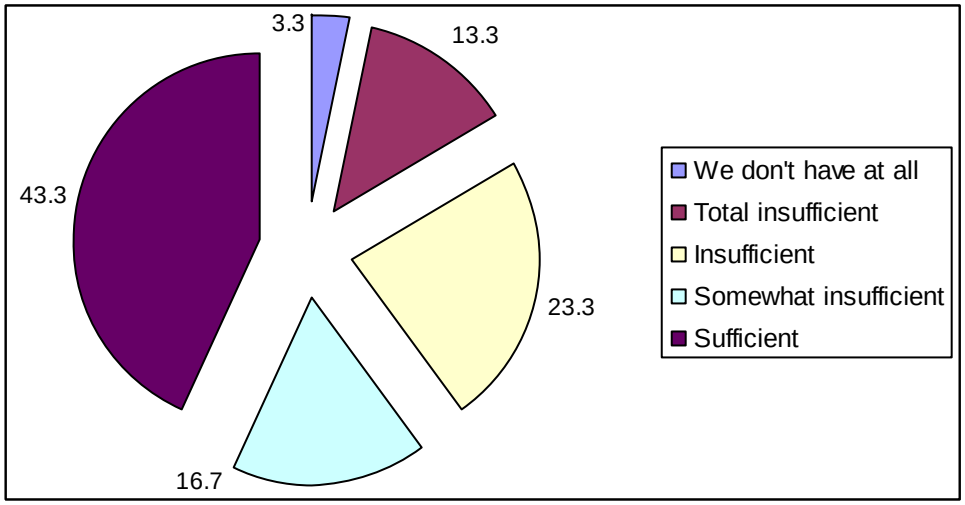
Table 16: Total employment by economic activity 1995 – 2006

Economic activity	Years											
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**
Total *(in 000)*	1138	1116	1107	1085	1065	1068	920	920	926	931.2	932.1	935.0
Health	26	23	25	28	26	23	26	26	27	27.6	24.0	25.0
percent*	2.3	2.1	2.3	2.6	2.4	2.2	2.9	2.9	2.9	3.0	2.6	2.7

Source: *INSTAT; *Calculated*

However, 43% of the respondents from the survey of Primary Health Care think that it is a considerable number of employees in the health sector and they fulfill the patient's needs, while 56.7 % considered the number as insufficient. (Figure 6.)

Figure 6: Sufficiency of staff

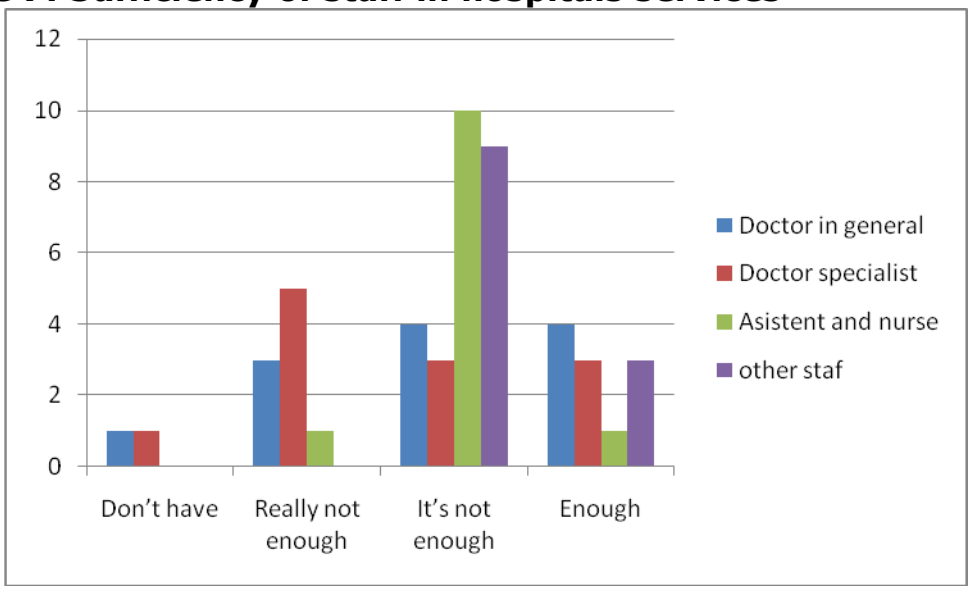


Source: *Q-79: For Primary Health Care Institutions' Directors questionnaire results*

The situation was complicated when the patients asked to fulfill their needs for doctors of different specialties. According to the survey only 6% of the respondents consider that the number is adequate. Meanwhile for all the others the number is not sufficient or there is deficiency in doctors of different specialties.

Nevertheless, it results the contrary with the number of nurses, where 60% considered that the number of nurses is sufficient. Therefore, the overall conclusion is that there are problems with the administrative and assistant staff. Only for 37% of respondents the assistant staff number is an adequate amount.

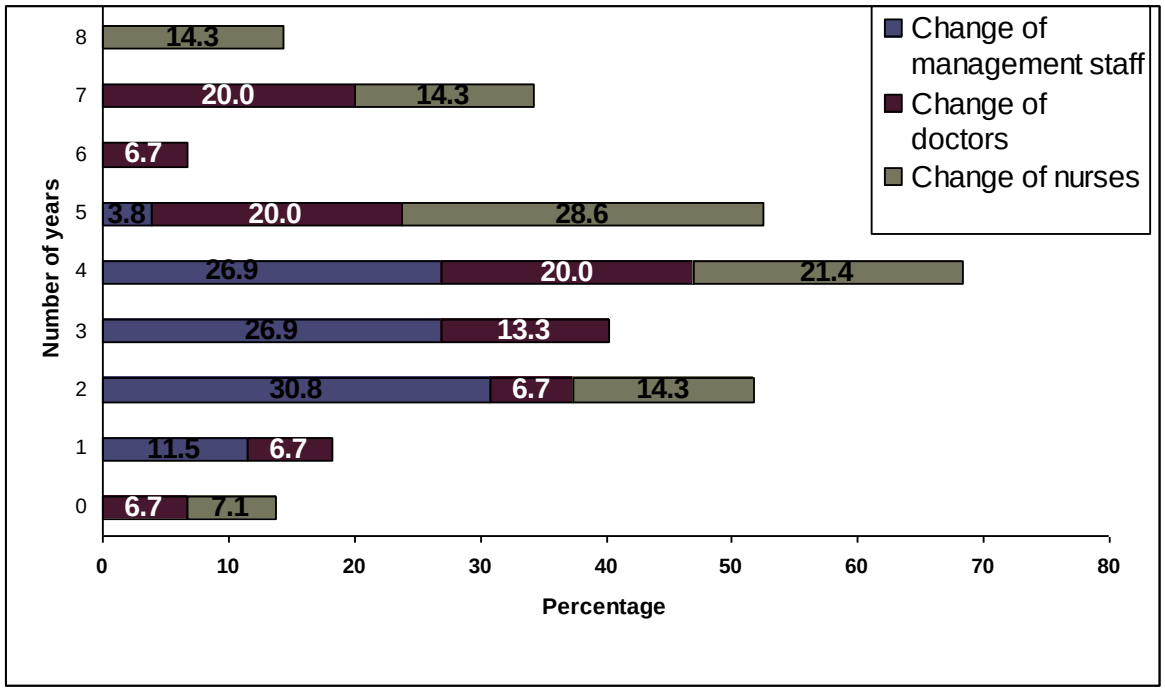
Figure 7: Sufficiency of staff in hospitals services



Source: *Q-79: For Hospital's Directors questionnaire results*

The answers received by interviews show that almost 100% of hospital's directors were changed once in 4 years. Also, it shows the inconstancy of administrative staff which is strictly related in the same time with the politicization of humane resources, due to the fact that once in every four years there are new parliamentary elections. The changes of doctors and nurses staff seem not following the same trend because 13% of the interviewees are pronounced that the period of changes is from 5 to 7 years.

Figure 8: How often is the managerial staff changed



Source: *Q-81, 82 & 83: For Primary Health Care Institutions' Directors questionnaire results*

Referring to the level of wages, the employees of Prime Health Care do not feel as the most favored one, compared with employees in other public sectors. Only 50% of them think that wages are same, and 47% believes are lower and very low.

The lack of the wage's motivation reflects the same level to the management of the institutions and to the level of service delivered to the patients. These factors and others have increased the mistrust in the Prime Health Care service.

The survey clearly shows the existence of discharges in the health system. In this term, 23% pronounced that in 2007 have been dismissed 1-6 persons. Over 30% of the respondents marked that during the last year 1-9 persons quitted voluntary from their institutions. This factor must be analyzed in the light of duty responsibility and migration of population into urban areas.

The performances of health sector employees hang on their trainings. The survey finds that about 85% of the respondents have not complete vocational training.
(Source: Q-94: Results for Primary Health Care Institutions' Directors questionnaire).

The raise of their performance has influenced the engagement of doctors in private centers as owners or as employees. As such, 50% of the respondents think that doctors of their institutions work in private health service centers.
(Source: Q-95: Results for Primary Health Care Institutions' Directors questionnaire).

The MoH is the owner and administrator of all hospitals, except the Military Hospital. Public hospitals are lead by a chief head physician, who is in charge of overall hospital operations and management, but he is not trained to manage the hospital. As a result, many of them lack the management capacity required to effectively manage a modern hospital. Furthermore, they often continue to operate as physicians at the hospital or in private practice, thus decreasing the time and effort devoted to hospital management. Public hospitals have limited financial and administrative autonomy. All health personnel are recruited and assigned to specific hospitals centrally by the MoH, following norm-based requests by the head physician.

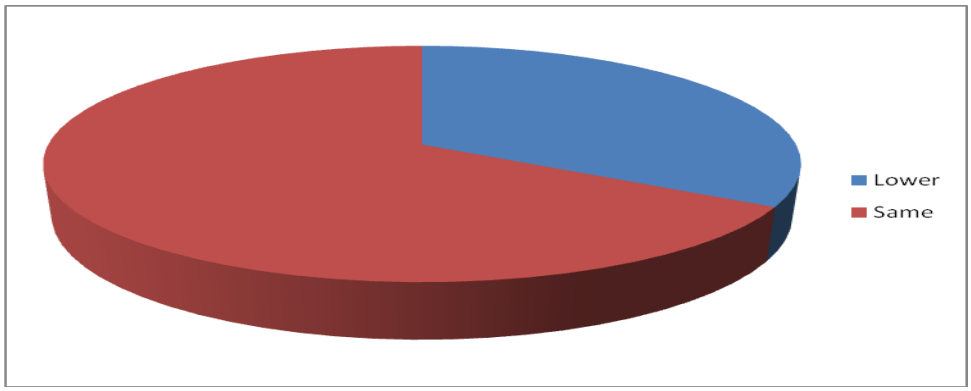
The survey provides a different view on the hospital services. From 6 interviewed hospitals only one of them declared that the staff is not enough. Also seems that needs for doctors in hospitals, in great part of them (82%) are in a satisfactory level.

More optimistic seems to be the situation to assistant staff and nurses where only in one case their number is insufficient. 100% of the respondents consider that requirements about administrative and assistant staff are satisfied.

(Source: Q-79: Results of Hospital's Directors questionnaire).
Regarding the change of directors in Prime Health Care Service, findings show that 10 out of 12 of respondents declared that directors are change once in 2-4 years.

In addition, at the hospital service all respondents think that their wage is the same or much lower than other sectors of economy.

Figure 9: The level of wages in health sector compare with other sectors



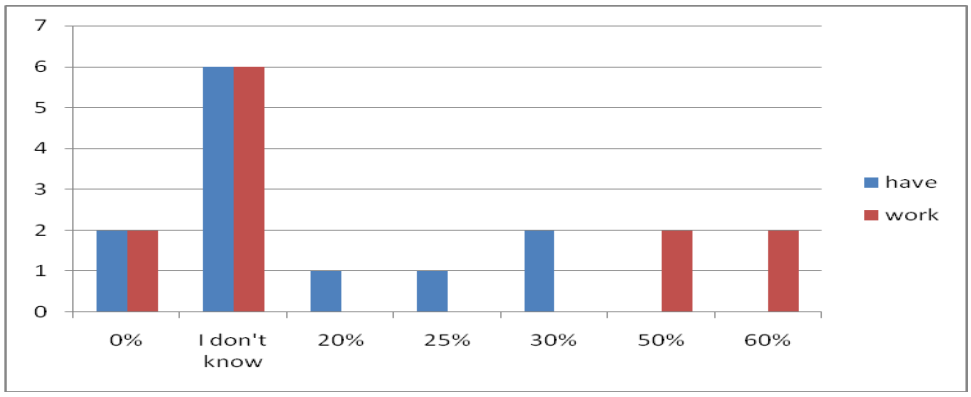
Source: Q-84: For Hospital's Directors questionnaire results

There are many cases of dismissal in the health sector. As such, in 75% of cases 1-10 persons declared that they have been dismissed from their hospitals. During 2007 there are many cases of transferred persons. In 57% of cases 10-20 persons have been transferred and 91, 6% of respondents pronounced that 3-20 persons quitted voluntary. (Source: Q-90-93: For Hospital's Directors questionnaire results).

Optimistic seems to be the situation in the training field where all interviewee's units received vocational training for their staff. In many cases the trainings have been provided to nurses, and only in 2 cases it has been provided vocational training in the management field.
Regarding the training of the doctors, they have not been taken in consideration by the Ministry of Health. As such, 50% of the respondents are "unsatisfied" from this decision. The MoH's decision seems to be related with returning of doctors in the elderly work place. Only in 25% of cases the doctors returned in the elderly work place after completing the training.

The survey shows that approximately 25% of doctors own private centers and 60% of them serve in private clinics, which affect negatively in their performance during their activity in public health sectors.

Figure 10: Doctors who hold and work in private centers



Source: Q-98 & Q-99: For Hospital's Directors questionnaire results

At the same time smaller hospitals have low occupancy rates and a significantly higher ratio of staff per utilized bed than larger facilities, pointing to inefficient use of scarce resources. Hospitals with less than 100 beds report occupancy rates that are substantially below those of larger hospitals. This reflects patients' failure to trust that these facilities can provide adequate quality of care. Insufficient human capacity and equipment in these small facilities lead people to circumvent small hospitals in favor or lager facilities. This in turn leads to two sets of inefficiencies. It causes unnecessary hospitalization of less severe cases at the more costly tertiary care level, and at the same time, leads to underutilization of facilities and human resources in the small hospitals. Hospitals with less than 50 beds have almost four staff per occupied bed and occupancy rates below 30 percent, pointing to high staff costs and low productivity. This compares to an average of about 2.5 staff for hospitals with 200 or more beds.
Underutilization of small facilities also leads to concerns about the quality of care, which such facilities can provide. Low patient volumes lead to inadequate patient loads per practicing physician, in turn endangering the quality of care.

The analysis provides additional information on the socio demographic and economic background of individuals who are sick and who seek care. To circumvent any self-selection issues among sick individuals, the analysis examines utilization based on all individuals, as well as by including all sick individuals only.

Albania's hospital capacity (3.04 beds per 1,000 people) compares favorably to that of many other lower middle-income countries, but is at the lower end of the European scale. With an average of 1.53 hospitals per 100,000 inhabitants, Albania reports similar hospital densities as

Croatia (1.78), Hungary (1.76), Turkey (1.66), and Slovenia (1.4), but a considerably higher density than the Netherlands (1.2) and Sweden *(0, 9).31* While Albania has one of the lowest bed densities in the ECA region, several Western countries, including Sweden, Finland, Spain, and Turkey, report lower densities than Albania.

Consolidation of hospital departments would allow for efficiency gains. Several hospitals in Albania have identical departments within the same hospital or within close proximity. For example, the Mother Theresa University Hospital in Tirana has four pathology departments, and several districts with two and more hospitals (e.g., Durres, Elbasan, Skrapar) have a pathology department in each hospital. Tirana has overall ten emergency departments in three hospitals with eight emergency rooms at the Mother Theresa University Hospital alone, an additional one at the Lung Disease Hospital and one at the Obstetric University Hospital. Emergency departments are costly, due to their resource intensity.

Therefore, most OECD countries have only a small number of emergency rooms per city; for example, Vancouver, Canada, with a population size similar to Tirana has only two emergency rooms for adults and one for children; similarly, Basel in Switzerland has three emergency rooms (one for adults, one for children, and one for OB/GYN). While physical dispersion of facilities may make merger of various departments somewhat difficult in the short term, appropriate planning for such mergers should be an integral part of developing an Albanian hospital map that would guide future investments in the hospital sector.

Private facilities are concentrated in the two largest cities, Tirana and Durres. Most private sector facilities are well equipped and organized; tend to offer high technology diagnostic and treatment services, and better infrastructure than the public sector facilities. The MOH figures suggest that about 4.300 medical professionals work in the private health care sector, with dentists and pharmacists accounting for about one third and 45 percent respectively. Two-thirds of private doctor offices and diagnostic facilities are located in Tirana and Durres.

While observing the main indicators of the health service (public and private) in Albania, it resulted to have the lower number of dentists for 100.000 inhabitants as compared with neighbor countries. Otherwise, the indicator of the nurses and nunnies is set differently. So, for 10.000 inhabitants Albania has 47 of them by positioning above Greece (36) and Macedonia (43).

The situation is shocking addressed to the number of doctors. Albania has 12 doctors per 10.000 inhabitants as half of Montenegro (20), Croatia (25), and Macedonia (26).

Table 17: Comparative core indicators

Indicator	Albania	Croatia	Greece	Montenegro	Slovenia	FYROM
Dentistry personnel density (per 10 000 population)	3.00 (2006)	7.00 (2006)	12.00 (2005)	4.00 (2006)	6.00 (2005)	6.00 (2006)
Number of dentistry personnel	1,035 (2006)	3,230 (2006)	13,438 (2005)	263 (2006)	1,198 (2005)	1,175 (2006)
Number of nursing and midwifery personnel	14,637 (2006)	24,872 (2006)	40,000 (2005)	3,436 (2006)	15,711 (2005)	8,833 (2006)
Number of Pharmaceutical personnel	1,173 (2006)	2,549 (2006)	8,977 (2000)	111 (2006)	905 (2005)	908 (2006)
Number of Physicians	3,626 (2006)	11,250 (2006)	55,556 (2005)	1,233 (2006)	4,723 (2005)	5,187 (2006)
Nursing and midwifery personnel density (per 10 000 population)	47.00 (2006)	55.00 (2006)	36.00 (2005)	57.00 (2006)	80.00 (2005)	43.00 (2006)
Pharmaceutical personnel density (per 10 000 population)	4.00 (2006)	6.00 (2006)	8.00 (2000)	2.00 (2006)	5.00 (2005)	5.00 (2006)
Physicians density (per 10 000 population)	12.00 (2006	25.00 (2006)	50.00 (2005)	20.00 (2006)	24.00 (2005)	26.00 (2006

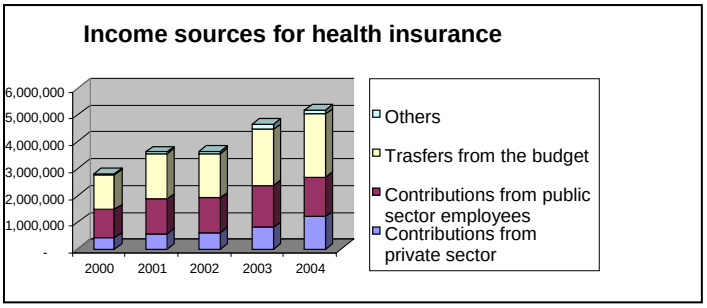
Source: *WHO All data*

3.2 Public health expenditures and internally generated funds

3.2.1 Financial management and source of funding

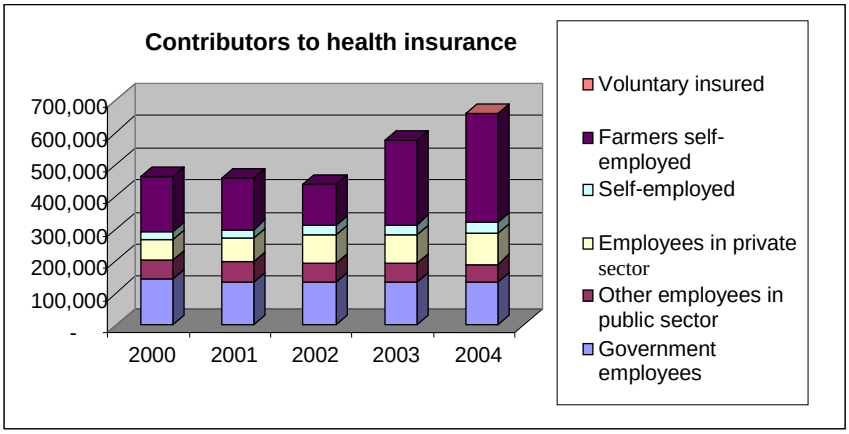
Although over two-thirds of funding for health insurance comes from general tax revenues, only about 40 percent of the population appears to effectively benefit from health insurance coverage. The HII is funded by payroll tax contributions (3.4 percent of salaries or wages up to a maximum of three times the annual average personal taxable income), contributions of the self-employed and farmers (between 3 percent and 7 percent of the minimum wage, depending on the category), and budgetary contributions for the dependent population. The dependent population includes all children less than one year, pregnant women, war veterans, the disabled, the unemployed and recipients of social assistance, cancer patients, people under compulsory military service, and pensioners.

Figure 11: The income sources of Health Insurance



Source: HII

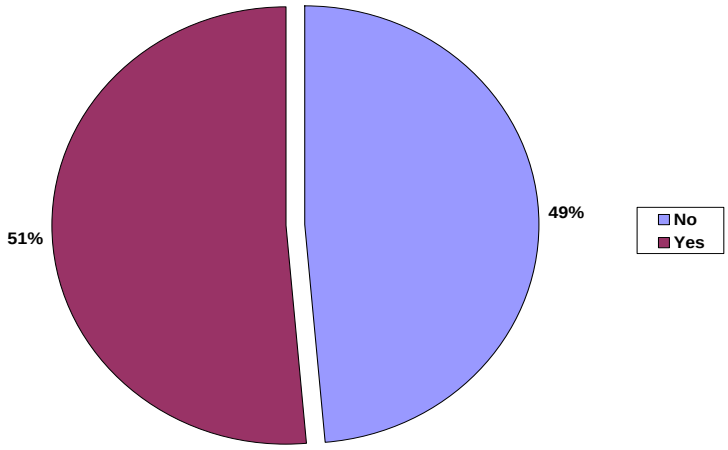
Figura 12: The Contributors of Health Insurances



Source: HII

According to the client/beneficiaries' questionnaire implemented by 2A expert team administered to 111 clients of the health sector, there are 51% of the respondents who declared that they pay the social and health insurance contributions, compared to 49% who do not pay (Fig. 13).

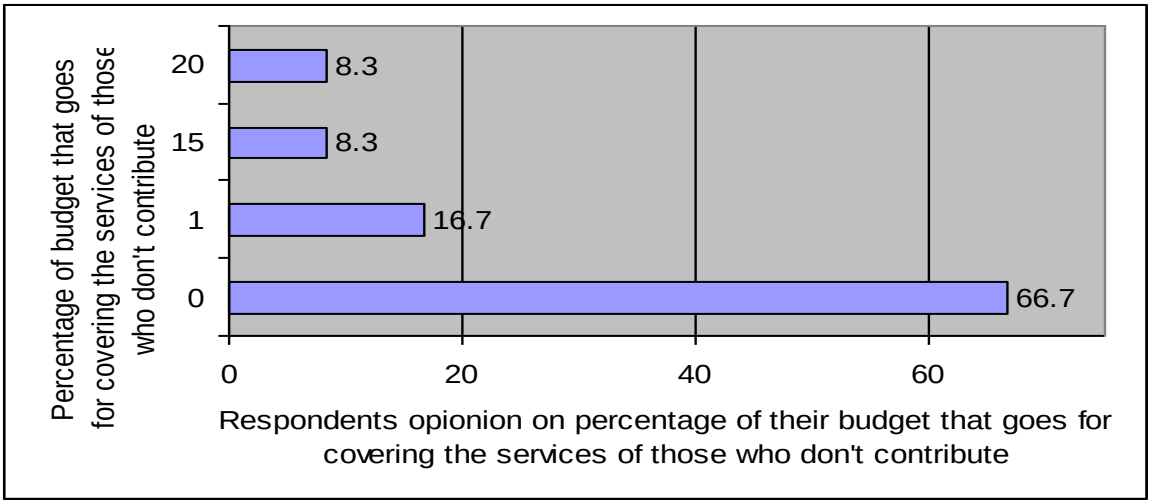
Figure 13: Respondents who pay or not social and health insurance contributions



Source: Q-9: For client/beneficiaries' questionnaire results

According to the hospital questionnaire implemented by 2A expert team administered to 6 hospital services, the majority of the head directors and financial officers (67%) of the hospitals declare that none of their budget goes to cover the services of those who don't contribute through the social and health insurance scheme. There are also 33% of them who declare that from 1-20% of the budget go to those who don't pay through the social and health insurance scheme (Figure 13).

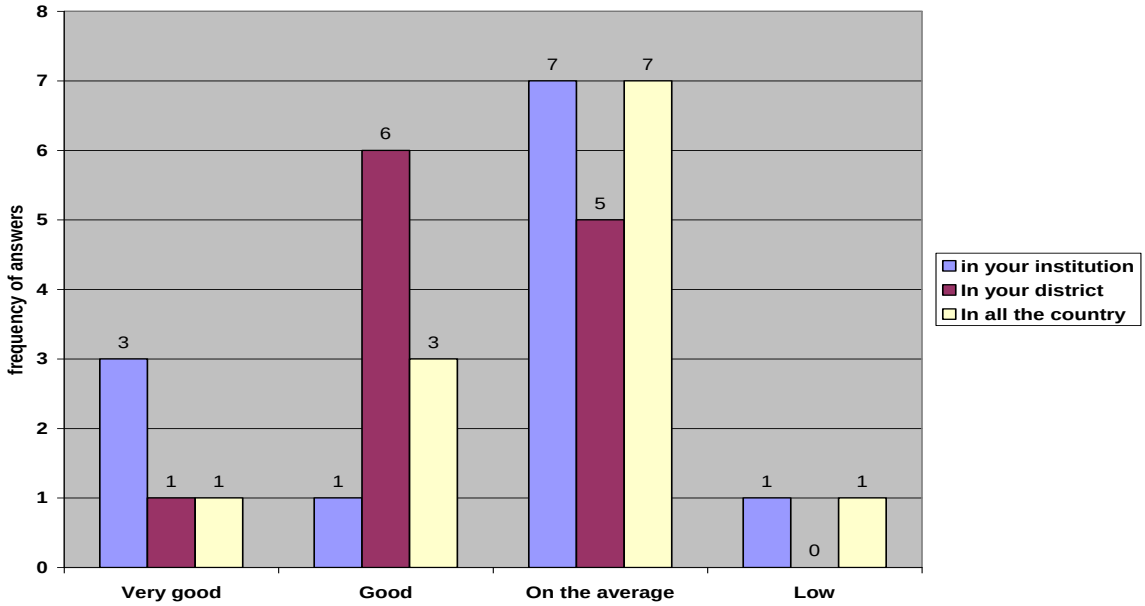
Figure 13: Respondents opinion on parts of budget which cover the services of those who don't contribute through the social and health insurance scheme



Source: Q-30: For Hospital's Directors questionnaire results

Referring to the hospital questionnaire results, there is a strong tendency to evaluate the management of health expenditures at an average level (Figure 14). As such, 33.3% of the respondents evaluate the management of health expenditures in their institution at a very good and good level, 58.3% of them consider it on the average level and 8.3% evaluate it at a low level. 58.3% of them think that the management of health expenditures is at a very good or good level in their district compared to 41.7% who says that the health management is on the average level. Analyzing the management of health expenditures at national level the respondents consider it with 33.3% at a very good or good level, 58.3% on the average level and 8.35% of them think that the management is at low level.

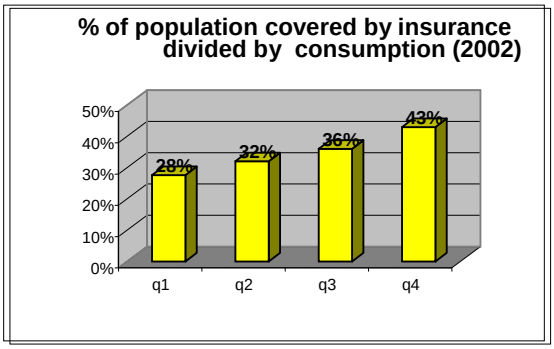
Figure 14: Respondents opinion on the management of health expenditures during the last five years (in percentage)

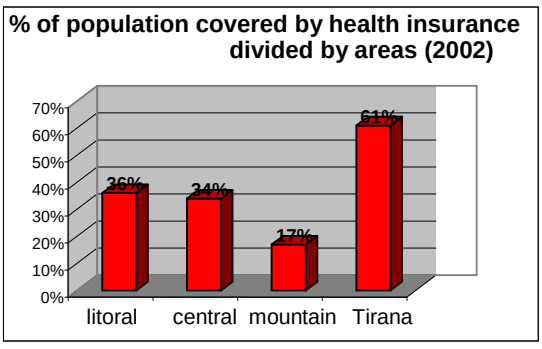


Source: Q-35: For Hospital's Directors questionnaire results

Despite a 40 percent increase in the number of contributors over the past 5 years, including a marked rise among farmer contributors, active contributors still account for about one third of the active workforce. The number of those covered by the state remains uncertain. While the law provides for the entire population to be covered, household surveys suggest that only about 40-45% of the population are covered by health insurance. Household survey data show significant regional variations in the health insurance coverage rate, with over 60% of the population living in Tirana reporting that they have a health insurance booklet, but less than 20% of the population in the mountainous region are being covered (Figure 15).

Figure 15: Part of the population who is covered with health insurances according to the region and consume

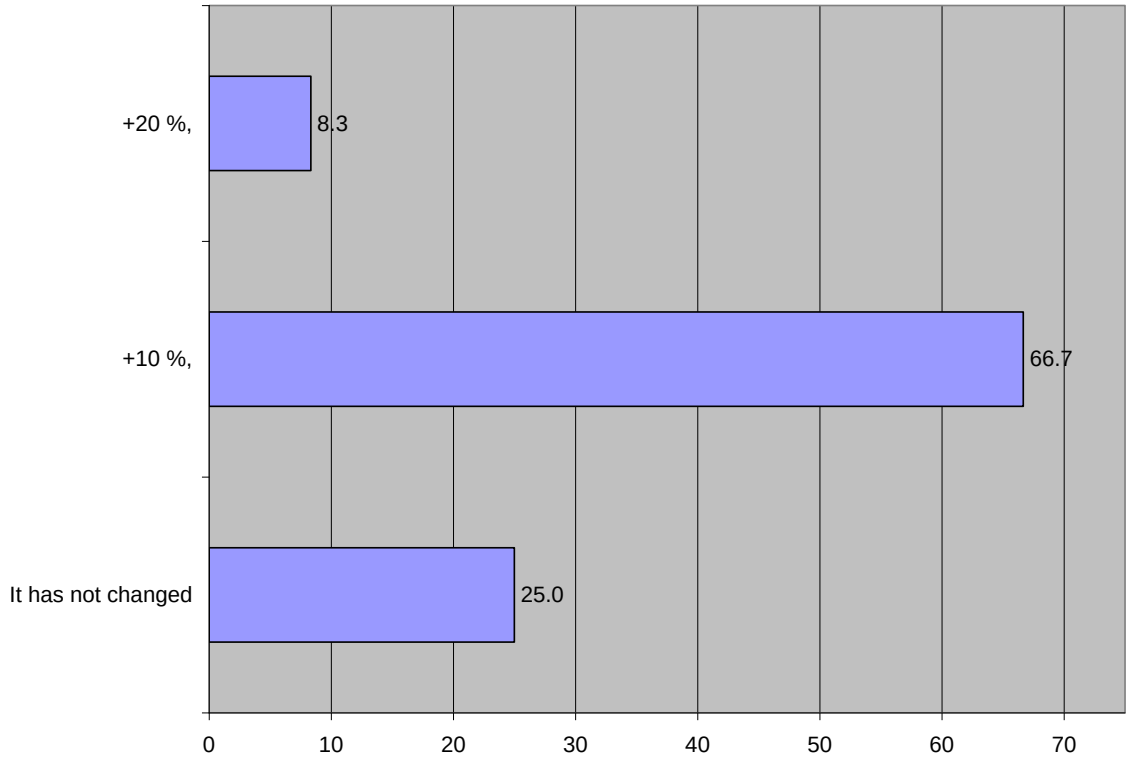




Source: *LSMS 2002*

According to the hospital' questionnaire implemented by 2A expert team administered to 6 hospitals, 25% of them declared that the budget has not change, 66.7% declared that the budget has changed +10% and only 8.3% of the respondents have received a +20% change in their budget.

Figure 16: Changed budget in 2008 compared to 2007



Source: Q-18: For Hospital's Directors questionnaire results

The overall low reported coverage is due to two factors. First, a large share of the active labor force works in the informal sector and thus avoids contribution payments. Second, anecdotal evidence suggests that knowledge of health insurance benefits appears limited among a significant part of the population. Therefore, it is likely that significant shares of those who are in principle covered through the state do not know and make use of their rights. Contribution incentives for the active labor force are overall weak, as the scheme provides limited benefits, covering only primary care (outside polyclinics), reimbursement of prescription drugs of varying degrees, and certain high end diagnostics procedures.

The Albania Poverty Assessment has shown that health expenditures have a strong impact on poverty, with the poverty incidence increasing from 25 to 34 percent if out-of-pocket

health expenditure is subtracted from household income. Outpatient care expenditures have a greater impact on poverty than hospital expenditures, owing to their more frequent occurrence. However, when low income households have to face hospitalization, the income shock is catastrophic, with the average hospital payment amounting to over four times the monthly per capita income of the lowest expenditure quintile. Lower income households also have a significantly higher likelihood of incurring catastrophic health care expenditures than better off households, as even relatively modest outpatient care expenditures can amount to an excessively high share of a household's budget. The average out-of-pocket expenditures for one episode of outpatient care amount to 50 percent of the average monthly per capita expenditure of the lowest consumption quintile, suggesting that even the need for a simple outpatient care visit can result in catastrophic expenditures for the lowest income groups.

The current provider payment system, fragmented at the primary care level and input based for specialist and inpatient care, fails to make providers accountable for performance.

Resource allocations which are driven by staffing norms and infrastructure fail to give providers any incentives to work efficiently and provide a high quality of care. Several steps have been undertaken to attempt to move towards more performance-based payment mechanisms. However, the measures introduced have not been comprehensive and financing remains fragmented, with the result that primary care providers are not accountable to anyone in particular for the results which they achieve. Primary care general practitioners are paid by the HII on a modified capitation basis (base salary plus capitation supplement depending on location and registered patients), which in principle depends on the number of registered patients. In practice, however, the registration system is not properly implemented, as demonstrated by the fact that the number of people that GPs declare as being registered amounts to about 1 million more than Albania’s total population. While the system allows for higher pay in remote areas to attract and retain GPs in such areas, it does not include any rewards linked to performance and quality targets. Furthermore, the fact that other primary care personnel and operations and maintenance costs are paid from a different source, gives primary care physicians limited control over the performance of their entire operation, thus diluting the incentives which the HII payment system was intended to introduce.

User Fees

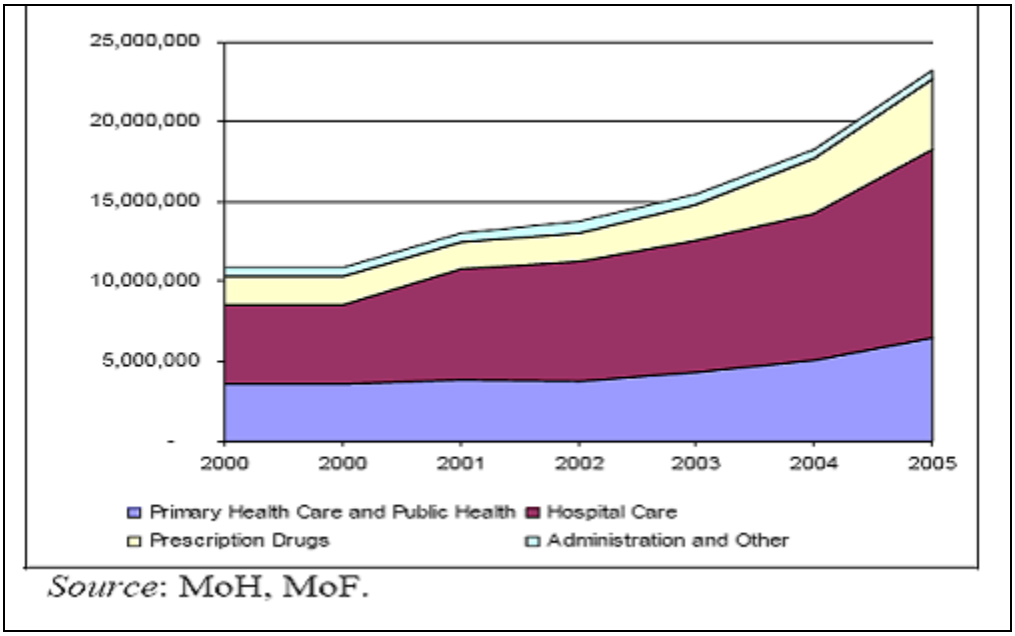
Although out of pocket payments account for over 60 percent of total health sector spending, formal user fees amount to a minimal share of public sector health expenditures. User fees are in principle charged for primary care for all those who are not covered under HII, for those who seek outpatient secondary care without referral and for certain diagnostic procedures. No formal fees are charged for stationary hospital care. With the exception of fees for diagnostic procedures, fees are minimal, are not rationally structured and are irregularly applied. Most primary care providers are not equipped to formally collect money. Providers have little incentive to collect fees, as they can retain only 10 percent of the revenues collected: the rest is transferred back to the district public health directorate.

Healthcare providers must utilize their share of collected fees as follows: 20 percent for minor investments, 50 percent for operating costs and 30 percent for staff bonuses. Over the past three years, total fees collected and reported have amounted to only about 1 percent of public sector expenditures in the health system. Household survey data, however, would suggest that the amounts collected should be substantially higher, indicating that there is considerable underreporting and abuse.

Resource Utilization

Hospital expenditures dominate public sector spending on health. Albania allocates a higher share of total public sector spending to hospital care than do OECD or EU-8 countries. Hospital expenditures account for about half of all public sectors spending on healthcare in Albania compared to an OECD average of about 38 percent. The trend over the past five years has been one of a growing share of public spending going to hospital care and prescription drugs, at the expense of primary care. This contrasts with the trend in most European and transition countries where a growing share is allocated towards outpatient care, as a result of more cases being treated in an outpatient setting and the falling duration of hospital stays (Figure 17).

Figure 17: Evolution of the public sector health spending by program 2000-2005



Source: MoH, MoF.

The growing importance of hospital expenditures in Albania was substantially driven by increased capital expenditures in the hospital sector. Given the overall poor state of the hospital infrastructure in Albania, this might be justified if investment decisions were guided by an overall strategic vision of how the hospital sector should evolve and be rationalized in the coming decade. However, there is little evidence that this is the case.

Effective coverage by HII is limited and only about one-third of the active work force makes contributions. Household survey data show that only about 40 percent of the population is effectively covered by HII, mainly concentrated in urban areas and the upper income quintiles, with significant regional variations.

Contribution incentives for the active labor force are overall weak, as the scheme provides limited benefits, covering only primary care (outside polyclinics), imbursement of prescription drugs of varying degrees, and certain high end diagnostic procedures.
Outpatient care in polyclinics and hospitals, and inpatient care, are financed by general revenues and in principle are free of charge if a patient has been referred by the primary care physician.
Household surveys show that the vast majority seeking care at these levels nevertheless incurs significant out of pocket payments, irrespective of insurance coverage. Similarly, household survey data also show that the possession of a health insurance booklet does not

significantly lower the amount of out of pocket expenditures for outpatient care nor does it affect the likelihood of having to pay for care, particularly outside of Tirana.

Overall, the incentives to pay health insurance contributions are limited. Furthermore, anecdotal evidence suggests that a significant share of the population has limited knowledge of health insurance benefits. Thus, it is likely that some of those who are in principal covered through the state do not know about, and make use of, their rights.

3.3. Budget planning

Based on the guidelines of Middle Term Budget Program preparation (MBP), the project budget drafting is a perennial and comprehensive process. In order to create the groundwork for the Middle Term Budget Program is necessary to have the structures below:

- Integrated Planning System approved from the Council of Ministers with a Decision no. 692 on 10.11.2005 "Implementing the Integrated planning System (IPS). The IPS contains a broad framework of planning and monitoring, which is drafted to insure a coherent, efficient and integrated function of policies and main financial processes of the Government. There are three main documents which cover all activities and central institutions:

❖ The National Strategy for Development and Integration, which establish the aims and middle and long term objectives for all sectors;

❖ Sectional and Intersectional Strategies, which ascertain the goals and the specific middle and long-term objectives of respective sector/sectors, and

❖ Middle Term Budget Program, in which each of the Ministries should identify the programs, objectives, their products and activities for the next three years in order to reach the settled goals within the approved expenditures ceiling at the fiscal plan of the Government

- The Comittee of Strategic Planning (CSP) leaded by the Prime Minister
- The working group for the Strategy, Budget and Integration in every Ministry
- Heads of Program Management Team

- Managment Program Team

The quots of the Middle-Terms Budget (MBP) Program are almost the same with the next fiscal year quots. The preparation of the MBP starts in March with the review of the policy, and in June the MBP is to be approuved and continue the process of drafting and budget approuvment for the next fiscal year. It should be ratified from the Parliament at the end of November or begining of December. Afterwards, in February of each year the Ministry of Finance issues the MBP guidline of the current year.

Ceilings of MBP are approved in February and the line ministries work together with budgetary institutions during March until May. Review of Program Policy, Program Expenditure planning and additional requests should be submit from each institution and the ministries to the Ministry of Finance not later than 2nd of May of each year. The Ministry of Finance presents the first draft to the Committee of Strategic Planning close to the Council of Ministers until 25th of June. Than, after the MBP is approved from the Government, the Ministry of Finance within 10th of July issues the complementary directive of budget planning. Through this directive, ministries and institutions receive the final ceiling of the MBP approved from the Council of Ministries. This phase initiates on July and is to be concluded for the Ministries of line at the end of August. Afterwards, the Ministry of Finance during September carries out consultations with the line ministries to discus with them their request and priorities. Moreover, the Ministry of Finance should send the project budget to the Government in October and during this month this last must approve it and submitted it to the Albanian Parliament. The different commissions of the Parliament discuss according to a foreseen calendar the next year fiscal project budget. Finally, during the project budget discussion, the political and expert leaders of the line ministries are called to argue.

At November the budget must be ratified from the Albanian Parliament and after this moment, the budget law is submitted to the President of the Republic who decrees it. The line ministries initiate to breakdown the budget for the subordinated institutions and they issue the final cash-flow appraisal.

Within 15th of December the Ministries/Central Institutions send to the Ministry of Finance the breakedown budget according to the expendable units and monthly dateline. Last, at 31st of December the Ministry of Finance approve the breakdown budget submitted from the Mnistries and Institutions (For more details see Figure 18 and 19).

Figure 18: Scheme of MTEF preparation

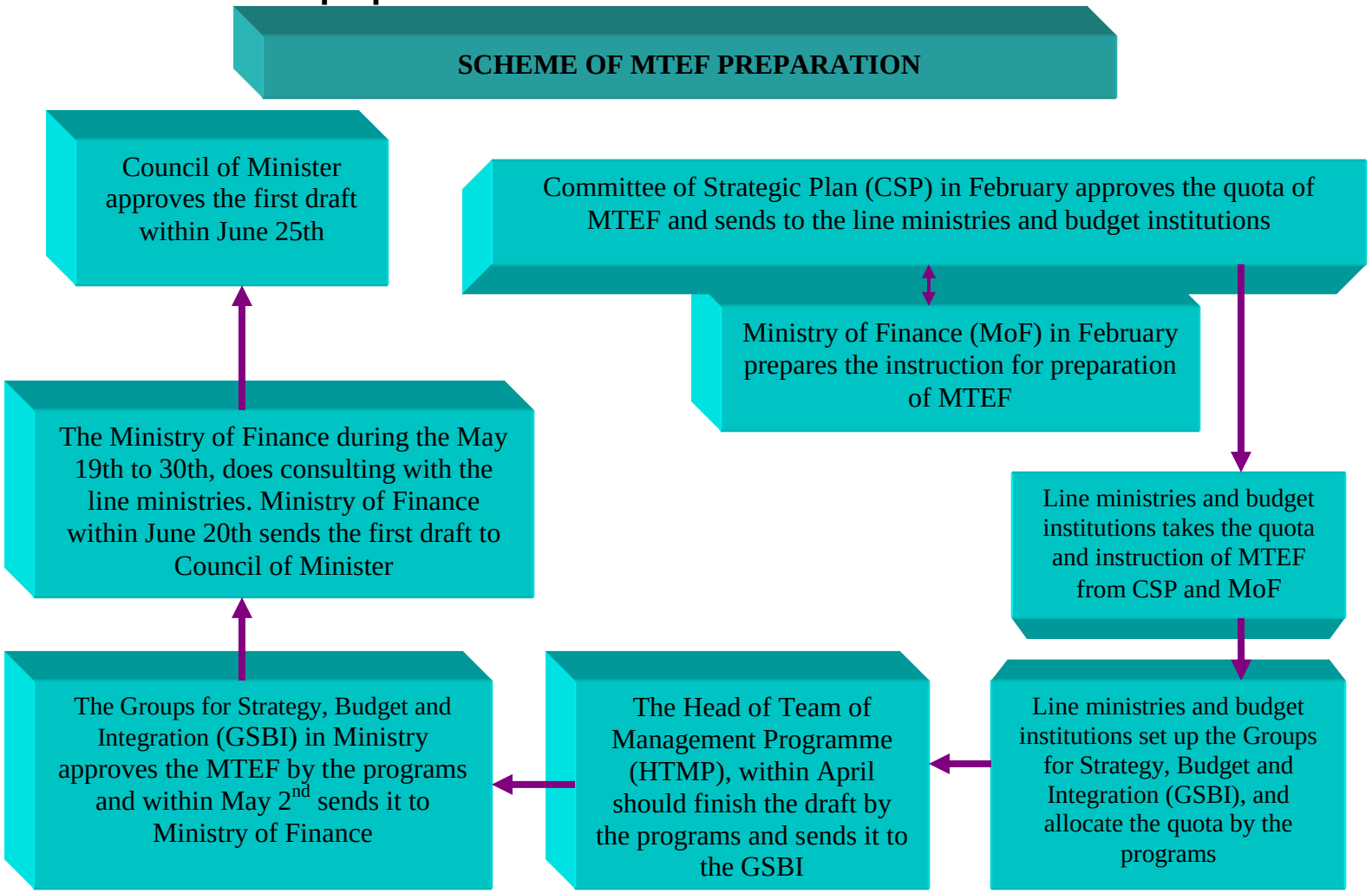
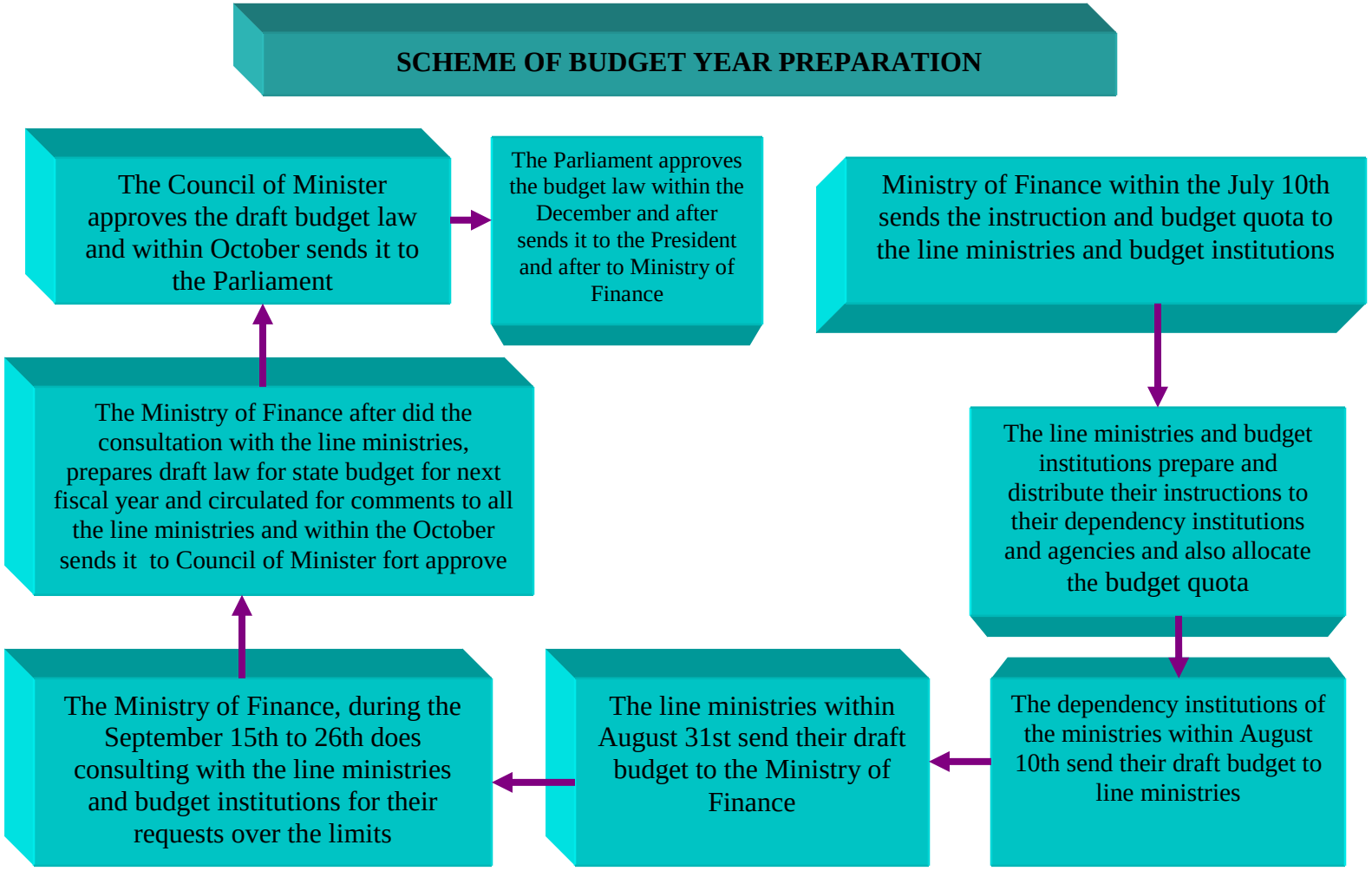


Figure 19: Budget year preparation



MTEF = Medium Term of Expenditures of Framework

The health service is composed of two major components: 1) primary health service and 2) hospital service system.

On the basis of this division and specifics in services delivery, operates the planning, implementation and supervision of the budget scheme. The Ministry of Health breaks down analytically the budget according to the underlined units (hospitals) and the Regional Directory of Public Health.
Also, the Ministry of Health assigns the funds for the hospital service to the dependant units together with the guidelines and necessary competences. The investment funds are break down as well from the Ministry of Health. They address to the units jointly with responsibilities and respective obligations. Both categories of budget fall under the responsibility of the Ministry of Health. The function of the primary health service is illustrated as below:

Primary health services operations are transferred to the competences of the Institute of Health Care, while the budget of state allocates to the budget of the health care insurances funds in order to cover these services. The state budget allocates contributes for insuring health of non–active people made by the Law No. 7870 on 13.10.1994 "For Health Insurances".

The Institute of health care insurances defines the monthly break down of the contribute plan transferred from the state budget, according to the datelines and procedures foreseen in the directive of the Minister of Finance for the implementation of the state budget. The break down at the monthly level is approved from the General Directorate of Treasure. The periodic allocation from the central budget to the Institute of Health Care Insurances (IHCI) is done from the Treasure branch of Tirana by order of Treasure Directory.

The planned fund concerning the first two months of the year is first passing through the IHCI and is to be convey to the next period. The fund for the next month is financed on the basis of factic report of the previous month presented at the Tirana branch of Treasure.

The investments in this service since 2006 and at present are made through competitive grants. The local government units and health institutions apply during the fiscal year with projects at the Ministry of Health. These applications are evaluated from the Ministry from an expertise point of view and presented to the Committee of concurrent grants. This committee is made of member of the Ministry of Health, Ministry of Finance and Ministry of Interior.

Table18: Source of funds, in million Lek, 2007

Source	Amount	Percent
Ministry of Finance	19,713	36.60%
Employer Funds	879	1.60%
Household Funds	31,456	58.50%
Donors Funds	1,708	3.30%
Total	53,756	100%

Source: INSTAT, Ministry of Health of Albania (2007), Ministry of Finance of Albania (2007)

The pace and sequence of steps required to implement the reforms needed to design and plan implementation of the new Health System Strategy to achieve these new roles and responsibilities for the HII, and concomitantly for the Ministry of Health (MoH), have yet to be decided. In the meantime, there is a need to focus on the way HII benefits are currently funded, in general, and whether one of its principal sources.

If this were to be done, there would need to be analysis of the precise impacts on HII's income (and, by implication, its ability to finance its expenditures). On the one hand, since any decline in HII's income could be addressed by one or more of several approaches, one could consider them all (or some combination of them): (1) raising new (possibly earmarked) taxes; (2) reducing spending (reducing either its own or spending by Government on some other purpose(s)); and/or (3) borrowing (increasing the fiscal deficit). On the other hand, if the HII payroll tax were to be maintained at its current level, one could raise the question of whether it constitutes (as it stands) an equitable and efficient way to fund the same benefits for payers (actives) and non-payers (non-actives) alike.

In this regard, whatever the tax rate required of actives/payers (i.e., the current rate, reduced rate, or none), the question arises: How does, or would, or should their b phl of contribution relate to the level of benefits they receive? In recognition of the fact (to be documented below) that they have relatively low use rates of benefits for which they currently contribute (most of which payments are largely a subsidy to non payers), might it be more fair to offer to actives/payers benefits that are not available to non-actives/non payers? Might such additional benefits even provide added incentives for actives to comply with the mandatory contribution requirement? Or would (or should) any reduction in the contribution rate simply be accommodated (at

least, in part) by a reduction in HII benefits for all HII beneficiaries—actives and non-actives?

Regardless of the above, however, any government health program (in this case, HII), that is required by *current* law to provide specific benefits to an identified covered population, needs to be able to rely on a predictable and sustainable revenue stream to cover the costs of that *current* commitment. The HII has recently experienced adverse conditions in this regard, accumulating large deficits in its prescription drug benefits program, which have had to be covered by a special one-time payment (not in the original HII budget) from the Ministry of Finance (of almost Lek 1.0 billion in 2005), and revisions to the coverage provisions.

While reduction or elimination of the 3.4% payroll tax for HII benefits may be in line with other recent reductions in social insurance taxes by the Government (from 41.5% to 32.5%, both including the 3.4% HII tax), and would further reinforce the incentives that lower rates are expected to have in enlarging the formal workforce, there is also the risk that doing so would undermine the predictability and sustainability of an important part of HII's financing. Without the revenue from the "mandatory" 3.4% payroll tax (even if not paid by all those who owe it) nor the revenue from the tax rates assessed on other informal workers (i.e., farmers, the self-employed, etc.), the HII would need to address a complex of questions—such as those raised above—to replace that lost revenue or that reduce expenditures on benefits. Any revenue raised from other sources to replace the lost payroll taxes, either from specific earmarked taxes or from general taxation, or any expenditures cut from HII benefits or from any other government program commitment (in lieu of any other tax increases), would be subject to annual review and adjustment through the political budgeting process. In that environment, sufficient funds may not be sustainable over time to continue financing its benefits commitments (especially if HII's medical expenses grow at a faster rate than do the new source(s) of financing, even if benefits were to be cut as the preferred course of action to finance to reduced payroll tax). In addition, some have argued that any move to lower the HII payroll tax—as well as any alternatives to it—would also have uncertain equity implications and unclear political feasibility. A principal question needing consideration is whether the potentially positive impacts on employment, on the size of the formal workforce, on Government revenues, and on economic growth might be sufficient to outweigh any potential negative effects in other dimensions. Comparing the potential

effects—positive and negative—across several dimensions, however, is problematic.

Currently, investment decisions in the sector are not guided by an overall vision of the sector's structure. This often leads to questionable investments, particularly in the hospital sector. Overall, the needs for investment in the sector remain substantial, as many facilities are in poor condition and lack basic equipment. Therefore, the need to make the most effective use of the country's limited resources for sectoral investments is pressing.

3.3.1. Budget planning and the role of actors

In the last decade there have been continues efforts for the reformation of all expertise and policymaking institutions of budget planning. The reforms have played a major role mainly to increase the participation of citizens and interest groups in the compilation, implementation, monitoring and supervising of the budget. Based on this philosophy, there have been attempts to decentralize and not concentrate the budget at the health sector.

Overall the attempts, it still results that there is centralization of tasks and budgetary competences in this sector, which impinge the use of transparency in these funds. In the meantime, it diminishes the coefficient of security and the foreseen service is not offered to the citizens at the required standards.

It is worthy to mention the fact that since 2006, the local government institutions do not have any role and responsibility in the health sector and as a consequence they do not have a specific influence in the preparation and implementation of the budget for this sector. In this term, before 2006 the local government units were provided together with the unconditional transfer, even with the budget part for primary health service operative. Moreover, the local government units issued the salaries payments and other operative expenditure for this service.

For the purpose of this issue were asked the local government units (municipality/communes) (Figure 20, 21 and 22)

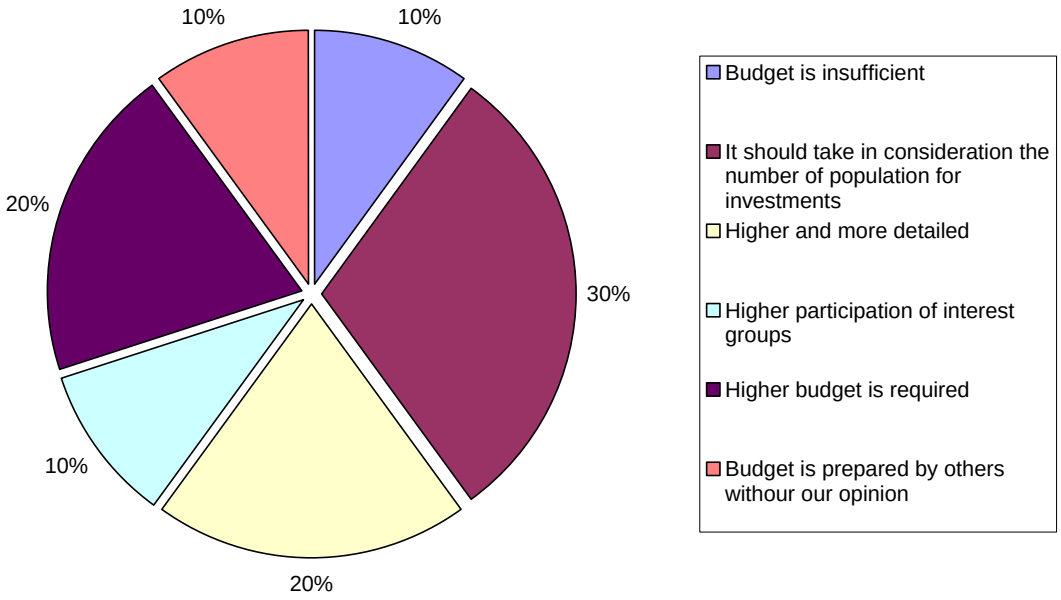
As a result, 30% of the respondents admit that for the distribution of the investments should be taken in consideration the number of population, which would definitely require the use of this criterion by a specific formula for the budget composition. Only 20% of the

respondents said that the budget should be bigger and more detailed, as well as other 20% assumed that if the budget would be bigger even the planning would be easier. Moreover, 10% of them declared that the budget is insufficient and this deficiency arised since the moment when quotas are being discussed. As a conclusion, both target groups in principle raise the problem of the low quota deriving from the Ministry, which leave few opportunities for a planning according to needs.

Following this question, 10% of the interviewees raise the problem of increasing the group of interest's participation and only 10% of them think that the budget is composed from the others without taking into consideration the opinion of groups of local government units.

Figure 20: Opinions for the composition of the budget

What do you think concerning the budget composition problems?

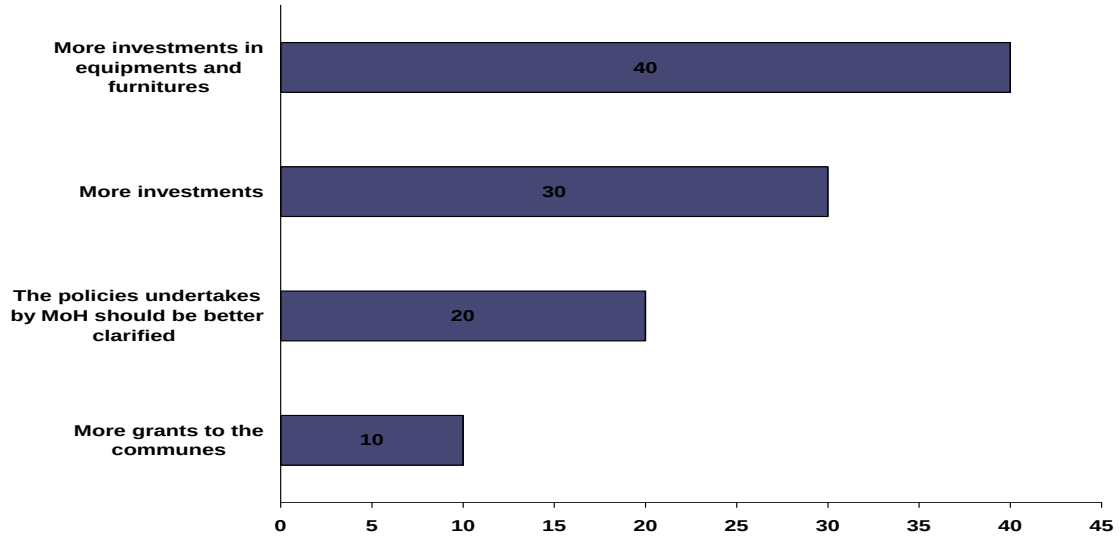


Source: Q-47: For Mayor and Head of Municipality/Communes questionnaire results

The local government units are interviewed even in relation with the ensuing investments. Approximately 40% of the interviewees ask for more investments in both equipments and apparatus. Moreover, 30% of them think that the investments should be more in the health sector. These findings explain the fact that in Albania the health

service still does not offer qualified services, which force the citizens to provide capable health services in the other countries. In addition, 20% of the interviewees require that the planning of competitive grants should be done according to clear and transparency criteria and procedures and 10% of them suggest that grants should be given more to the communes.

Figure 21: Opinions concerning the improvement of the investments schemes

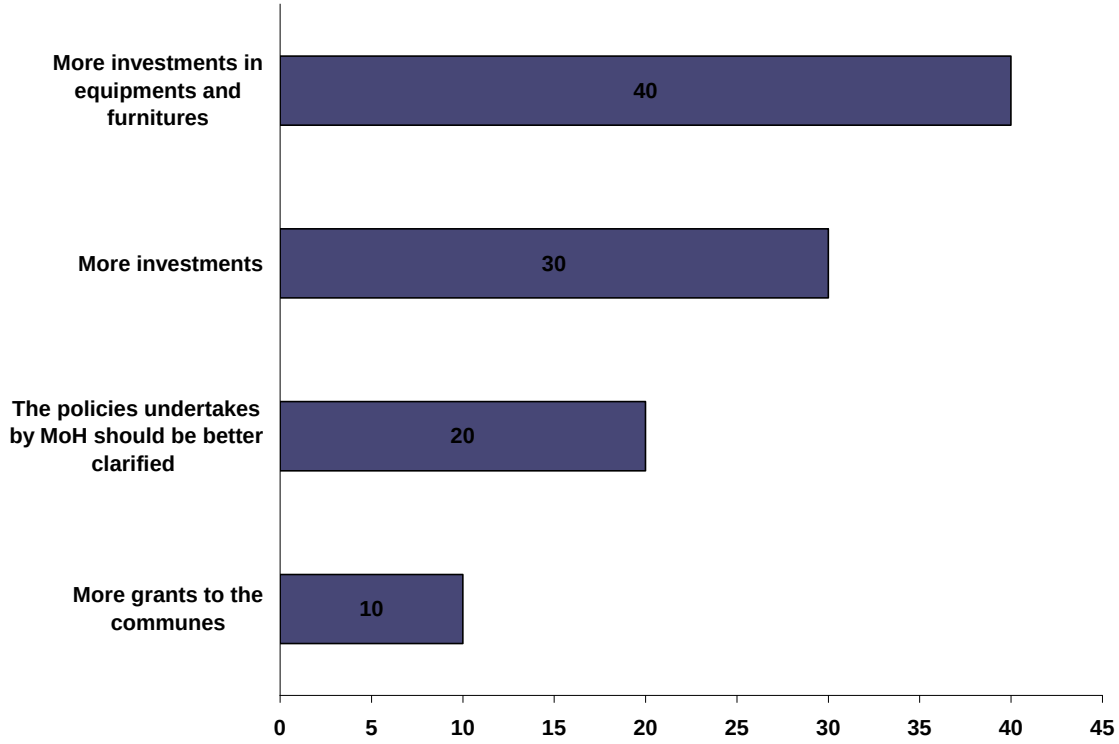


Source: Q-46: For Mayor and Head of Municipality/Communes questionnaire results

As observing from the respondent requests, it results that the competitive grants for constructions and reconstructions are not distributed according to transparent criteria and procedures. In addition, due to the fact that 10% of the interviewees have asked more grants for the communes it was ensured that the health service in the rural areas is less present.

Referring to both graphs, we identify that the role of the local government in the budget planning is minor, which damage the efficiency and effectiveness of planning and use of budget funds in the health sector. On this purpose, there have been interviewed even the employees of the primary health service. From this questionnaire it results that 60.2 % of the budget is foreseen for payments and social insurances, 27.9% for medicaments and 8.4% for services towards those who do not pay.

Figure 22: Budget Distribution



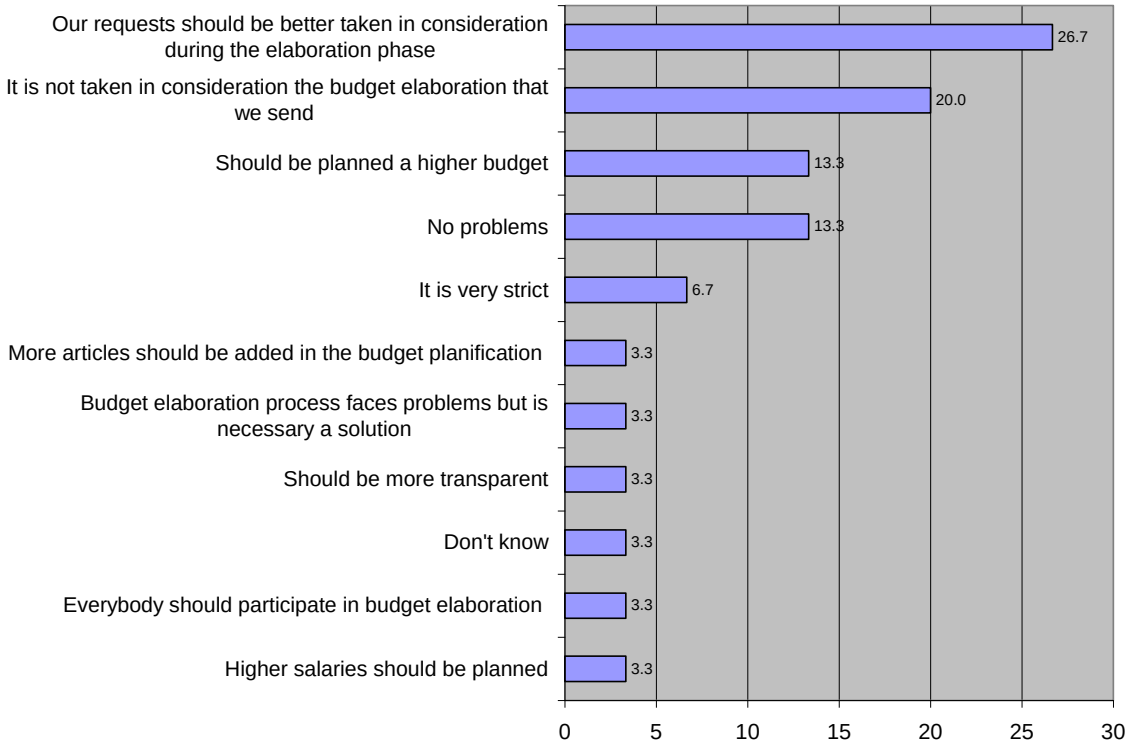
Source: Q-32: For Primary Health Care Institutions' Directors questionnaire results

As resulted from the graph, the biggest part of the budget is addressed to payments and social insurances. Part of the budget is directed to those who do not pay. This clearly shows a weakness of the system itself, in which apart problems of organization there are also social problems, evasion in the contribute payments and benefits from the sector without contributing.

Therefore, is necessary to clarify the social protection scheme, which should not be confronted with the planning and financial health service scheme.

The institutions of the primary health service raised the following problems:

Figure 23: Problems of budget compostion



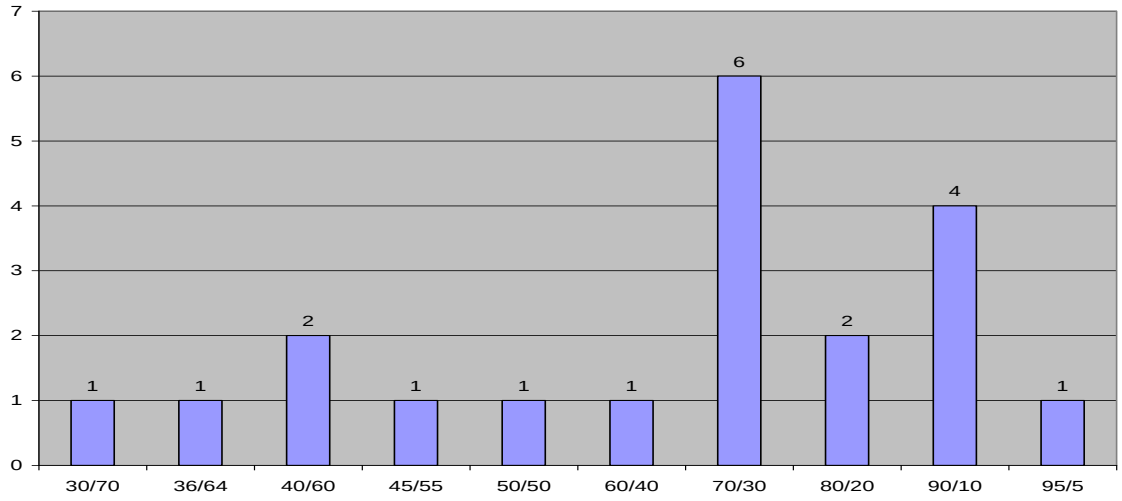
Source: Q-124: For Primary Health Care Institutions' Directors questionnaire results

Around 27% declare that it should be taken more in consideration their requests, 20% asserts that the outlined budget form the institutions of the primary health service is not considered from the higher instances. At about 13% of the interviewees assumes that it should be planned a superior budget than the one we outline each year, 5% of them require the budget to have more analytical articles in the planning, and 5% believes that the budget should be more transparent since the planning, through the enlargement of the participation in the planning.

Referring to the issued surveys, it results that the majority of the primary health service institutions use the 70% of the budget for operative spending and 30% for capital expenditures. The rest of the institutions have a deeper rapport of the above mentioned, where the operative spending occupy 90-95% and the capital ones 5-10%. These indicators emphasized the fact that a considerable part of the

institutions of this service do not undertake progressive policies through investments.

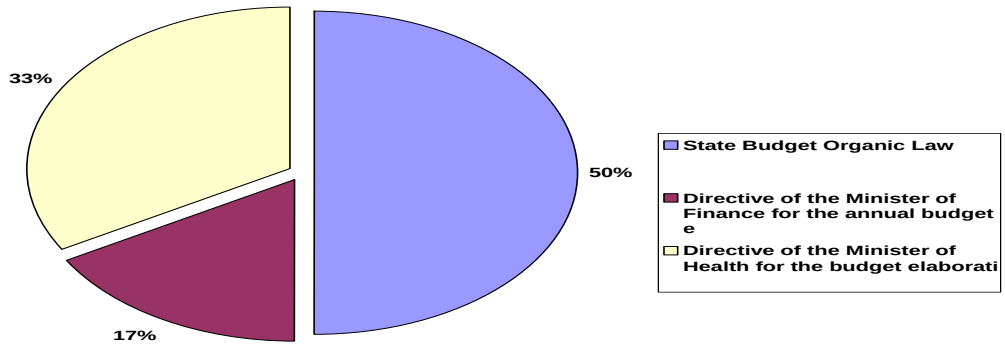
Figure 24: The balance of occurring and capital expenditures



Source: Q-31: For Primary Health Care Institutions' Directors questionnaire results

The same situation is identified also in the hospital system (Figure 25). Over 50% of them asserts that (during) the consultations for the budget are based on the organic law of the state budget, 17% based on the directive of the Ministry of Finance and 33% on the Ministry of Health directive. As resulted, the line Ministries and especially the Health Ministry invest minor efforts to instruct the dependant institutions concerning the budget composition.

Figure 25: Main mechanism in the budget composition



Source: Q-6: For Hospital's Directors questionnaire results

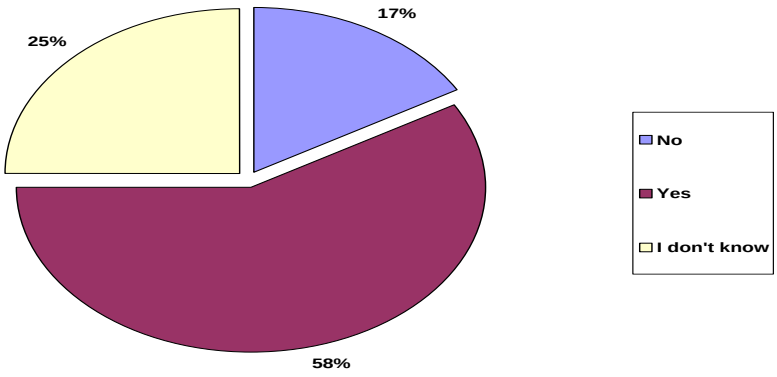
The majority of the interviewees express doubts in relation with the budget planning in the health sector. They affirm that the process is not opened, inclusive and transparent. These consequences have brought weakness in the administration of funds in the health sector.

It has to be underlined that the role of the local government units in the budget planning is very insignificant. They are not part of the budget calculations, apart than having the opinion of the primary health institutions which are under the jurisdiction of these local units for ambulances and health centers. Therefore, in many cases the investments made from the local government in the local infrastructure (streets, water-supply) are not coordinated with the investments or strategies of health sector development in specified areas.

As mentioned even at the beginning of this chapter, since 2003 in Albania is applied the Middle-Term Budget Planning composition method. This methodology is wide spread in the majority of central institutions, and consequently these last should extend it to the institutions and agencies on their dependence.

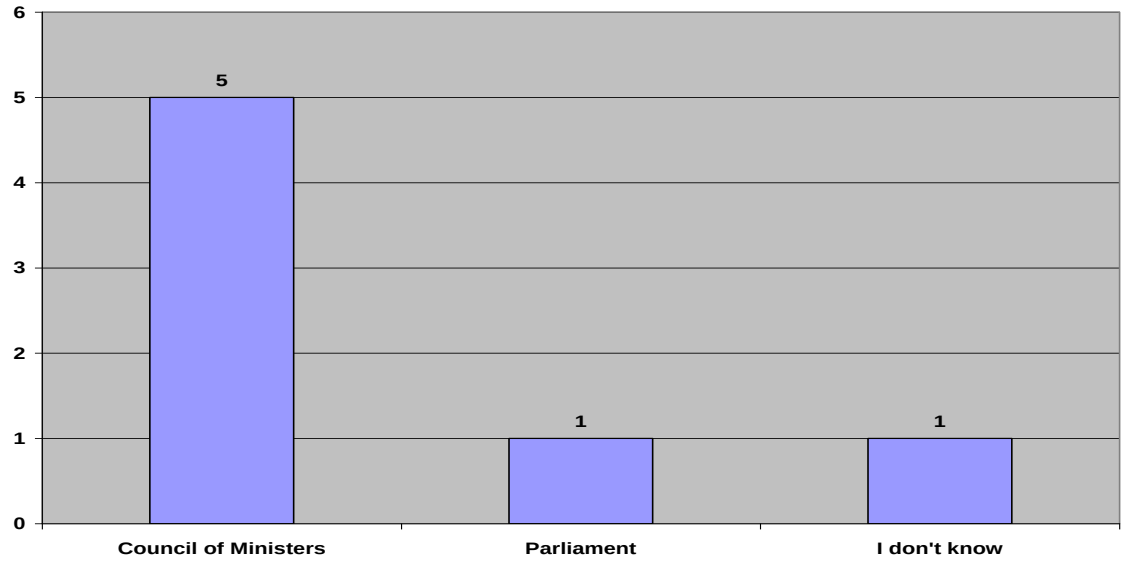
As interviewed, 58% of the hospital service institutions (Figure 25 and 260 have approved that they do not know this procedure, moreover a considerable part of them do not have information who approve this budget or rather affirm that is the parliament who ratifies it while is the Council of Ministers. This clearly shows that the Middle-Term Planning institutions still remain weak and not efficient.

Figure 26: Information regarding the Middle-Term Budgets



Source: Q-11: For Hospital's Directors questionnaire results

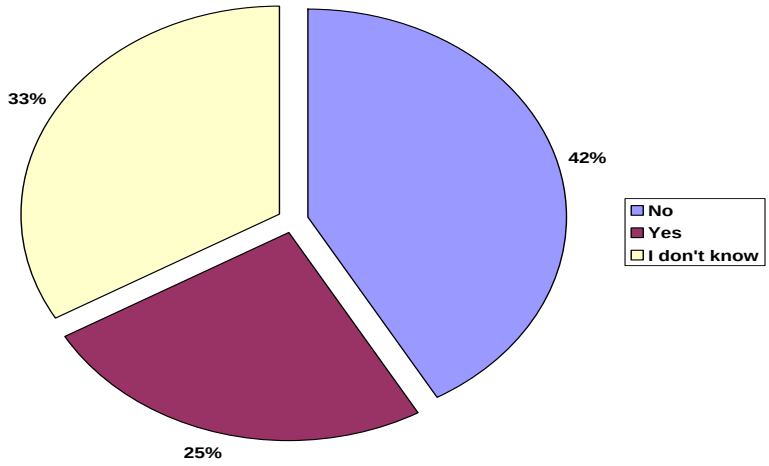
Figure 27: Information concerning the Middle-Term Budget approvement



Source: Q-12: For Hospital's Directors questionnaire results

In order to raise efficiency and effectiveness in the priorities and budget planning is necessary to publish these data in order to discuss and draw suggestions within a wider group of participants. The interviewees of the hospital service were asked on this issue (Figure 28, 29 and 30) and they provided us with this information: 25% asserts that the data of the Ministry of Health is made public, 33% of them admits that those are made public from the health care institutions.

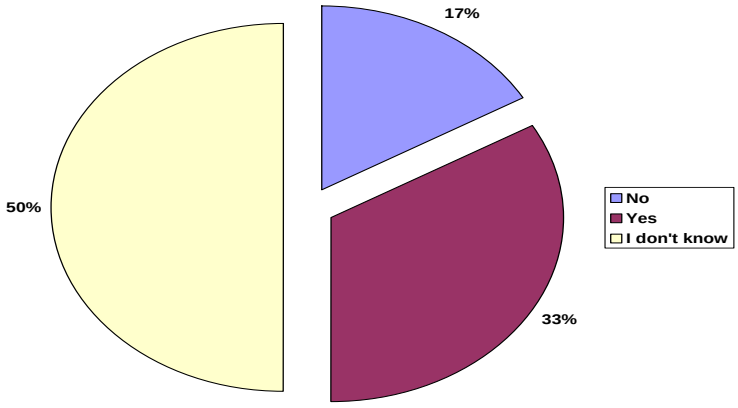
Figure 28: Publication of the budget from the Ministry of Health



Source: Q-10: For Hospital's Directors questionnaire results

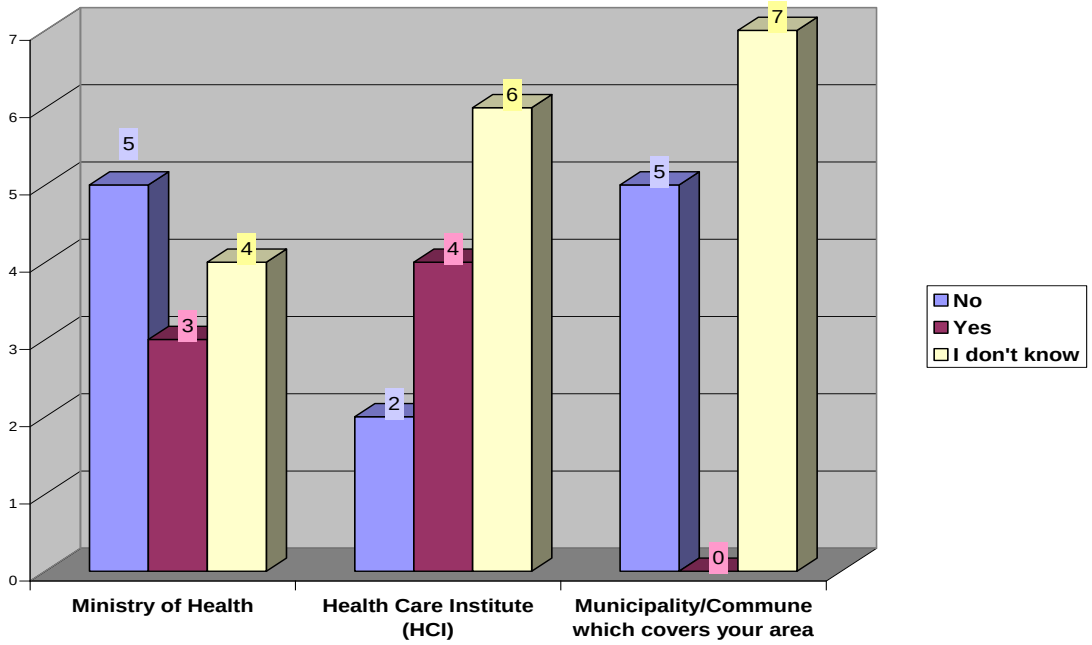
In both cases, it results that although the budgets were made public, the method used to deliver the information was impossible for the public or group of interests to be utilized. Therefore, the planning of funds initially lacks transparency, by diminishing in this term the planning quality as well as can influence the drop of efficiency in the public funds utilization.

Figure 29: Publication of the budget from the Health Care Institute



Source: Q-10: For Hospital's Directors questionnaire results

Figure 30: Publication of the Budget



Source: Q-10: For Hospital's Directors questionnaire results

3.4. Budget execution

3.4.1. General overview

The state budget starts on 1st of January and finishes on 31 December of each year. It is broke down yearly and monthly and is submitted for implementation at the Ministry of Finance. The state budget is composed of the combined fund (local and central budget), social insurance budget and health insurance budget.

The yearly budget plan accorded from the Ministry of Finance for the combined fund (local and central power budget) and for the special funds in terms of title, chapter and article represents the maximum allowed limit to be spent from the institutions and Treasure branches. The excess of the limit is an impingement of the financial discipline as stated in the Law No. 8379, on 29.07.1998 "For the Composition and Implementation of the state budget in the Republic of Albania". The General Directory of Treasure at the Ministry of Finance approves the monthly openings of the budget, which are obligatory for the Treasure branches. From 2008 and on it will be proceeded through the new computerized system of the Treasure (AMoFTS).

3.4.2. The health sector

The Ministry of Health breaks down analytically the budget according to the underlined units (hospitals) and the Regional Directory of Public Health.
The Ministry of Health assigns the funds for the hospital service to the dependant pending units together with the guidelines and necessary competences. The investment funds are break down as well from the Ministry of Health addressed to the units jointly with responsibilities and respective obligations. Both categories of budget fall under the responsibility of Ministry of Health. The function of the primary health service is illustrated as below.

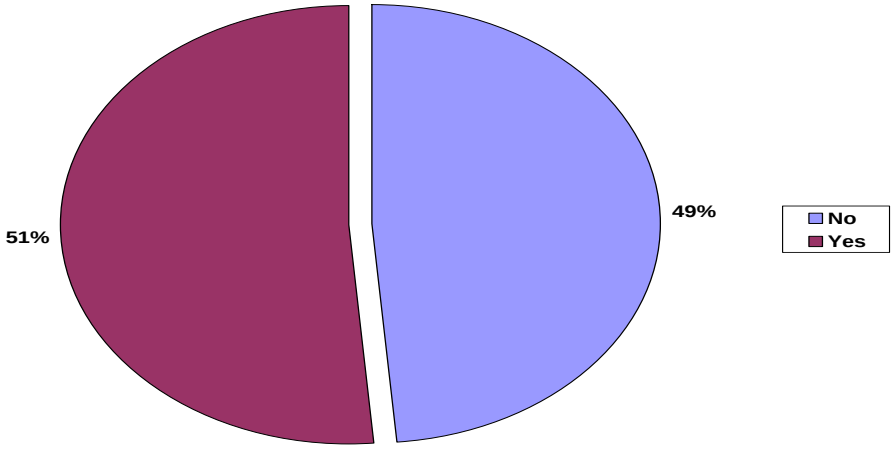
3.4.3. Differences in who pays and who benefits: Cross-subsidies in the financing

While it is not certain how contribution rates were set (at their current levels) for those in the active population, it has always been the case that the non-active population consumed the HII benefits at a much higher average rate than did the active population. Thus, even though the government does pay for roughly half of the total costs of all insured, this amount does not cover the full costs of benefits for non-actives. There is thus a considerable cross-subsidy from the active to the non-active population because of the large difference in use rates. In fact, because of the high transaction costs of accessing insured benefits (to be described below), few contributors use the benefit, with many preferring to self-treat by going directly to a pharmacy and paying 100% of the cost of the drug needed and/or desired, with occasional advice from the pharmacist.
Albania's decision to institute a compulsory social health insurance scheme in 1995 was based on an assumption that a health insurance system would increase revenues to the health sector, and it did accomplish that goal. However, there was limited compliance from the beginning, and the total collected was never more than roughly one-half of HII's total costs—including the costs of the non-active insured who received the benefits without paying for them. Moreover, the amounts collected have always been much less than was actually owed by everyone required to pay—with the shortfall accounted for by both underreporting the numbers of employees and underreporting the wages they are paid (which is almost always no more than the minimum for all employees that are declared).

Collection of the contributions from the active (employed) population has always been difficult because a majority of Albania's workers are farmers and/or are self-employed, and do not make enough to afford to pay the required contribution—that, in any event, could not legally be made separately from all other social insurance contributions. Since the Social Insurance Institute (SII) had been in existence since 1980, and had a network of collectors operating from district offices, it was decided that the HII payroll tax would become a part of the social insurance (SI) tax collected by the SII. In order to join HII through payment of the 3.4% contribution, one had to pay all other SI taxes also owed by the employed. Many workers, especially in rural areas and low-paying jobs in urban areas, could not afford to pay the entire SI tax (which was roughly six times the HII tax).

The interviewed beneficiaries of the health service were asked if they pay health insurances contributes (Figure 31), and the results consist: 49% of them do not pay contributes. In addition, they were asked if the offered services are to a good quality as to pay health contributes and only 4% of them relied positively (Figure 34), 96% - somehow and a small quantity were not satisfied or just a little.

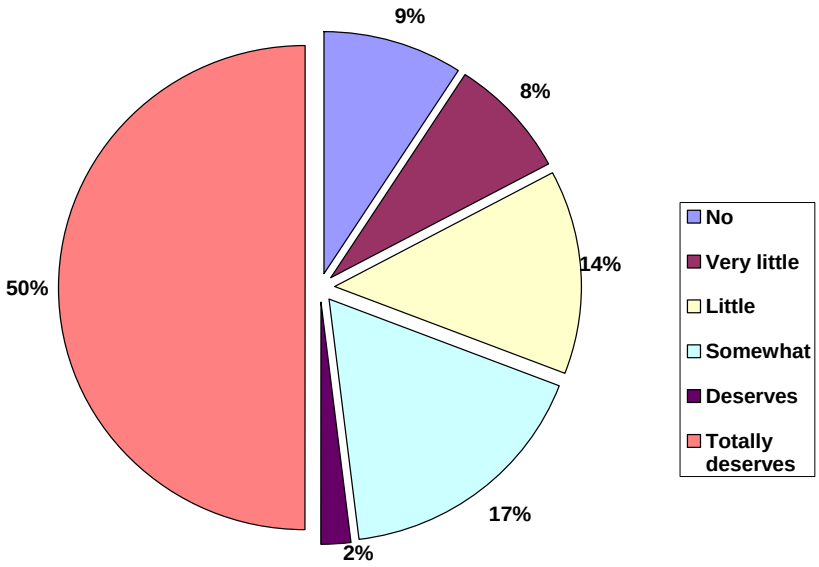
Figure 31: Contributes payment for Social Insurance



Source: Q-9: For client/beneficiaries 'questionnaire results

As observing, the system is not yet working under the principle "who pay benefits the service".

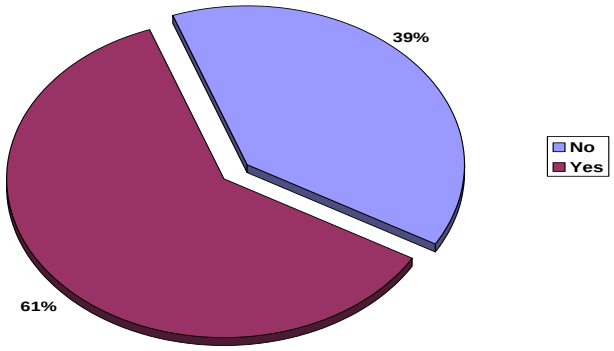
Figure 32: Opinions on the paid contributes amount



Source: Q-9: For client/beneficiaries' questionnaire results

The differences between the contributors and beneficiaries have caused premises for a considerable fiscal evasion. Therefore, the contribute coming from the general taxation for the primary health service is being increased year after year. In this case, this should be considered the reason for stimulating in an indirect way the bribe and other corruptive elements in this sector. As such, around 61% of the interviewees who benefit from the service declare that after the visit to the doctor have paid to him of to the nurse different amount as a bribe.

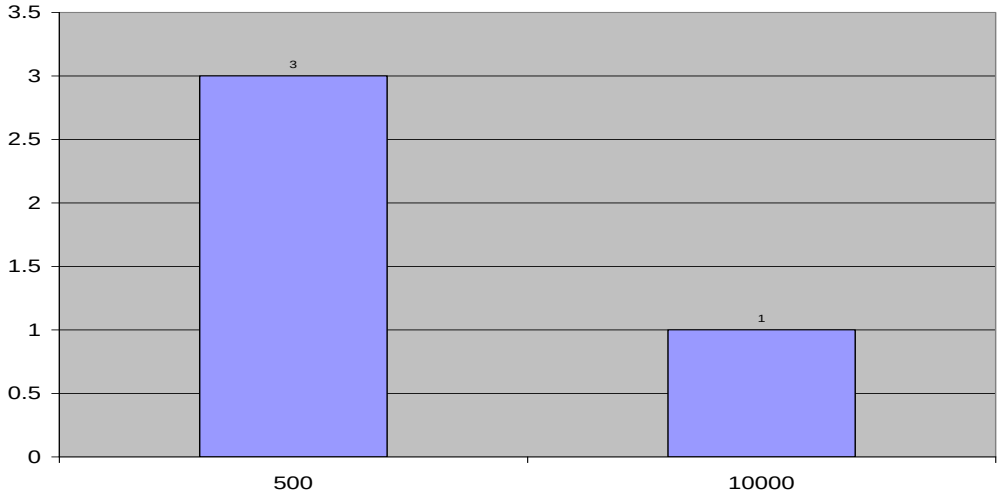
Figure 33: Payments as bribes to the doctors



Source: Q-9: For client/beneficiaries' questionnaire results

The majority of them affirm that the minimal amount paid was 500 Leke and 30% paid 1,000 Leke.

Figure 34: Minimal amount paid to the doctor



Source: Q-9: For client/beneficiaries' questionnaire results

In December, 2006, the Council of Ministers decided to launch nationwide the policy of HII being the sole source of PHC finances as of January 1, 2007. This policy includes gradually increasing the autonomy of each Health Center in administrative, management, and budgetary matters, and gives the HII authority to divert 15% of the Health Centers' historical budgets into performance-based payments. The bases for those payments, now being devised, are (1) the level of activity (to be paid out of 10% of historical budgets reserved by the HII), and (2) the level of quality at each facility (to be paid out of 5% of historical budgets reserved by the HII).

On the expenditure side, a number of factors are contributing to high health costs and limited effectiveness of health expenditures. In addition, the health care delivery network is fragmented, which leads to inefficiencies in the utilization of health services. In the EU, it is increasingly recognized that controlling costs without sacrificing access and quality of care requires better integration of primary care with specialist services and improved coordination across different levels of care. Many countries have established gatekeeper functions, which manage the use of specialist services. For example, in Slovenia, government's reform efforts focus on strengthening primary care and rationalizing secondary and tertiary care.

The budget of the Ministry of Health for the 2008, plans funds for investments for: health centers and ambulances of primary health service in the competitive grants form. **The local government units benefit from these funds by submitting projects.**

During the composition period of the project budget for the next fiscal year, the primary health service institutions in collaboration with the local government units ask the Ministry of Health to finance different projects for reconstruction and construction for buildings and primary health service objects. These requests are called application for financing coming from the funds of competitive grants for this sector.
In accordance with the criteria of Annex 3 of Law No. 9836 on 26.11.2007, "For the State budget 2008", these applications are evaluated from the Committee established on this purpose. After taking a decision from the Committee of competitive grants, funds are transferred with a special meaning to the respective beneficiary local unit.

The local government units can be financed even from their own resources for construction, reconstruction of health centers and primary health service ambulances. Concerning new objects, they

should take in consideration the approval of the Ministry of Health. Also, they should respect the established standards from the Ministry of Health, which monitors, assesses and controls dhe implementation of the standards for reconstruction, construction and equiping of the health centers and ambulances.

Together with the transfer of the primary function under the Health Care Institute, the state budget transfers into the budget of the Health Care Insurances funds to cover this service. Also, the state budget transfers contribute for the health insurance of non active people according to Law No. 7870, on 13.10.1994 "For the Health Insurance".

The Institute of Health Care Insurances defines the monthly break down of the contribute plan transferred from the state budget, according to the datelines and procedures foreseen in the directive of the Minister of Finance for the implementation of the state budget. The break down at the monthly level is approved at the General Directorate of Treasure. The periodic allocation from the central budget to the Institute of Health Care Insurances (IHCI) is done from the Treasure branch of Tirana by order of Treasure Directory.

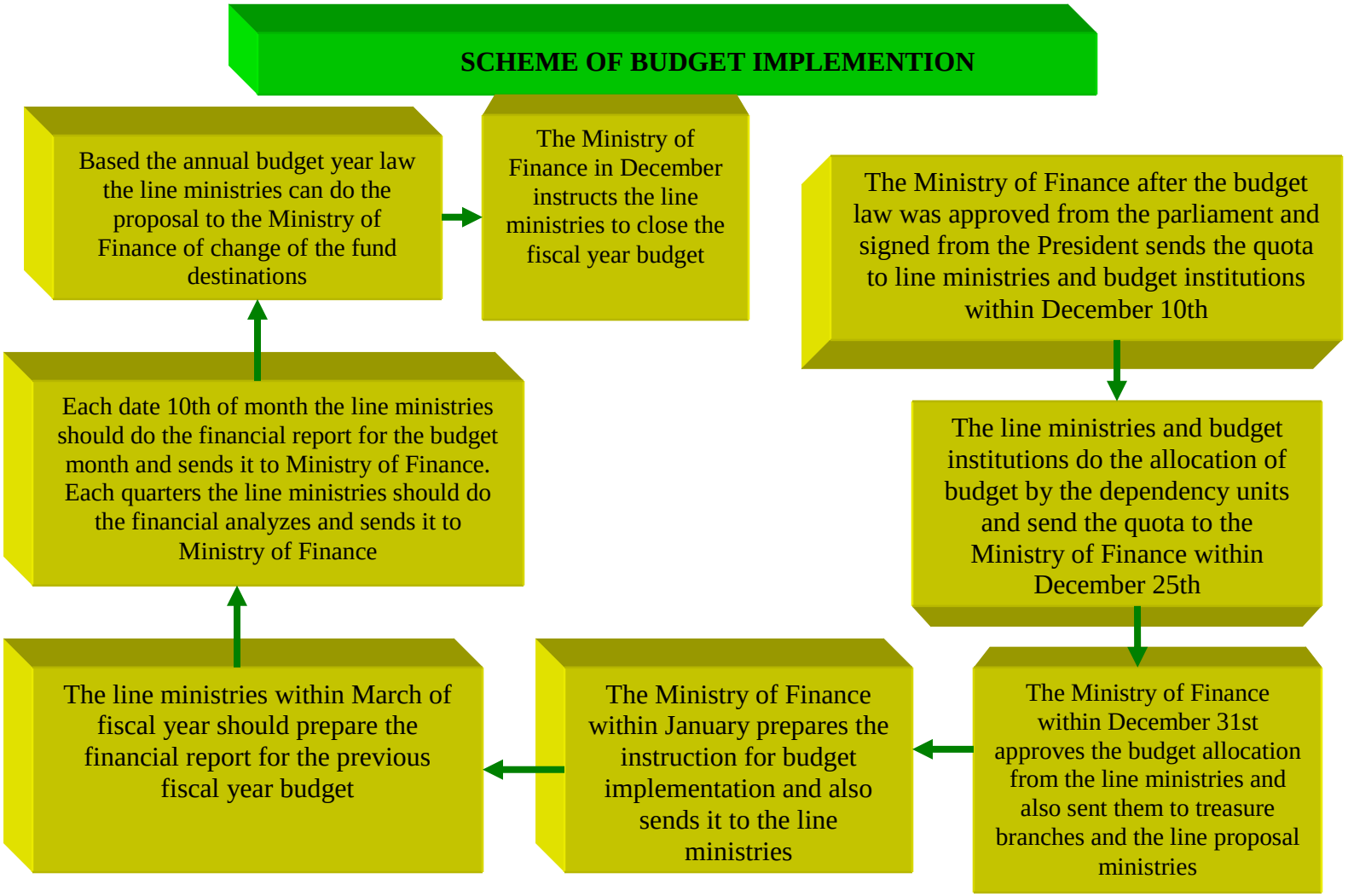
In sustain of Article 4, Law No.9836, on 26.11.2007 "For the state budget of 2008", the primary health service cost as part of health insurance budget is reported in a specific way every month from the Health Care Institute at the General Directory of Treasure according to all articles and subarticles budgetary classification. Part of the report is also the summarized information on the foreseen number of employees and realized in fact for the primary health care service. The budget implementation report of health insurances is sent within the 8^{th} of the next month from the HCI to the General Directory of Treasure.

The bank accounts which reveals the health insurances contributes cash cashed from the General Directory of Treasure, are considered accounts of the state budget incomes and are reported at the end of each day from the second level Banks to the Bank of Albania in a visible way together with the rest of the expenditures and income bank accounts of the state budget. The reserved fund of the HCI, established by law, is administrated in a special account in the Bank of Albania. Its investments are accomplished by the Director of Treasure with the decision of HCI until the foreseen measures of the legal directive in power. The interest related with the investment of the fund is transferred to the HCI account at the second level banks.

HCI execute the transaction of payments at the accounts opened by the Ministry of Finance by request and on behalf of HCI, at the second level banks. In this account flow periodically the incomes cashed by the General Directory of Treasure on behalf of the HCI and the transfers of the state budget, as well as other incomes which are cashed directly from the HCI.

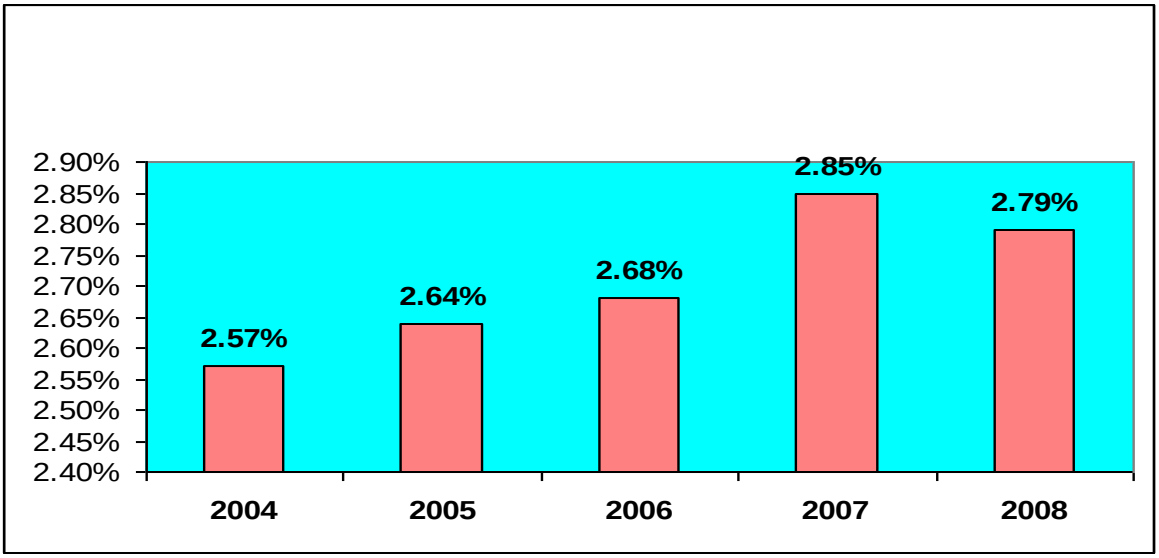
At the beggining of each month, the second level banks send officially at the Ministry of Finance (Treasury Directory) the confirmation for the situation of liquidities at the end of the previous month in the HCI account. The Ministry of Health within its group contains funds for primary health service, which are managed equally with other funds of the Ministry as part of the same group.

Figure 35: Scheme of budget implementation



The expenditures at the health sector are raised in absolute value from year to year. As seen at the Figure 6, they are increased also in relative value, but in 2008 it is observed a decrease of the relative value. In fact, in absolute terms there is an increase of 2 milliards Leke, but the relative term does not have this augment because the component which is meant for this sector did not reply to GDP growth pace.

Figure 36: Level of expenditures for health care as % of GDP



Source: INSTAT and MOF

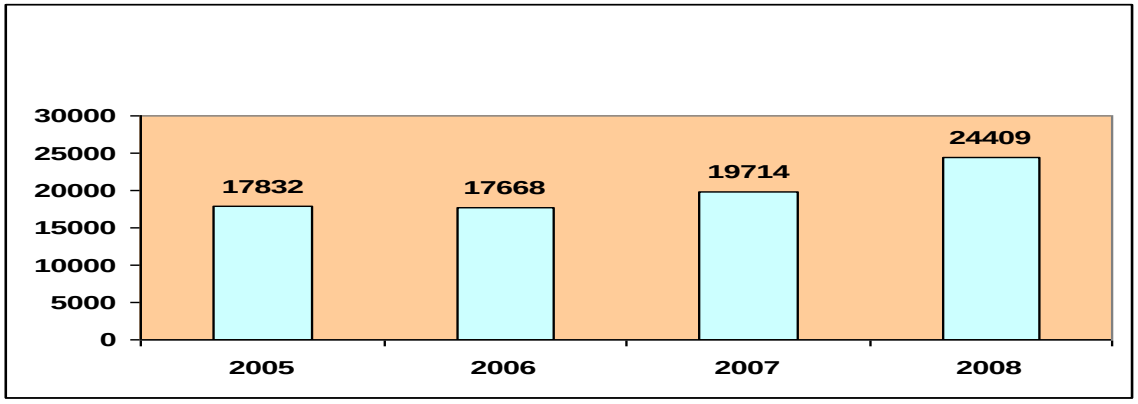
As observing from Tabel 7 and 8, the budget in 2006 faced a decline comparing to 2005 of -1%, while in 2007 is increased 12% compared to 2006, in 2008 is increased 24% comparing to 2007. During the last two years there is an increase comparing as noticed with the previous years.

If we observe the structure of the budget among the years, we assert that the budget of investments occupies a relatively low position comparing to the operative budget. This indicator emphasizes once more the fact that the sector suffers the lack of reformations and having development strategies. In 2006, 13% of the health system budget (Ministry of Health) was used for investments and 87% as current expenditures. Whilst in 2007, 12% goes to expenditures for investments and 82% as current expenditures. In 2008, this balance seems improved as 20% are planned for investments and 80% for current expenditures (salaries, insurances, operatives and

maintenance). The structure of the 2008 budget is already planned, but taking into consideration the experience of the previous budgets where the level of achieved investments is less than 80% this balance might be diminished.
We highlight that the balance of the planned state budget expenditures is approximately 25% for capital investments and 75% current expenditures, while in the local administration this balance is 35% for capital investments and 65% current expenditures.

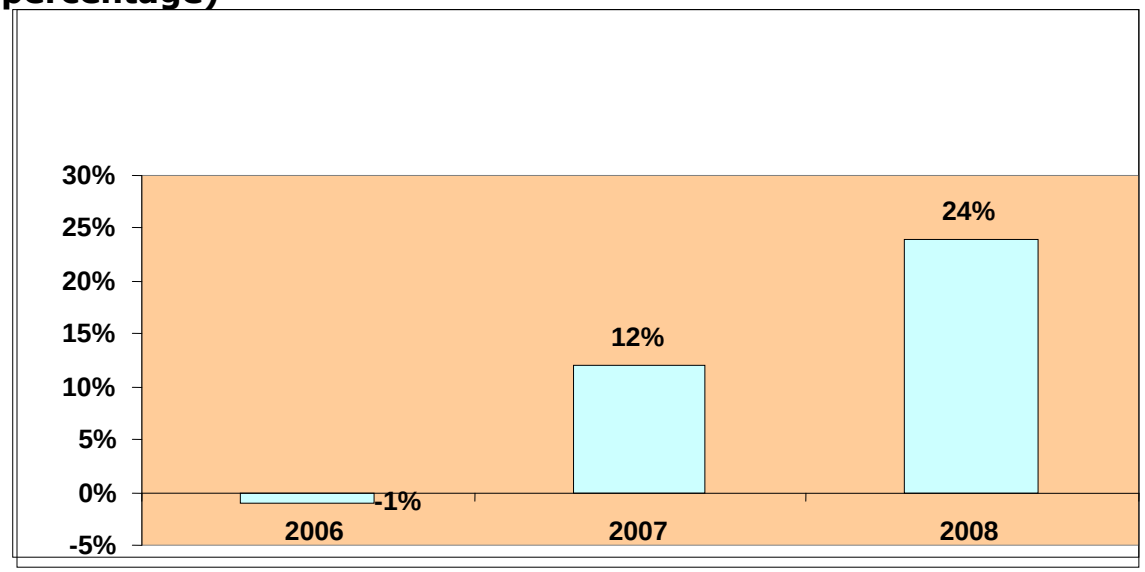
Throughout the analyses of the budget for the period of 2005-2008, it results that the planning and achievement of the capital investments do not work properly.

Figure 37: Budget of Ministry of health (thousand leke)



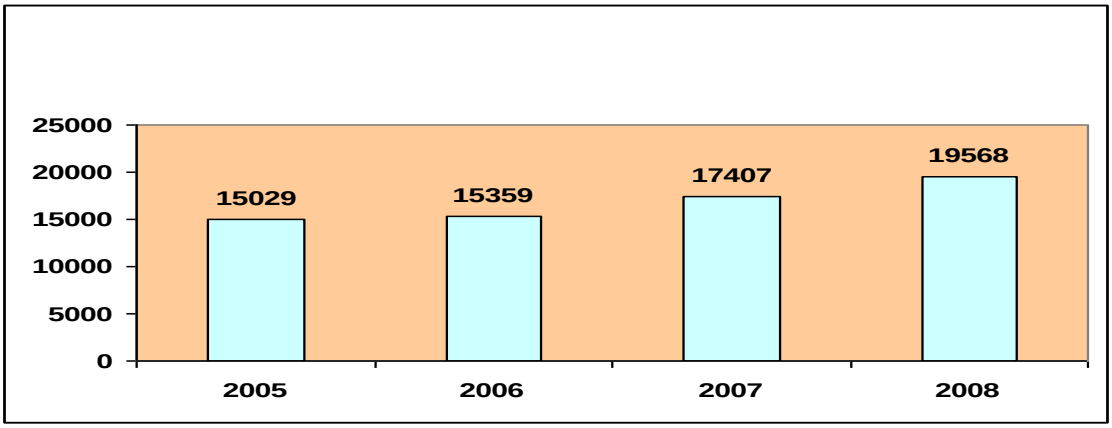
Source: MOF unpublished

Figure 38: Increase of budget for the Ministry of Health (in percentage)



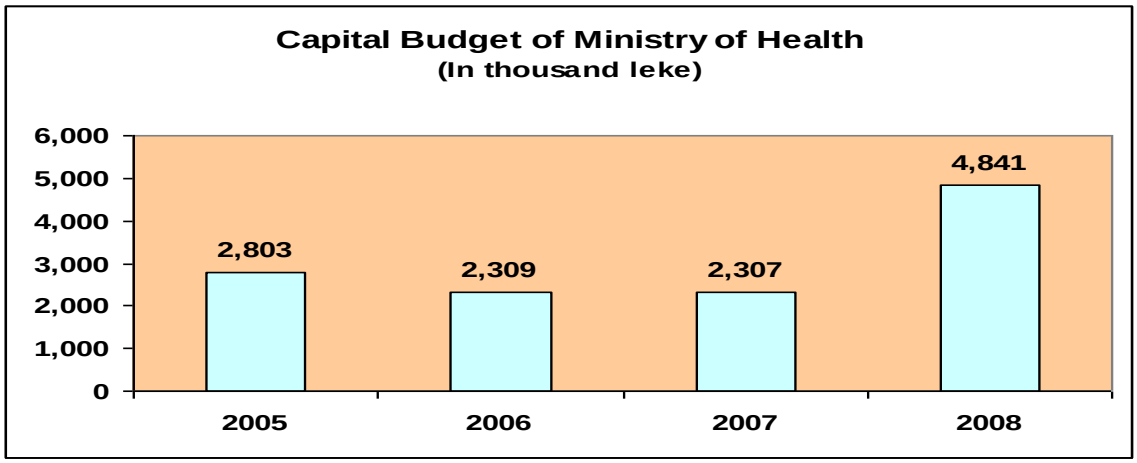
Source: MOF unpublished

Figure 39: Increase of operation budget for the Ministry of Health (in thousand Lek)



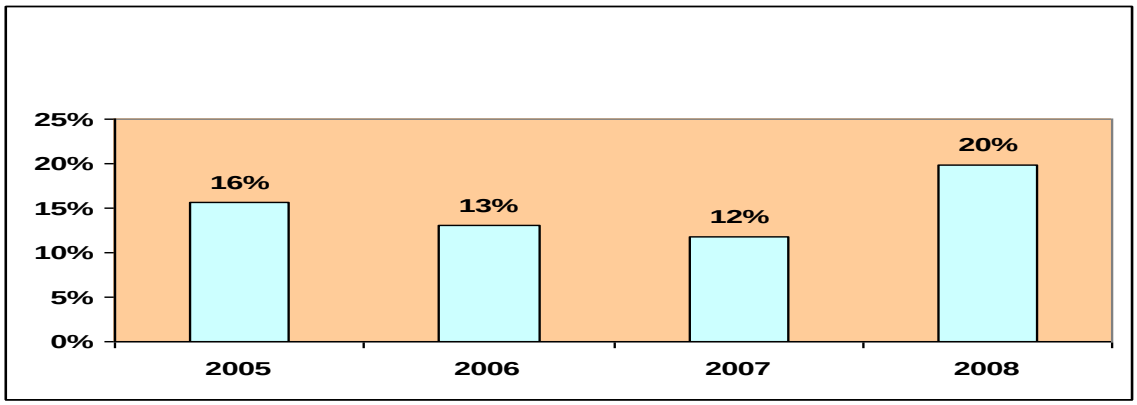
Source: MOF unpublished

Figure 40: Capital expenditures for the Ministry of Health in thousand Lek



Source: MOF unpublished

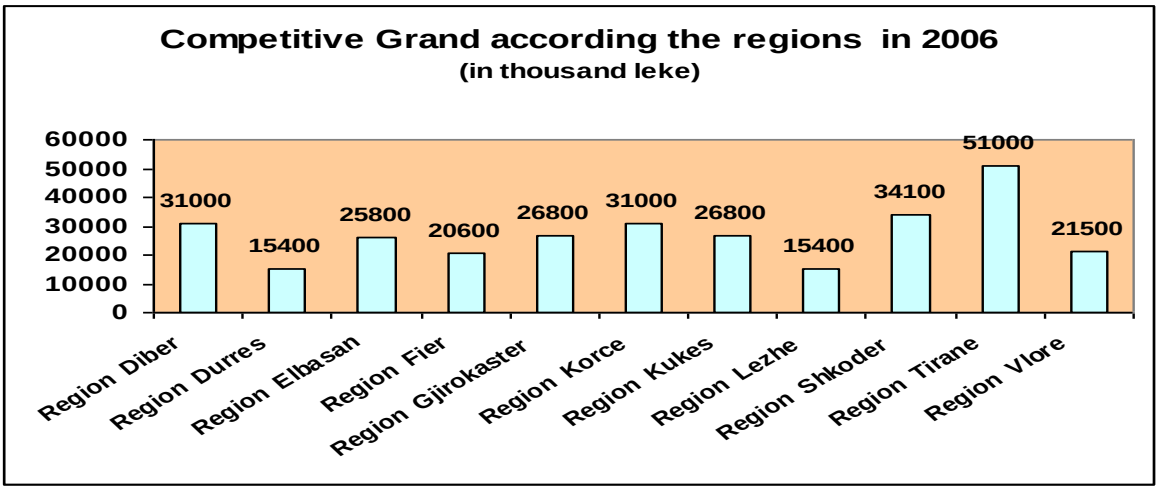
Figure 41: Capital expenditures for the Ministry of Health (in percentage)



Source: MOF unpublished

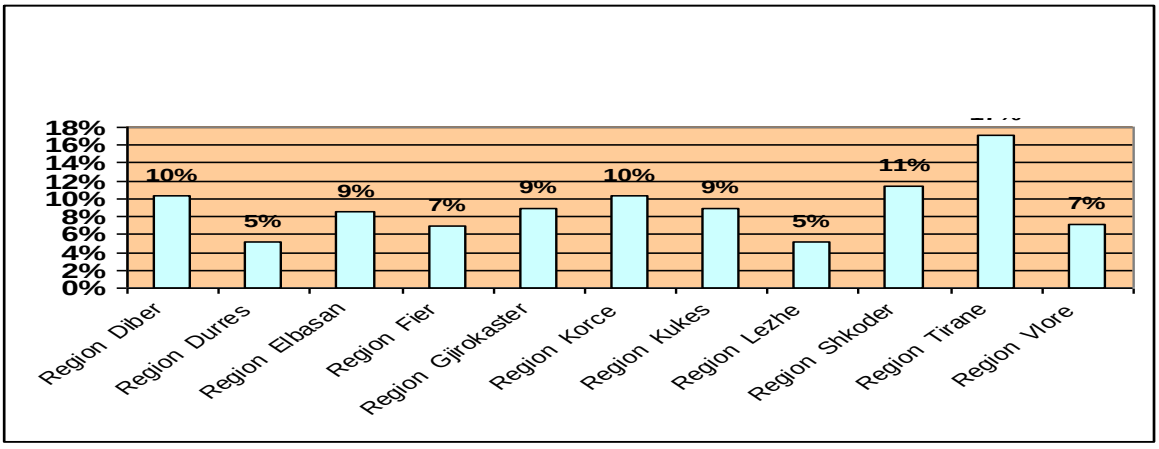
From the competitive grant in 2006 have benefit more the local government units of Tirana, Shkoder, Korce and Diber region. While in 2007 there were district of Tirana, Shkoder, Diber, and Durres. It is worthy to mention that during these two years, the districts of Fier, Vlore, Lezhe, and Berat have benefit less than the other districts.
Moreover, 40% of funds from the competitive grants are used for reconstruction and 60% for the new constructions. Whilst in 2007, 60% of the fund was distributed to those objects which were financed in 2006 indicating the fragmentation of this fund among years and objects. This definitely aggravates the efficiency indicator of public funds utilization.

Figure 42: The competitive grants according to regions in 2006 (in thousand Leke)



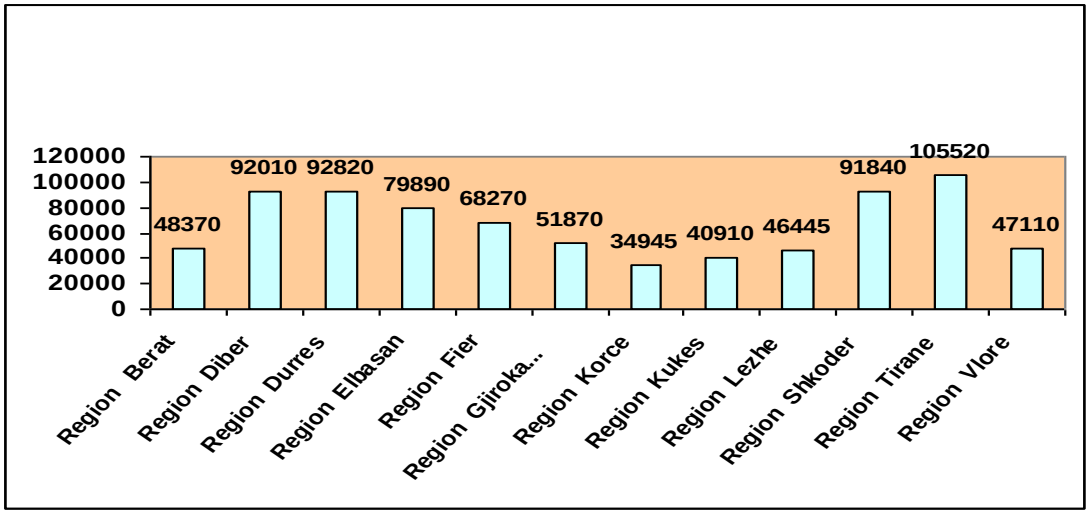
Source: MOF unpublished

Figure 43: Competitive grants according to regions in 2006 (in percentage)



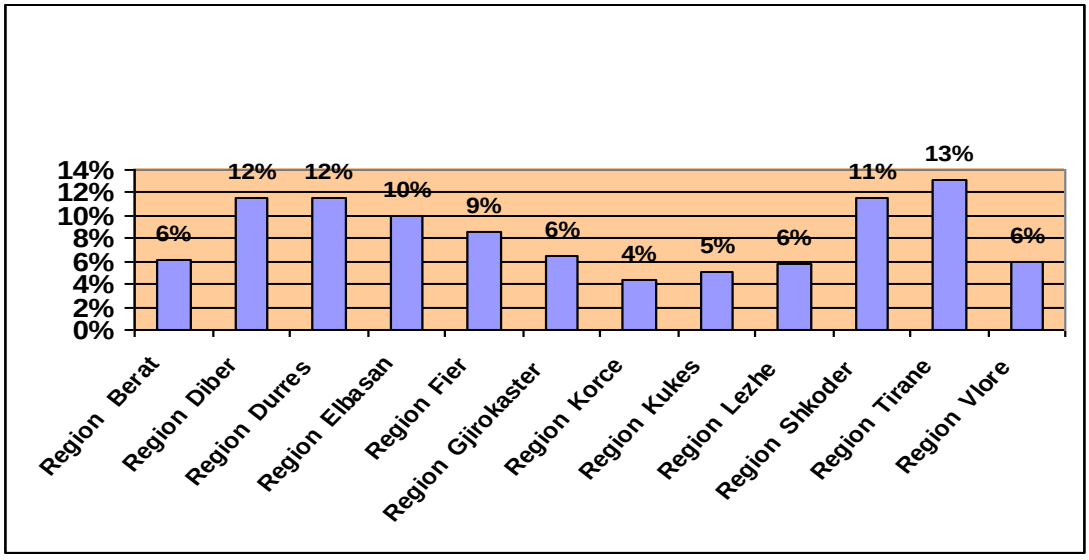
Source: MOF unpublished

Figure 44: Competitive grants according to regions in 2007 (in thousand Leke)



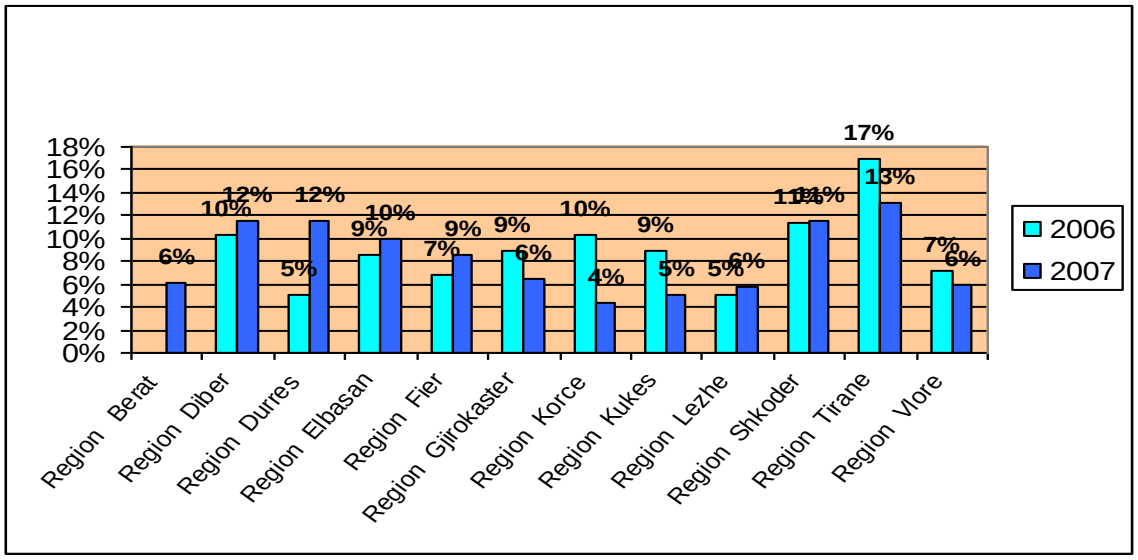
Source: MOF unpublished

Figure 45: Competitive grants according to regions in 2007 (in percentage)



Source: MOF unpublished

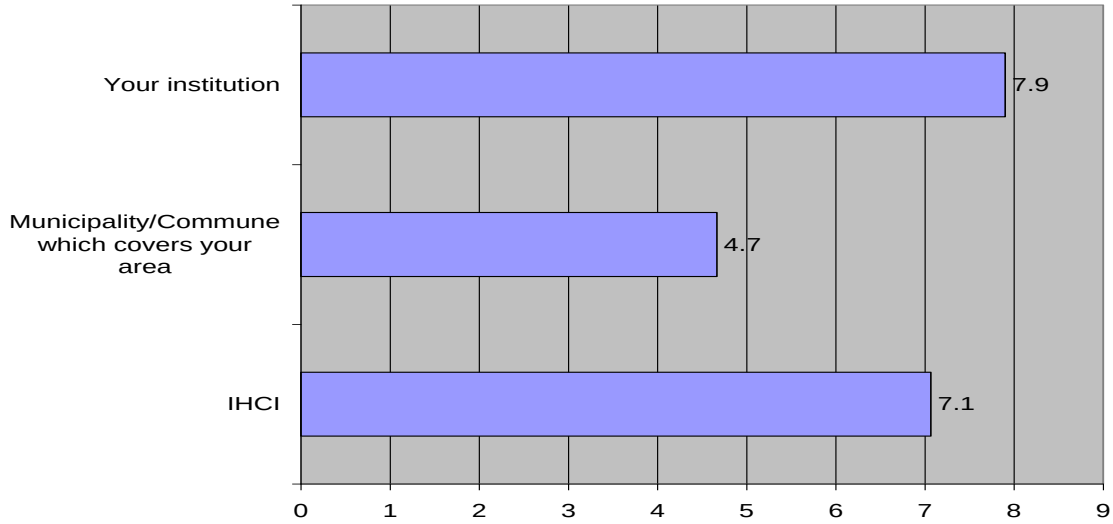
Figure 46: Competitive grants according to region in 2006 and 2007 (in percentage)



Source: MOF unpublished

Budget expenditure management for the Albanian public economy as a whole and for the health system in particular remains a crucial problem. In this regard, despite the weakness of the system, the reforms made in the financial systems of public funds management such as: the Treasure's offices from the center to the basis through which flow all state budget funds, credits, loans, and different grants accorded in favor to the health sector.

Figure 47: Management quality of expenditures from your institution

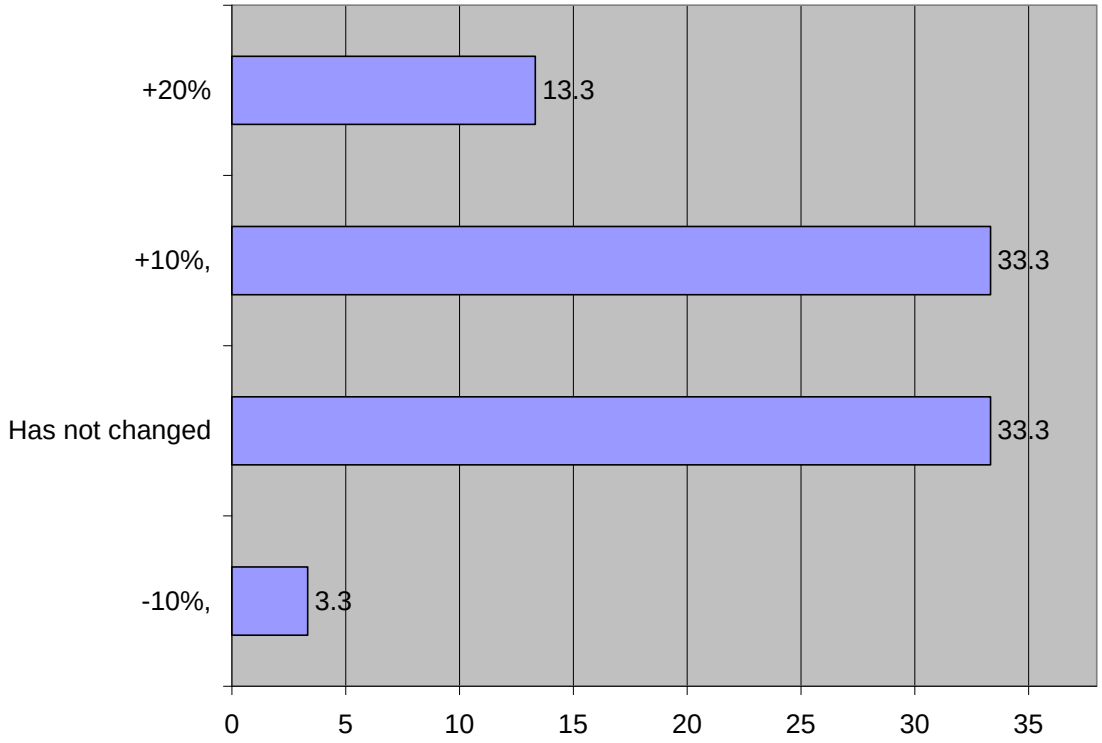


Source: Source: Q-38: For Primary Health Care Institutions' Directors questionnaire results

The implementation of the budget is strongly linked with its quality prediction. The latest, is affected by the quality of the process in budget composition, by the participation and contribution of the interested actors and broadly.

During the transition period in Albania, changes and continues shifts of destination in the budget utilization are being observed. The requests start in January-February when the budget implementation begins. These facts are a clear testimony of a lack of responsibility from the institutions which draft the budget and accomplish budgetary policies. As such, at the Ministry of Finance there have been identified progressively numerous cases proposed from the Ministry and central and local institutions to change expenditures destination. These cases have been diminishing but still present in Albania.

Figure 48: Changes in destination of funds

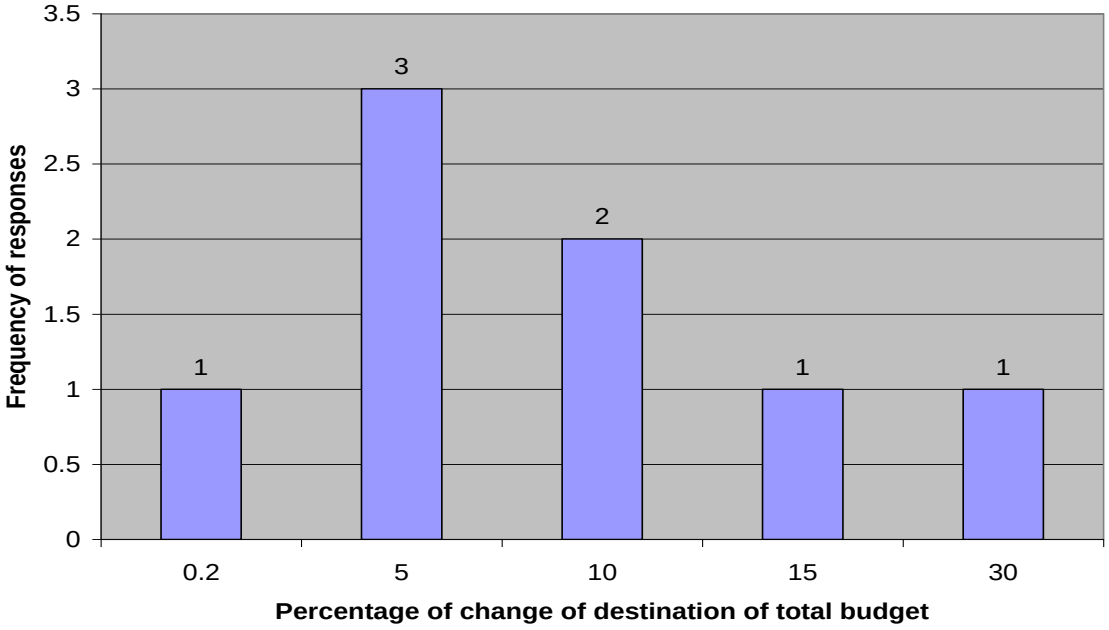


Source: Q-20: For Primary Health Care Institutions' Directors questionnaire results

Certainly, this phenomenon is present even at the health sector. The interviewees of the primary health service (Figure 48 and 49) assert that often shifts of budget expenditures destination occurred during fiscal years. Related to this, 30% of them declares that during the

budgetary year funds are differently reallocated. The amount of funds destination allocation varies from 10 – 30% of the budget institution.

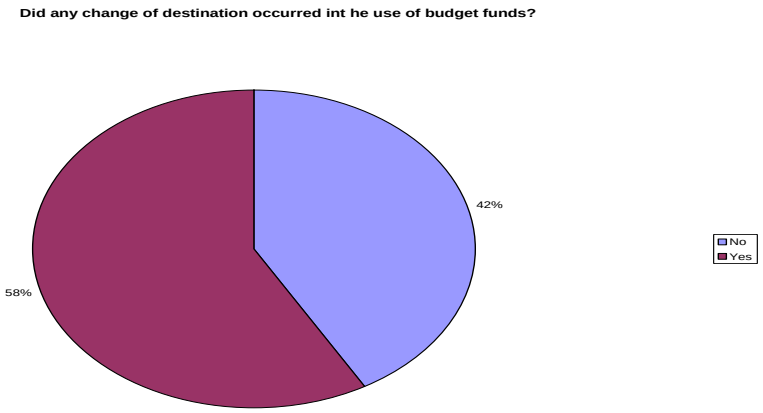
Figure 49: The percentage of change of destination in the total of budget



Source: Q-27: For Primary Health Care Institutions' Directors questionnaire results

At the hospital service, this phenomenon is more observable. Hence, 58% of the interviewees attest that during the budgetary year there are changes of use and destination of budgetary funds.

Figure 50: Changes of destination in the budget of hospital service



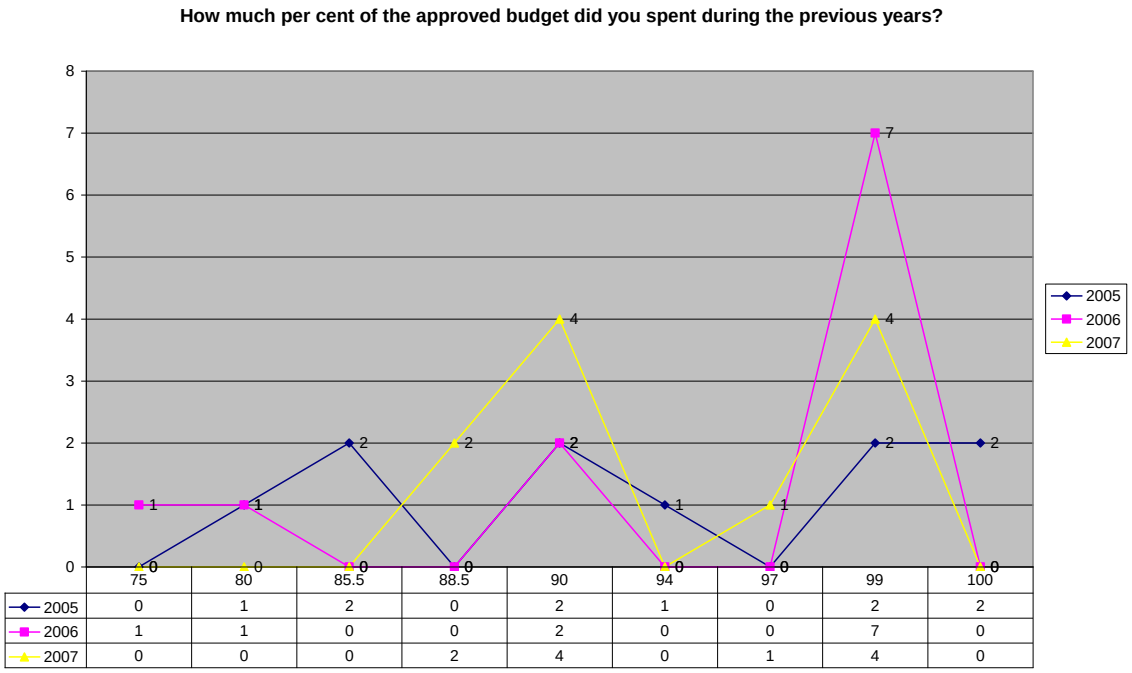
Source: Q-18: For Hospital's Directors questionnaire results

This phenomenon not only reflects the low level in the scheduling of budgetary priorities, bur also is likely to be influenced from the politics in different regions and areas, or by the abusing preferences of the administration which held the authority to propose the shift of funds in any time of the year.

The shift of destination in the utilization of the budgetary funds creates effects even in the realization or consumption of budgetary funds within the fiscal year. In various cases, the intensity of changes is during the third and forth trimester. As a result, these changes or tentative for changes are time consuming and bureaucracy by influencing that funds are not consuming within the fiscal year. Due to the survey for the respective periods 2005-2007 at the hospital service, results that the majority part of these budgetary institutions have a budget realization from 75- 90% of the fiscal year budget.

When comparing these indicators with the needs carried out by this service, than they become more serious to be realized and adjusted.

Figure 51:The percentage of budget spent during the year



	75	80	85.5	88.5	90	94	97	99	100
2005	0	1	2	0	2	1	0	2	2
2006	1	1	0	0	2	0	0	7	0
2007	0	0	0	2	4	0	1	4	0

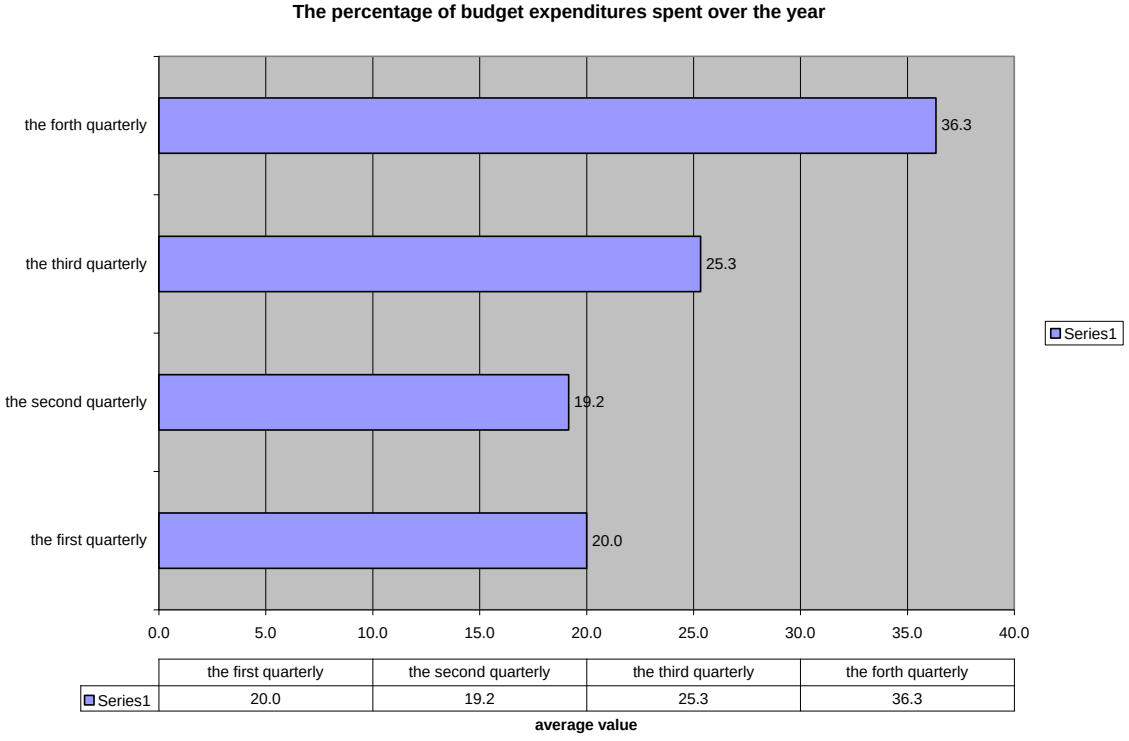
Source: Q-18: For Hospital's Directors questionnaire results

The unified distribution of expenditures during the year would be in accordance even with the objectives of the monetary policy in order to maintain a stable level of prices. If referring to the figures, we notice a disproportion in the accomplishment of these expenditures. A

considerable part of them is achieved during the last period of the year by influencing the inflation, which is higher during this period due to other factors of the season.
Further analyzing the budget execution for these institutions, we notice that the execution of capital expenditures did not have mensural. Naturally, is common the trend to repay the obligations at the end of the year, but to this extent at the end of the year it could not be guaranty the affectivity of the utilization of financial resources of the budget.

As seen from the figure, 36.3% of budget expenditure is spent in the last trimester, which testifies that this is affected from the shifts of destination or other subjective delays in the procurement and realization of public investments. Based on the yearly directive of the Minister of Finance for budget implementation, all non procurator budget funds of investments until November 1, are not used from the institution which disposes them. Based on this financial discipline established from the financial authorities, the budgetary expenditures in the fourth trimester should be insignificant.

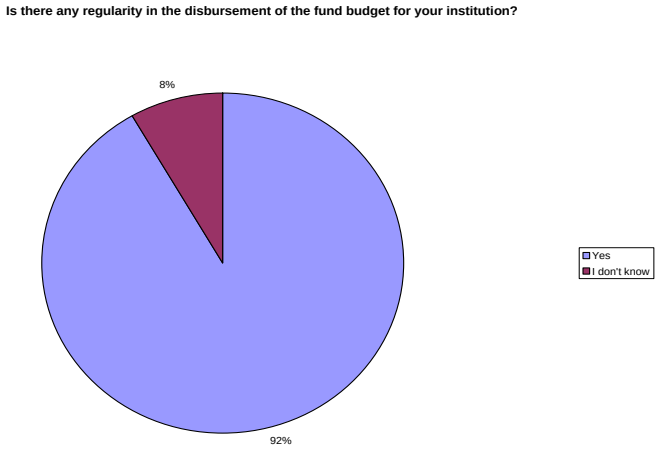
Figure 52: The percentage of the spend budget during the year according to trimesters



Source: Q-18: For Hospital's Directors questionnaire results

The question addressed to the hospital service if there is any rule in their institution concerning the budget implementation, 92% of them replied positively confirming that there are regulations and directives for the budget implementation.

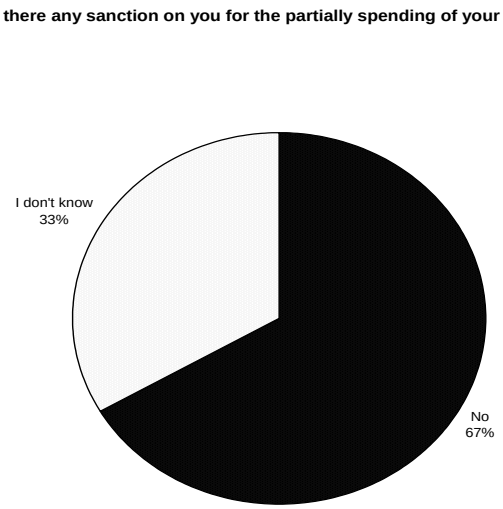
Figure 53: The existence of rules in disbursment



Source: Q-18: For Hospital's Directors questionnaire results

While to the question if there is any sancion if they do not spend their budget, 67% answered that there is not any. In reality, there is no sanction concerning the non consuming of it clearly stated. According to the yearly Directive of the Minister of Finance, to implement the state budget each institution is obliged to report for the financial indications and explain the reasons of failing to execute the budget in a periodical way. On the basis of this raport, in a vertical way is measured the work performance of each institution, which means that in the same vertical way even at the horizontal, at the health service administration should be evident the rensponsability of each for the non realisation of the budget and this latest should be accompanied with different sanctions.

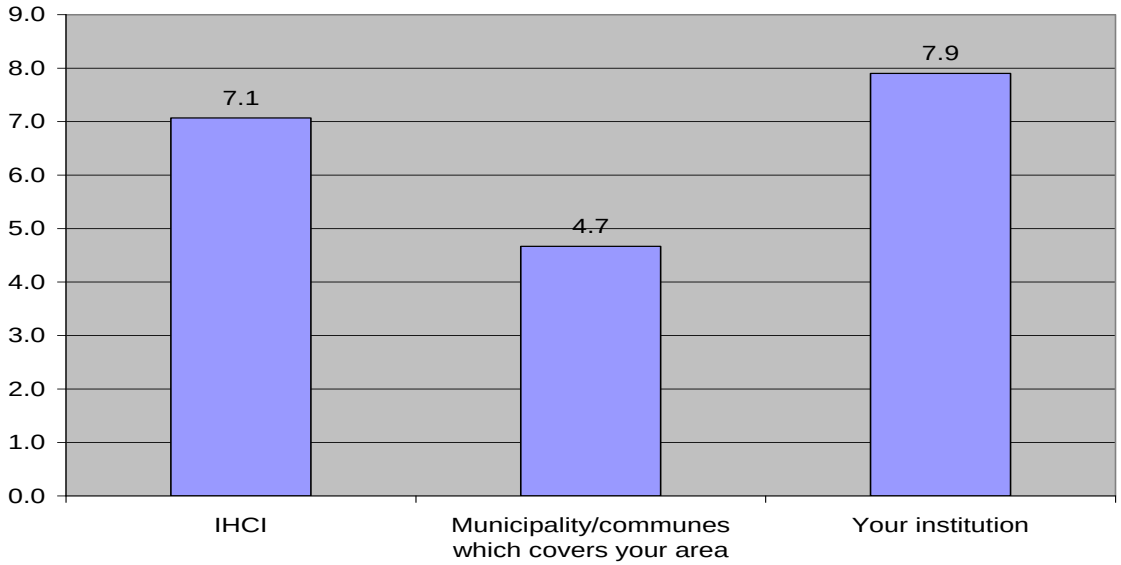
Figure 54: Responsabilities when non spending the budget



Source: Q-18: For Hospital's Directors questionnaire results

In accordance with the managment of the budget as a whole, actors who execute this duty were asked. As such, from the answers received from the primary health service results that communes and municipalites are evaluated with a coeeficient 4.8, Health Care Institution – 7 and their institutions approximately 8.

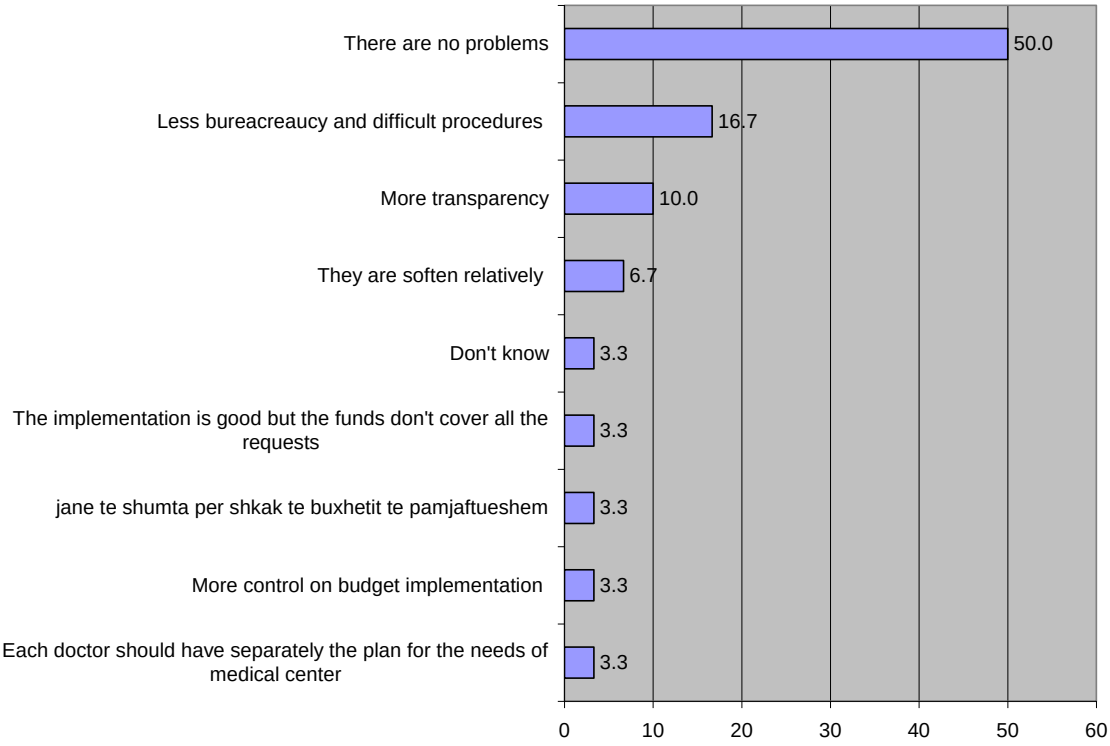
Figure 55: Quality of expenditures in the primary service



Source: Q-38: For Primary Health Care Institutions' Directors questionnaire results

These institutions are asked concerning their budget implementation and around 50% of them declares that their budget implementation is facing different problems from the burocratic ones to the measurement of the performance by inputs and no outputs.

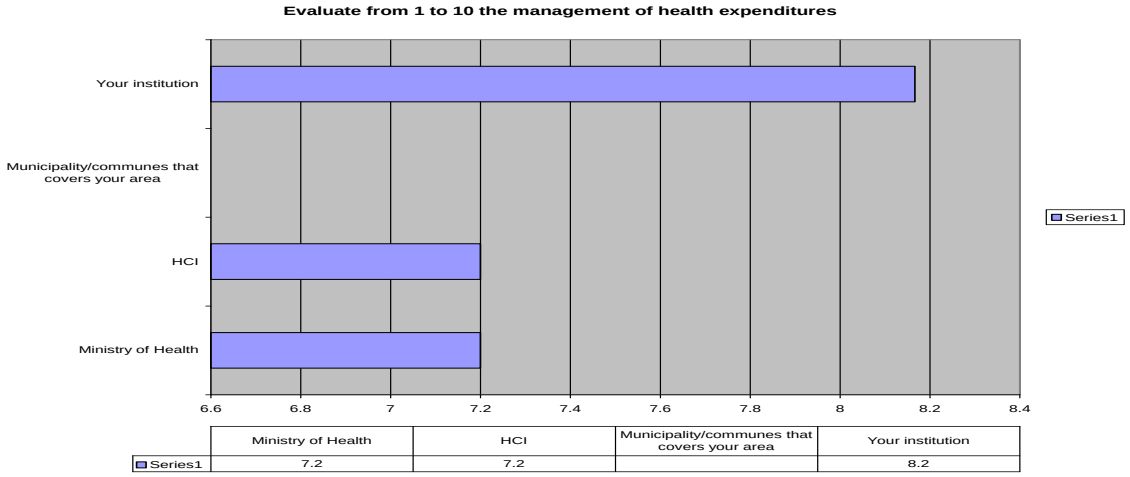
Figure 56: Opinions on the budget implementation problems



Source: Q-125: For Primary Health Care Institutions' Directors questionnaire results

The institutions of the hospital service were asked as well and confirms that the Ministry of Health evaluates with 7.2, the Public Health Institute with 7.2 while their institutions with 8.2. To the question related with the level of funds menagement during last 5 years, the majority asserts that funds are managed on the average level.

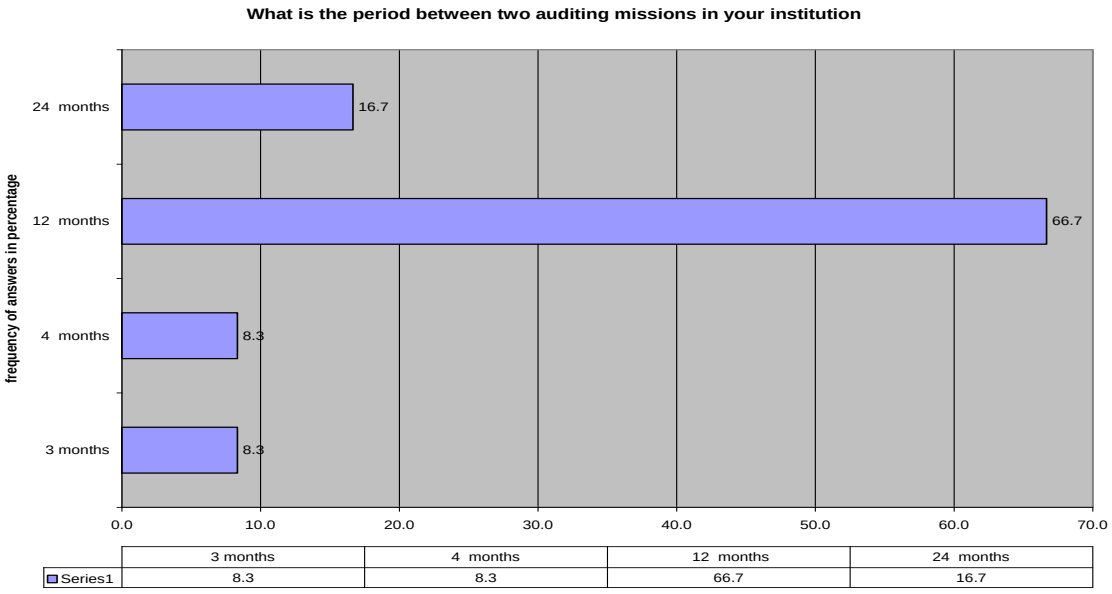
Figure 57: Expenditures management degree in your institutions



Source: Q-18: For Hospital's Directors questionnaire results

The institutions itselves consider the funds managment better in their institutions and bad in the other institutions. Despite the subjectivism in the evaluation and self evaluation all assert that there are problems in all the system as far as budgetary and not budgetary funds managment are concerned. Although, the audit is accomplished yearly or over two years and less audit are done in periods of 3-4 months.

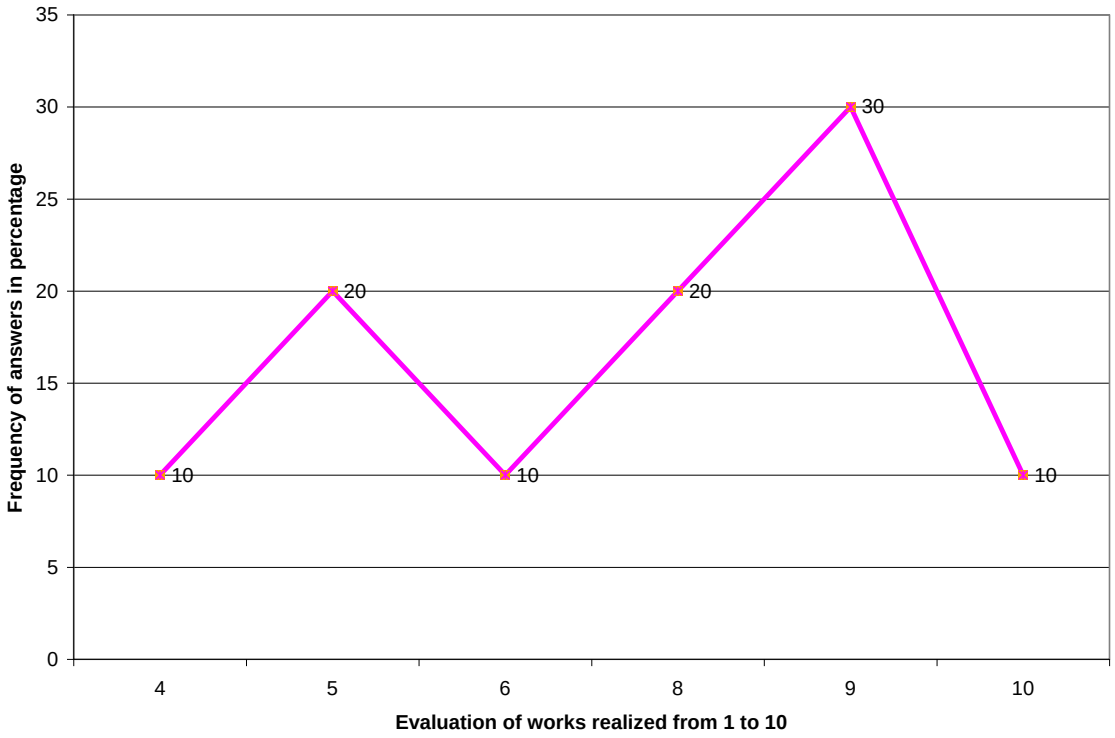
Figure 58: Periods between 2 audits



Source: Q-18: For Hospital's Directors questionnaire results

Concerning the assesment on investments, the majority of communes and municipalities do the evaluation 4-8. It clearly shows a lack of coordination within this untis, enterpreneurs and institutions of primarly health service related with the standarts of workings from the competitive grant funds for investment in this sector.

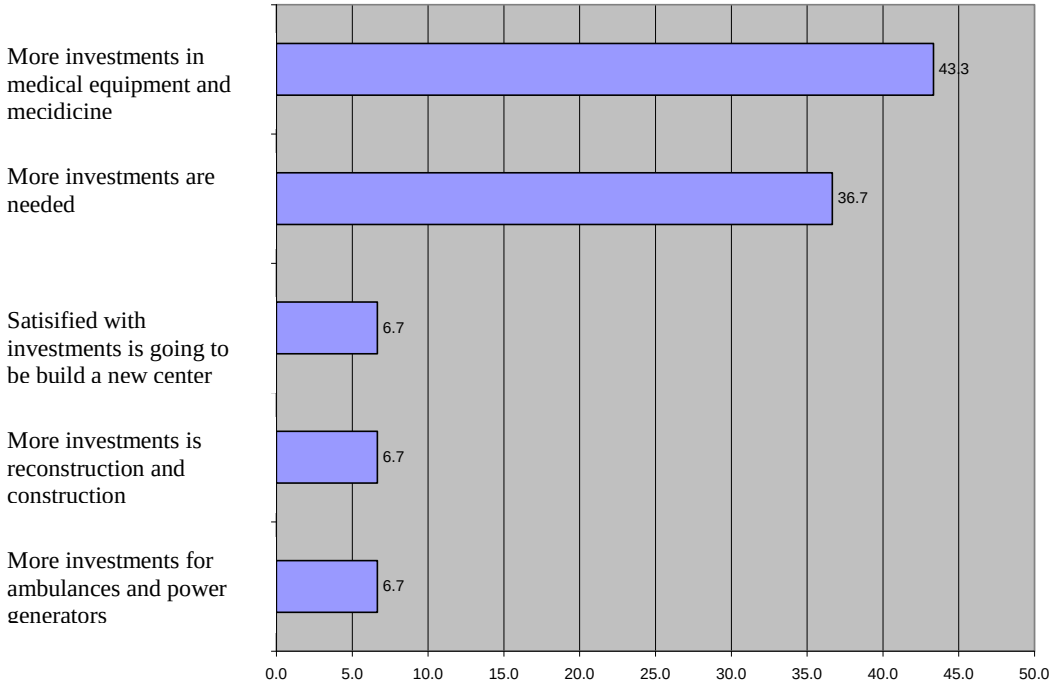
Figure 59: Quality of investments realized with the competitive grants



Source: Q-4: For Mayor and Head of Municipality/Communes questionnaire results

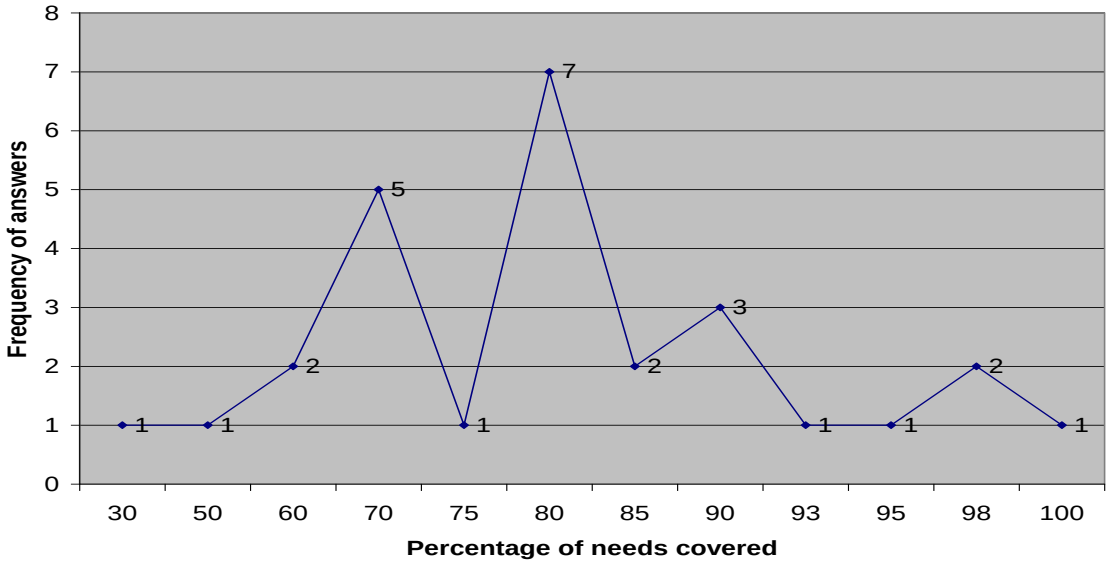
All the interiewees replied there is a need for more investments in medical equipments and medicaments. As well as, regarding their addressed request for the 2007 budget, they declared that only 70% have been accepted.

Figure 60: Opinios to improve the investment scheme



Source: Q-18: For Hospital's Directors questionnaire results

Figure 61: The percentage of needs to be covered with budget 2007

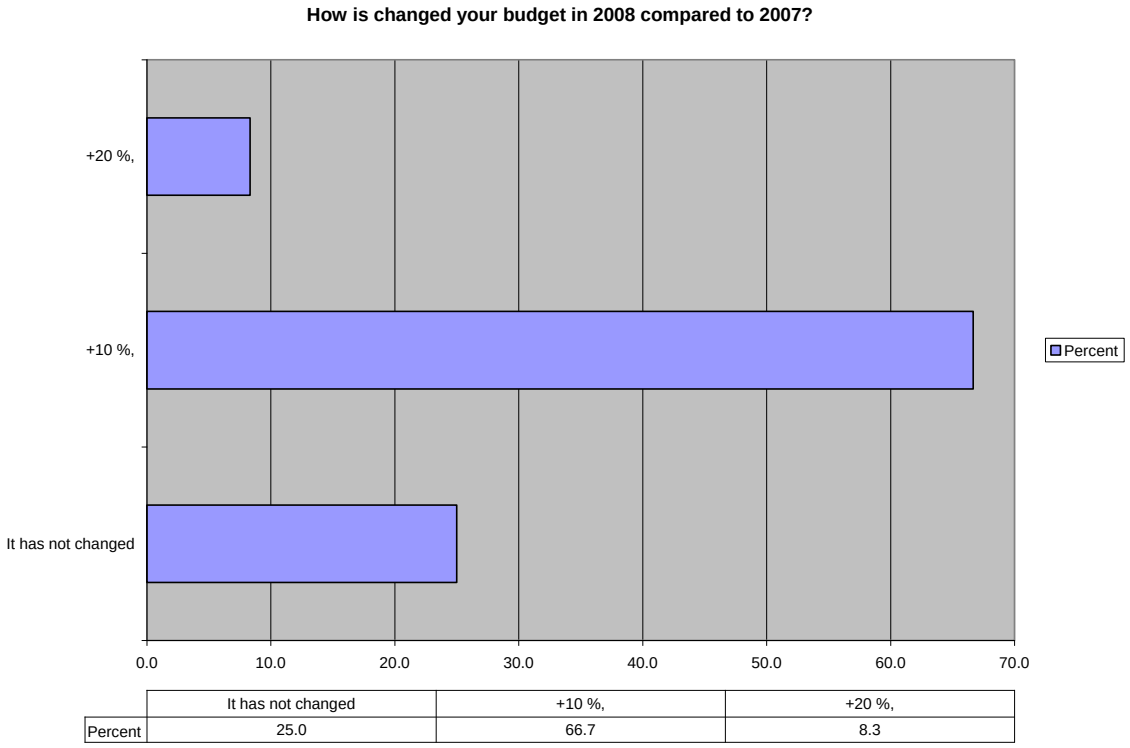


Source: Q-24: For Primary Health Care Institutions' Directors questionnaire results

The hospital service asked on how the budget of 2008 is presented in the report with the one of 2007 identify these results: 66% of them

declares that there is 10% increase, 8.3% assess that the raise is 20% of budget and last said is no raise made. Overall, there is an increase of it of +10% in the majority of the institutions which is standart each year taking into consideration the economic growth of 6% and inflation around 4%. As seen, there is few garancies in the budget needs fulfillment of institutions with this little budgetary raise.

Figure 62: Changes of budget 2008 comparing with 2007



	It has not changed	+10 %,	+20 %,
Percent	25.0	66.7	8.3

Source: Q-18: For Hospital's Directors questionnaire results

3.5 Health service provision and quality

3.5.1 Satisfaction of patients

Beneficiaries' questionnaire
Random exit interviews were conducted on more than three clients for each institution utilizing primary health care centers and hospitals through a specific questionnaire. A total of 124 clients were sampled and 111 were successful interviewed giving a response rate of 89%.
The client/beneficiaries' questionnaire was administered to 111 clients from 37 primary health care service and hospital services. The instrument gathered information general data, the clients who pay or not social and health insurance contributions, on accessibility to medical care, availability of drugs and other inputs, payment for the services (user fees/cost sharing) and the client's perception of the quality of services provided by the health provider, etc,.

The client/beneficiaries' questionnaire consisted in 68 questions and the interviews are held on April 21-29, 2008 to 111 Albanian clients above 18 years old in 6 prefectures who were selected on random basis.
Most of the findings represent the percentage toward the total in accordance with the given alternatives evaluated from the interviewees, while a part of them are given on a scale from 1 to 5 or evaluating from 0 to 10 (For example: How do you evaluate the organization of health system in our country? 1=very bad, 2=bad, 3=on the average, 4=good, 5=very good)
This evaluation scale is used to solicit the respondent's opinion in depth. The data analysis is made based on the average of the results in order to enable the readers to understand the perception of the respondents fully.

3.5.2 General data

The majority of respondents are female 55% and 45% are male (Fig. 63 Gender of the respondents). There is more or less an equal representation for each category of age with 69% representing the majority of clients who are over 35 years old. The young category (18-24 years old) is represented with 18% and there are only 13% of clients who are between 25-34 years old, as it is showed in Fig. 64.

Figure 63:
Age of the respondents

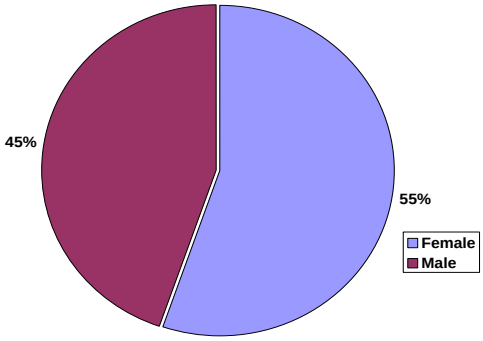
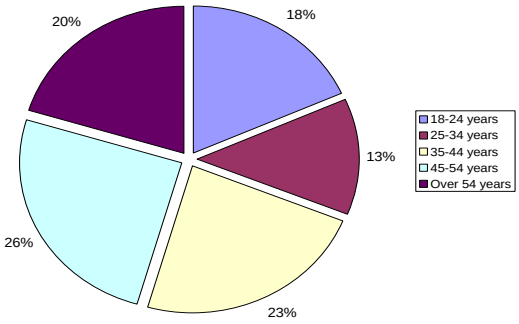


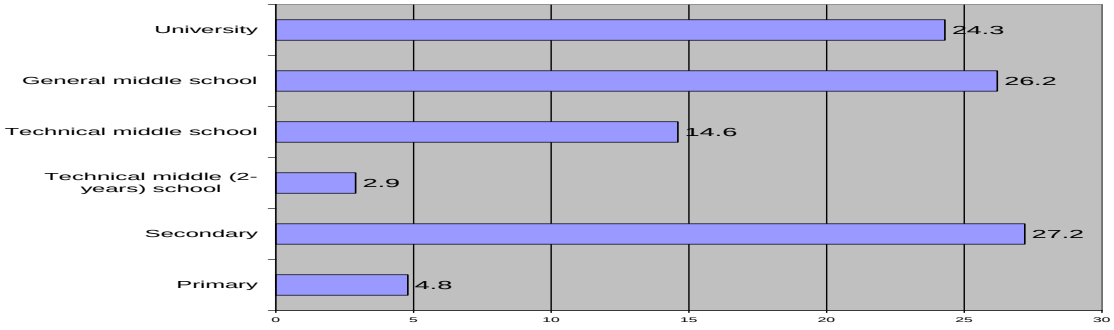
Figure 64:
Gender of the respondents



Source: Q-9: For client/beneficiaries' questionnaire results

The majority of respondents have a secondary level of education (27.2% of the sample). There are 26.2% of the respondents who have finished the general middle school and 24.3% have a university degree. Only 2.9% of them followed a technical middle school and 4.8% have a primary education (Fig. 65 Education level of the respondents in percentage).

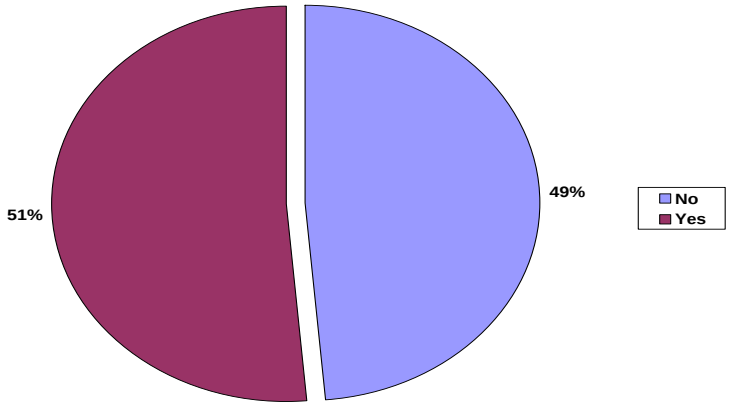
Figure 65: Education level of the respondents in percentage



Source: Q-9: For client/beneficiaries' questionnaire results

The majority of respondents 51% pay the social and health insurance contributions compared to 49% who not pay (Fig. 66 Respondents who pay or not social and health insurance contributions).

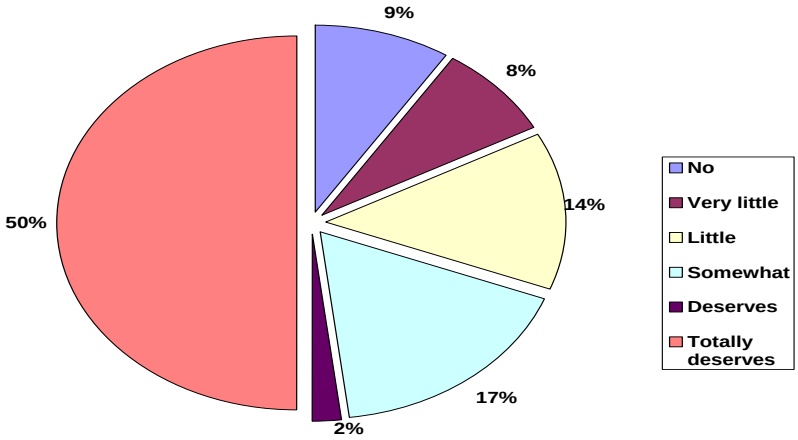
Figure 66: Respondents who pay or not social and health insurance contributions



Source: Q-9: For client/beneficiaries' questionnaire results

The opinion if the service provided is in accordance with the contribution paid by the respondents, 50% of them consider that the service totally deserves what they pay. There are also 9% who believe that the service doesn't deserve and 8% who believe that it deserves very little (Fig. 67 Respondents' opinion on relation between service quality and contribution paid).

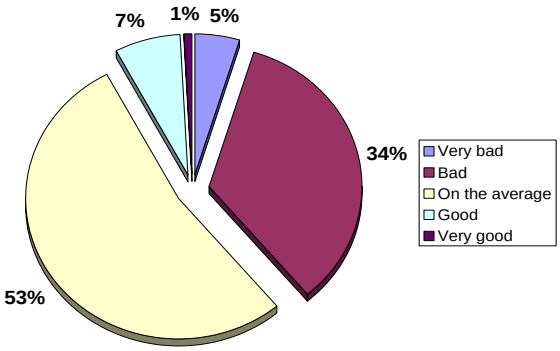
Figure 67: Respondents' opinion on relation between service quality and contribution paid



Source: Q-9: For client/beneficiaries' questionnaire results

The health system organization is considered by 53% of the respondents that is on the average level. Another relevant category of clients (34%) says that the health system is bad organized and only 7% appreciate that the system is good organized. A last category scarcely represented is very good by 1% (Fig. 68 Respondents' opinion on health system organization).

Figure 68: Respondents' opinion on health system organization



Source: Q-9: For client/beneficiaries' questionnaire results

3.5.3 General information on the visits at the medical centers/ambulances

Analyzing the distribution of clients according to the fact that if they have been at a health center during the last three years, it emerges that the only 35% of the respondents have been visited (Fig.69). There is a higher percentage of 65% that have been not visited due to determinant reasons showed in Fig.8. It can be observed that a great part of clients (23%) have not preferred of being visited because the doctor/nurse asked him/her to pay a bribe. A considerable number of clients (27%) consider that service has a low quality and 20% of them believe that the staff is not committed to work (Fig. 70).

Figure 69: Respondents' opinion on being visited at health center during last three years health

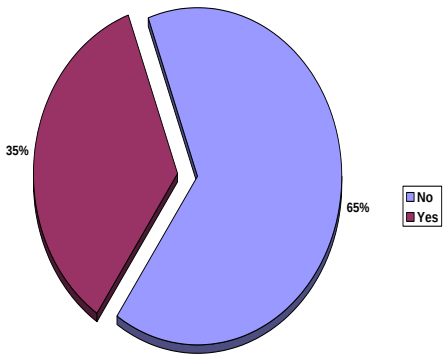
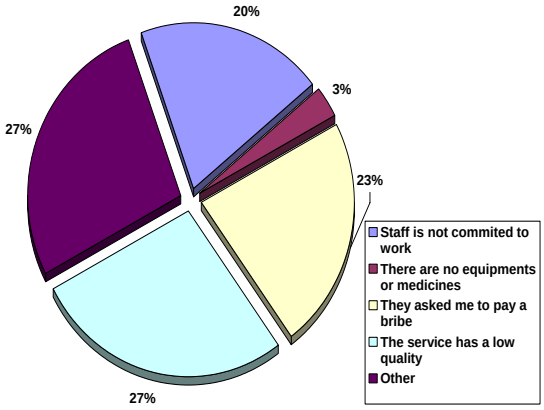


Figure 70: Respondents' opinion reasons for not being visited at center during last three years



Source: Q-9: For client/beneficiaries' questionnaire results

The majority of the clients (53%) believe that the quality of the service provided by the medical center/ambulance is on the average level. There are 25% of the clients who consider that the quality is bad and 5% consider that it is very bad. Only 23% of them declare that the quality is good and 1% declares that it is very good (Fig. 71). Analyzing the level of changes occurred on the quality of the services in the medical center during the last 3 years, 66% of the clients declare that they have noticed little, very little, or not any changes in the quality of the services. There are 28% of them who declare that changes have occurred on an average level and there are only 6% who declare that very much change have been registered (Fig. 72).

Figure 71: Respondents' opinion on quality of the service provided by the medical center/ ambulance

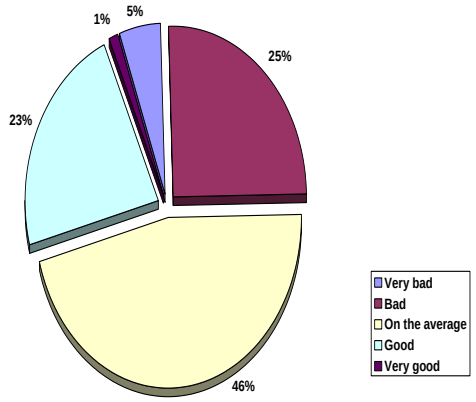
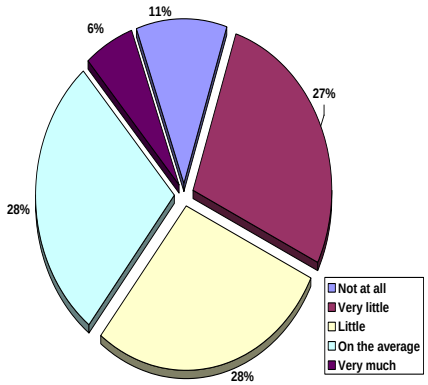


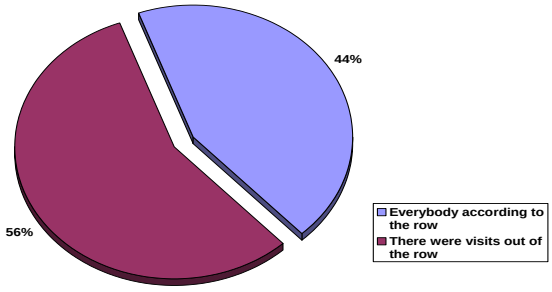
Figure: 72 Respondents' opinion on any changes on the quality of the services in the medical center during the last 3 years



Source: Q-9: For client/beneficiaries'questionnaire results

Analyzing the respondents' perception if they have been visited or not according to a row, it is prevalent the number by 56% of those who declare that there were visits out of a row (Fig.73).

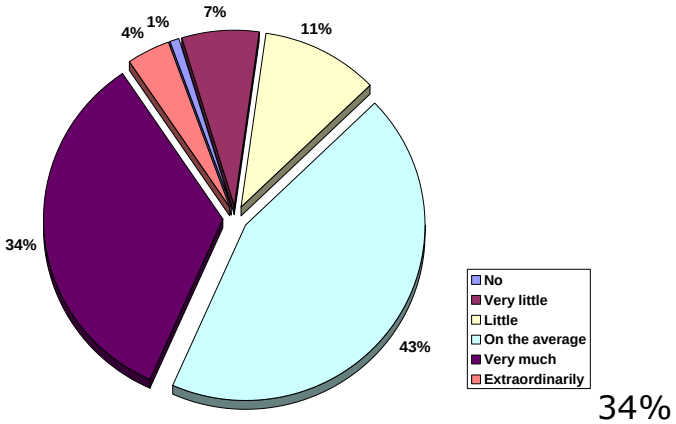
Figure 73: Respondents' opinion on being visited or not according to a row



Source: Q-9: For client/beneficiaries'questionnaire results

The majority of the respondents (43%) declare that they have been treated on an average level during a visit at the medical center/ambulance. There are also 34% who are very much satisfied on how have been treated. Only 11% consider that they have been treated badly and 7% have been treated very badly (Fig. 74).

Figure 74: Respondents' opinion on how was treated during the visit

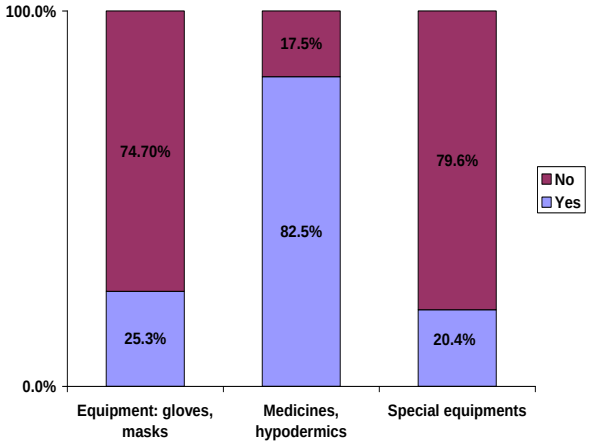


34%

Source: Q-9: For client/beneficiaries'questionnaire results

Figure 75 illustrates the respondents' opinion on clean instruments used during the visit by the doctor/nurse. The majority of clients consider that the doctor/nurse have not used cleaned gloves & masks (74.7%) and special equipments (79.6%). There are also 82.5% of the clients who believe that the doctor/nurse have used clean or new medicines or hypodermics.

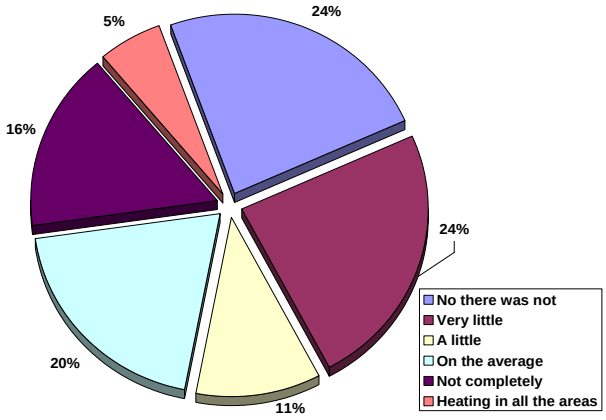
Figure 75: Respondents' opinion on clean instruments used during the visit by the doctor/nurse



Source: Q-9: For client/beneficiaries' questionnaire results

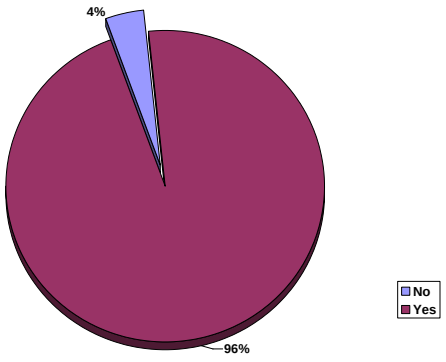
It can be noticed in Figure 76 that 59% of the clients who declared that the medical center/ambulance has not or a less extended heating system. There are also 20% who evaluate this service on the average level and only 5% have declared that the medical center/ambulance has a heating system functioning in all the areas.

Figure 76: Respondents' opinion on a central heating system in medical center/ambulance



From the Figure 77 it could be argued that the doctor/nurse by 96% make notice in the visiting book regarding the visits they carry out.

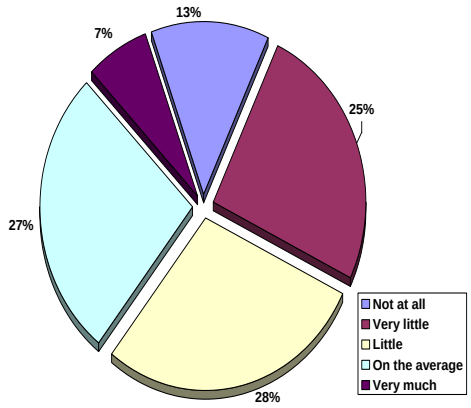
Figure 77: Respondents' opinion on if the doctor/nurse made any notice in the visiting book regarding the visit



There are 53% of the clients who believe that little or very little has changed in the conditions of the equipments and building in the medical center during the last three years. 13% of them considers that none change has happened with the conditions. It can be noticed that

27% of the respondents believe that changes have occurred on an average level and there are also 7% who declare that very much changes have been registered (Fig. 78).

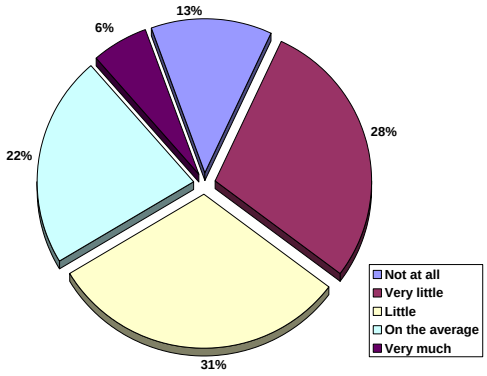
Figure 78: Respondents' opinion on level of change of the conditions of the equipments and building in the medical center during the last three years



Source: Q-9: For client/beneficiaries 'questionnaire results

Perception among 72% of the clients on the dissemination channel of information (posters, leaflets, others) regarding the diseases and services are that little, very little or nothing has been done to spread the information regarding the diseases and services provided by the medical center/ambulance. 22% of the respondents consider that the information is spread on an average level and only 6% consider that the information is very much spread to the respondents.

Figure 79: Respondents' opinion on the dissemination channel of information (posters, leaflets, others) regarding the diseases and services



Source: Q-9: For client/beneficiaries 'questionnaire results

As shown in Figure 80, 61% of the clients have confirmed that have paid money to the doctor/nurse for the visit they made. From the clients who paid money they declare that 43% that they paid because the doctor/nurse made her/him understand to do in that way. 22% of the respondents declare that they have been asked to pay. There are also 35% of the respondents who paid voluntary (Fig. 81).

Figure 80: Respondents' opinion on paying they paid money to the doctor/nurse for the visit will, or the that made

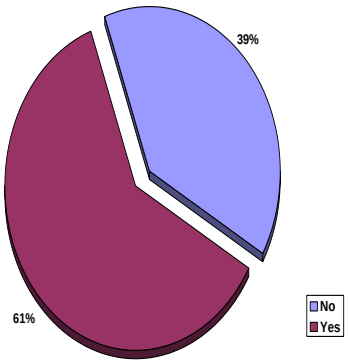
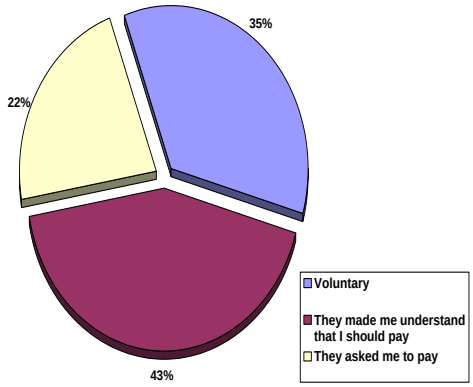


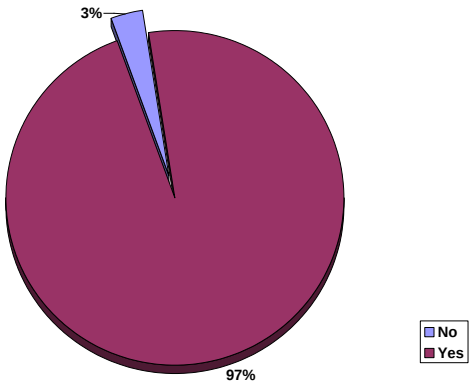
Figure 81: Respondents' opinion on if money according to their payment was requested



Source: Client/beneficiaries' questionnaire results

A wide spread phenomenon is the recommendation of the doctor/nurse to respondents regarding any specific pharmacy to buy the medicines which has been confirmed by 97% of the respondents (Fig. 82).

Fig. 82: Respondents' opinion on if the doctor/nurse recommends any specific pharmacy to buy the medicines



Source: Client/beneficiaries' questionnaire results *Hospitals' questionnaire*

The hospitals' questionnaire was administered to 6 hospital services one per each prefecture, the head of the institution and one person responsible for the financial management provided the information, a total of 12 managers were interviewed.

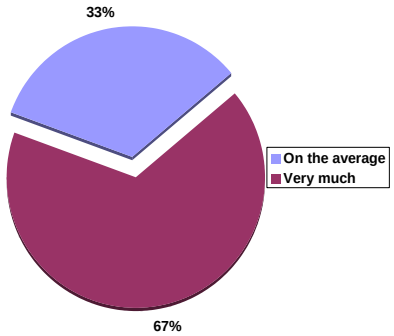
The hospital' questionnaire consisted in 123 questions in total within it was a special section where the respondents provided answers to 24 questions regarding services and quality of service provided by the hospitals.

Most of the findings represent the percentage toward the total in accordance with the given alternatives evaluated from the interviewees, while a part of them are given on a scale from 1 to 5 or evaluating from 0 to 10 (For example: How do you evaluate the organization of health system in our country? 1=very bad, 2=bad, 3=on the average, 4=good, 5=very good)

This evaluation scale is used to solicit the respondent's opinion in depth. The data analysis is made based on the average of the results in order to enable the readers to understand the perception of the respondents fully.

In general head of hospitals and their financial managers consider that the patients have a strong confidence on the quality of services provided by the hospitals staff (Fig. 83). According to the results from Hospitals' questionnaire 67% of the head of hospital and their financial managers believe that the patients have very much confidence on the quality of services provided by the hospitals staff. There are also 33% of them who believe that the patients have on the average confidence.

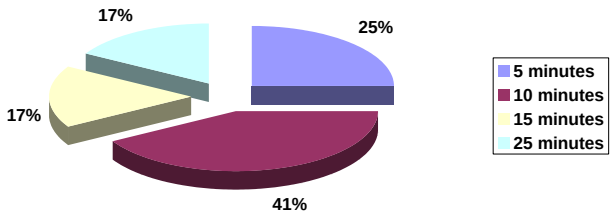
Figure 83: Respondents' opinion on the level of confidence that the patients have in the quality of services provided by the hospital staff



Source: Client/beneficiaries' questionnaire results

Analyzing the perception of head of hospitals and their financial managers it results that the patients wait on the average 12 minutes before they are served. 41% of them consider that the patients wait generally 10 minutes before they are served. 34% of them believe that the patients wait from 15 to 25 minutes or more and there are also 25% who say that the patients wait only 5 minutes before being served.

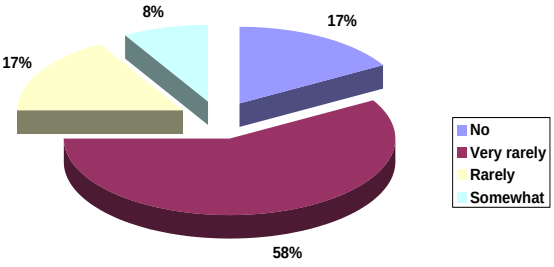
Figure 84: Respondents' opinion on the minutes a patient on the average wait before is being served



Source: Client/beneficiaries' questionnaire results

The perception of 75% of the head of hospitals and their financial managers is that very rarely or rarely the unit staff serves specific persons out of row and 17% of them declare that none have been served out of row. There are also 8% of them who have noticed that specific persons have been served out of row (Fig. 85).

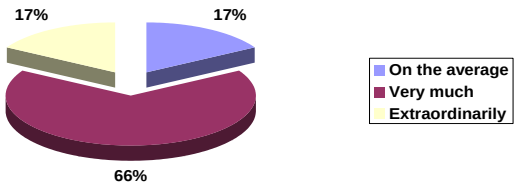
Figure 85: Respondents' opinion on any case when the unit staff serves specific persons out of row



Source: Client/beneficiaries' questionnaire results

Figure 86 illustrates that 66% of the head of hospitals and their financial managers declare that the staff have very much patience with the patients, and 17% of them consider the patience as extraordinarily. There are also 17% of them who believe that the level of patience is on the average level.

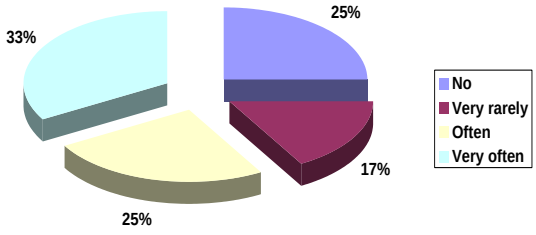
Figure 86: Respondents' opinion on planning the level of patience of the staff with the patients



Source: Client/beneficiaries' questionnaire results

Analyzing the head of hospitals and their financial manager's perception on planning the visit of patients in their unit it results that 42% of them consider that the visits of the patients are not planned or are planned very rarely. There are also 25% of them who believe that the visits are planned often or even 33% who believe that the visits are very often planned.

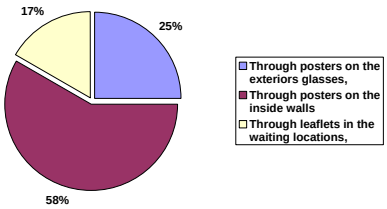
Figure 87: Respondents' opinion on planning the visit of patients in their unit



Source: Client/beneficiaries' questionnaire results

The majority of the head of hospitals and their financial managers at a 58% level believe that the information for the patients is distributed through posters on the inside walls, 25% of them declare that the information is distributed through posters on the exterior glasses and 17% of them through leaflets in the waiting locations (Fig. 88).

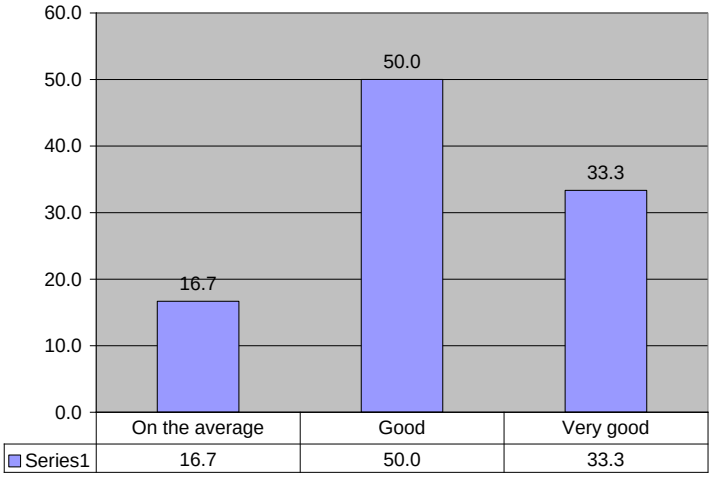
Figure 88: Respondents' opinion on distribution channels of information for the patients



Source: Client/beneficiaries' questionnaire results

As shown in Figure 89, 83.3% of the head of hospitals and their financial managers consider the level of cleanness in the surroundings of your unit as good even very well. Only 16.7% of them consider it as on the average level.

Figure 89: Respondents' opinion on the level of cleanness in the surroundings of your unit

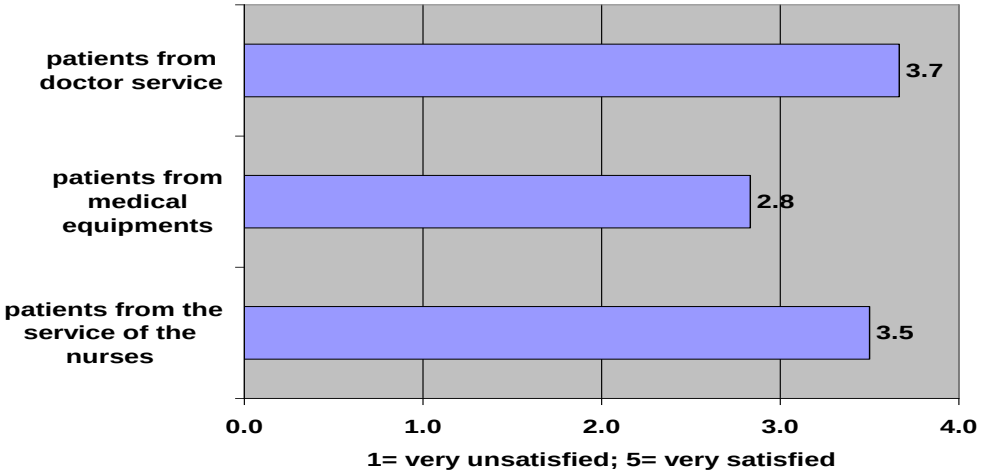


Source: Client/beneficiaries'questionnaire results

The head of hospitals and their financial managers consider that in general the level of satisfaction of the patients from the doctor service, medical equipments and service of the nurses is above the average (1=very unsatisfied to 5=very satisfied), considering the that the

patients have a higher level of satisfaction from the doctor service followed by the service of the nurses and at the least position by the medical equipments (Fig. 90).

Figure 91: Respondents' opinion on the level of satisfaction of the patients from the doctor service, medical equipments and service of the nurses



Source: Client/beneficiaries' questionnaire results

3.5.4 Decentralization

The decentralization is an important reform not only for the local power, but also for other economic and social agencies and each sector. In this context, the decentralization at the health sector takes an important role for the decentralization within the sector, as well as for the responsibility sharing with the local government units.

The experience of sharing responsibility with the local government is not too positive. It is characterized from frequently changes and reciprocal mistrust in the sharing of this responsibility.
As all the other sectors, even the health sector is under a total process of reformation, where some of the important objectives are:

- improvement of the regulatory system, financial and management system of the institutions
- decentralization of the competences, functions and responsibilities etc.

In the framework of reforming the regulatory system, the purpose is to gradually transform the role of the Ministry of Health from an administrative institution of the system into a policymaking one, to

plan, coordinate and monitor. This can be realized through: decentralization of the competences and responsibilities from the central power to the local power and from the Ministry of Health to its depending institutions at the regional and local level.

An important measure in this regards would be the enlargement of the Regional Health Authorities, which will have the following responsibilities: composition of the regional plan of development, monitoring the activities of the institutions and the direct management of the regional programs of public health. These authorities will be lead by panels where an important role is given to the representatives of the local government institutions. Concerning the financial improvement of the system and its management, the objective is to enlarge the resource basis, increase the financial allocation, and raise the effectiveness and efficiency of their use. This can be reached by enlarging the health insurances scheme with the intention to fully cover the basic health service finance form this scheme. Initially, the primary health service should be included in the scheme. While the public health service due to its specific nature as a service offered to all citizens or particular groups even those who have not a health problem, should continue to be financed from the state budget and Ministry of Health. The Ministry of Health has a crucial responsibility to guaranty the primary health care and public health protection. This responsibility has to be shared between the Ministry and local government institutions. In addition, the Ministry of Health is responsible to ensure the citizen's axes and guaranty their equality in relation with the basic health services, quality of services according to standards, national programs implementation of public health etc. On this purpose, it plans the policies for development, better oriented specific programs and capital investments, ensures human resources qualification and their further training, establishes standards and service protocols, and monitors their execution. The Ministries accomplish the above duties in accordance with its dependences institutions, as well as with other public and private institutions among which the local government institutions play an important role.

Several aspects influence on the health situation of the population and the health system is only one of them, but not the most important one. As such, all the actors including the institutions and each citizen have their responsibility in the conservation and improvement of the health. In this aspect, the local government institutions can play a crucial role in the coordination of all these actors and supporting the health institutions the public or private ones.

In relation with the level, amount of responsibilities and functions, these organs should have financial resources, materials, properties and human resources. The resources should be used in accordance with the established standards from the Ministry of Health.

Moreover, the local government units can have regulatory, serving, administrative, financial and investing authority (own or delegated) within the National Strategy policies for primary health care and public heath protection and in accordance with the EU standards.
The local government institutions, as the closest public authority with the beneficiaries, have an independent authority to undertake initiatives on community interest if these are not falling under exclusive responsibility of another state public authority at the local level (Law No. 8652, on 31.07.2000 "For the organization and functioning of the local government", Article 7, point 1).

Since 1999 until the 2003, the local government institutions have executed as a delegated function the financing of the operative services for the maintenance and function of the primary health care institutions and public health protection.

In these conditions, it should be clearly defined the role of the Local Government Units, concrete responsibilities and their competences in relation with the common responsibility for the primary health service and public health protection.

Based on the point 2, Article 4 of Law No. 8652, on 31.07.2000, ""For the organization and functioning of the local government", as well as in other legal acts the relations between the local government institutions and central power are based on the subsidiary principle and collaboration for resolving common problems.

In 2004, a major step was made as far as the decentralization of the common functions in the pre university education system, primary health service and work and social affairs are concerned. Following this philosophy, have been approved three Government Decisions with the assistance of the World Bank:

- By Council of Minister Decision on 4.10.2004 were approved the document "For decentralisation policies at the preuniversity education sector"
- By Council of Minister Decision No. 636 on 30.09.2004, were approved the policies document of primary health service

- By Council of Minister Decision No. 637, on 30.09.2004 were approved the policies document for the decentralisation of the economic and social services assitance.

These decisions established the competences between the central power and the local one, in conrete terms the investment competency was transfered to Municipality, District Center, and District for other local government units. This scheme presuppose that the Local Power respect the standart and national policy for the development of the education, health and work and social affairs. Moreover, by this measure it was intended to reinforce and consolidate the District as a power which formulates and harmonise the national policies with those of local level.

This scheme started to be implement in 2005, but than was distorted by replacing it with a more centrailsed scheme or equal to the traditional one (before decentralisation).

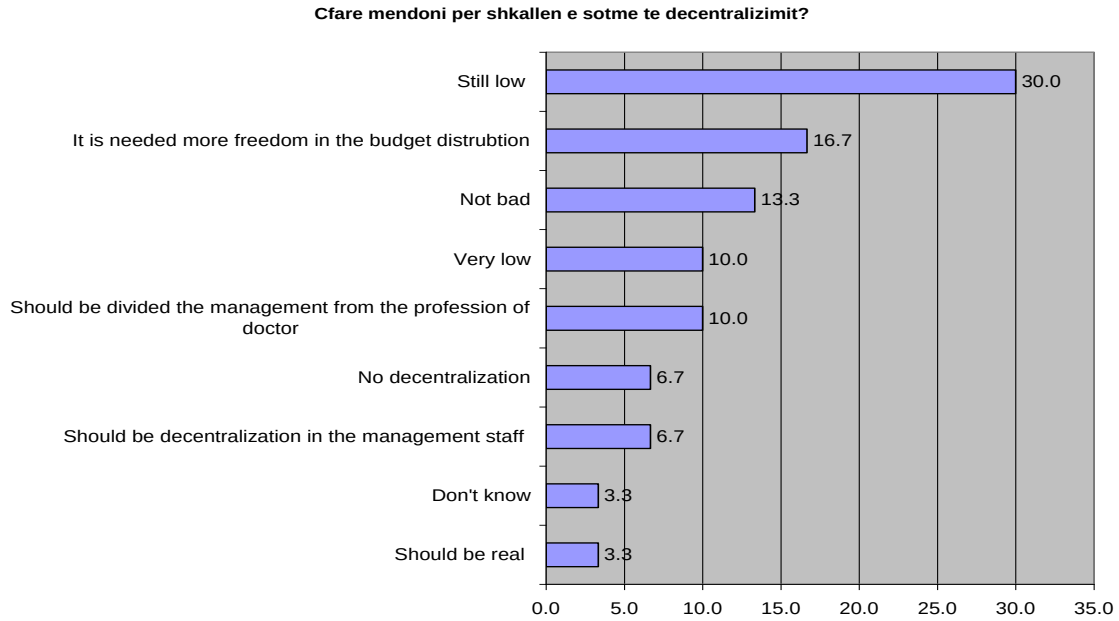
During 2006-2008 it was applied the scheme of "Competitive Grants" for financing the investment expenditures in the primary health service. The experience of these years has shown that the competitive grants scheme is subjective because there are no clear competition rules and it falls more under the political judgement than the technical ones or other interested actors in these investments.

As analysed even at the composition and implementing part of the budget, the local power role is not considerable. It does not have a primary role in the investments policies, only if asked. Moreover, it does not play any role in the service performance measuring, while the citizens address their request and objections against the services to the local aothorities.

A survey made from USAID/LGDA pose a question to the citizens related to what do they think for the primary health service, 90% of them inculpate the local power because under their perseptions this service is under their authority.

The interviewees at the primary health service (Figure 92) in general declare that the decentralisation level in this sector is still low, meaning that the problems of budgetary funds are almost centralised from their superior at the Mnistry of Health or Health Care Institute. On this concern, only 13.3% of the interviewees declare that the decentralisation is not bad. All the rest belive that there is no decentralisation or it is at a very low level.

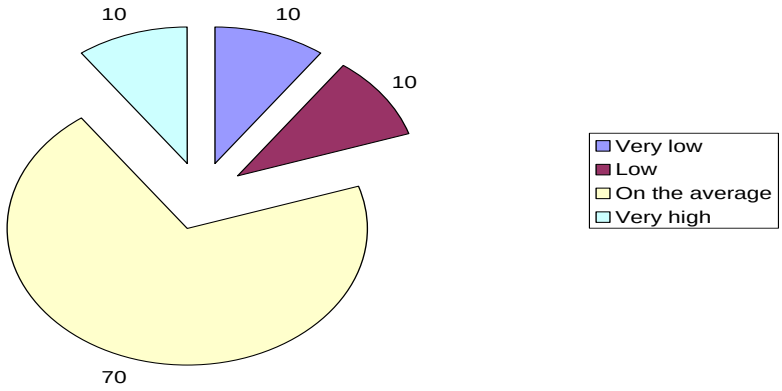
Figure 92: Opinions regarding the decentralisation degree



Source: Q-126: For Primary Health Care Institutions' Directors' questionnaire results

The Local Power asked on the collaboration level between the local government units and the Ministry of Health generally declares for a lack of cooperation. As such, 10% of the interviewed assert that the level of collaboration is high, whilst the rest affirm that this level is on the average, low and very low. This situation arises due to the fact that the decentralization of this sector comparing to the Ministry of Health and the local power is still at the low level.

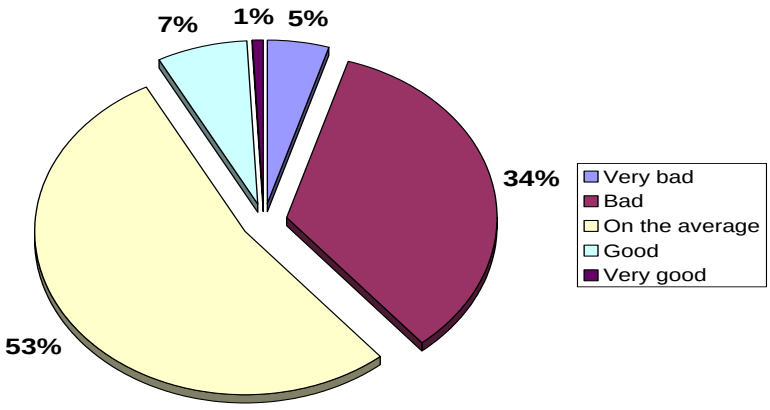
Figure 93: The collaboration degree between the local powers with the Ministry health



Source: Q-44: For Mayor and Head of Municipis/Communes' questionnaire results

The beneficiaries of the primary health service (Figure 94) were asked on how do they evaluate the actual health system and declare that in general they are not satisfied. As such, only 1% declares that it is very good, 7% believe that it is good and the rest affirm that the actual organization is on the average, bad and very bad.

Figure 94: Assessments of the Health System Organization



Source: Q-13: For client/beneficiaries'questionnaire results

Following the above analyses, it is most indenspensable that the health service in general should be decentralised.

In addition, through the decentralisation in the field of competences such as: administrative, services, investments and financial, it should be reappraise the role the local power should play in order to provide health services to the citizens.

4 PUBLIC EXPENDITURE TRACKING SURVEY (PETS) IN ALBANIA

4.1. Summary of PETS and its major findings in Albania

About the PETS - Albania	
Year of data	2005 - 2007 to the extent possible
Sample	Primary Health Care Centers 10 out of 50 units (20%) Polyclinics 7 out of 582 units (1.2%) Health Posts 14 out of 700 units (2.0%) 1 National Hospital Center and 5 Regional Hospitals out of 44 units (11.4%) Municipalities 2 out of 65 units (3.1%) Communes 8 out of 308 units (2.6%)
Level of administration studied	Government, region, district, local administration, and health centers
Expenditures tracked	Non-salary expenditures from government level to regional and district health offices
Other data collected	Data on budget processes and record keeping. Data at the health centre level on user fees, staff, equipment and procedures governing the use of funds
Type of PETS	Diagnostic
Reference	**"IMPROVING PUBLIC EXPENDITURE EFFECTIVENESS IN HEALTH SECTOR *(Case of Albania)"***
Other comments	The study encompassed the health sector

PETS major findings - Albania	
Key characteristics of resource flows	No government disbursements for non-salary expenditures at facility level, only for the regional and district health offices. Health workers are paid by central government. Half of client/beneficiaries of health service declared that they pay the social and health insurance contributions, meanwhile there are clients who benefit from the social and health insurance scheme without paying.

Financial management systems	Planning of budget based on historic data. Lack of coordination and involvement of different actors in the planning process. The planning and implementing phases are considered as two separated processes not necessary linked with each other. Poor bookkeeping, lack of internal financial controls and auditing requirements. Atmosphere for leakage and mismanagement of funds. Better financial management at health centre level than at district and regional offices (due to more local involvement). Changes in destination of use of funds. Concentration of the realization of investments in the last trimester, especially in December. No sanction against the officials who not spend the budget on time. The existing monitoring mechanisms need to be enhanced and policy changes are needed to make the process more transparent.
Leakage of funds	Potentially large leakage of funds, more investments is needed. Large discrepancies between amounts transferred by treasury and the amounts received by regional and district health offices, but it is impossible to tell whether this is caused by poor bookkeeping or by leakage of funds.
Delays	Delays in transfer of funds from central government to different ministries and to other central and local public administration institutions.
Corruption	Not explicitly discussed. There are evidences from Client/Beneficiary Survey results confirming the existence of corruption forms in the health sector: ◆ 14.5% of clients/beneficiaires declare that they have not been visited in the medical center because the staff asked her/him to pay a bribe; ◆ 53% of clients/beneficiaires declare that persons who have been visited without waiting the row may be rich people thay may have paid for that; ◆ 61.1% of clients/beneficiaries declare that they paid money to the doctor/nurse for the visit that she/he made; ◆ 42.8% of clients/beneficiaries confirm the payment because the doctor/nurse made the client understand that she/he should pay to benefit the service and 22.2% declare that have been asked to pay; ◆ 5.8% of clients/beneficiaries declare that they provide a gift to for the medical visit; ◆ 59% of clients/beneficiaries declare that the doctor/nurse recommend her/him a specific pharmacy to buy the medicines.

4.1. Health facilities conditions and management

The survey identifies that the management and efficiency of health centers and ambulances is still very low.

- Concerning, 63% of directors of the primary health objects asked from the survey, said there are no divided toilets between men and women
- Moreover, the facilities face electrical energy problems. So, 50% of the interviewees confirm that the voltage is at middle and low level
- More than half of them testify that the heating is partly or entirely missing in their environments
- 83% of interviewee hospital directors say that the electrical energy was off for more than 30 minutes. The problems of electrical energy are related even with the voltage where only 42% answer that is good and very good.
- 44% of interviewee directors say the water coming is not potable or hardly potable
- In six observed hospitals results that the answer to the question: "Do your equipment function regularly?" – Half of them reply that at maximum half of them are working, which clearly show the low performance of their operation.
- There are still continues problems concerning cleanness at the hospitals where 16.7% of the interviewee directors answer that this indicator is over the average.
- From the survey it results that 67% of hospitals have to 130 rooms and only two of them have 295 of them. Therefore, in Albania exists a large number of hospitals which are too small and do not fulfill the required standards for full capacities.
- It is impressive the fact that the interviewees do not calculate or calculate at small scale the yearly coefficient of using the hospital beds. Regarding, 25% of the interviewee directors do not know how much this coefficient for their hospital is. Whilst, for 16% is 13, for an other 16% is 40.3 and 25% declare 50 and only 8.3% declare 52. Therefore, there is a significant difference between regions.

4.2. Human capacities conditions

-43% of the respondents from the survey of Primary Health Care think that it is a considerable number of employees in the health sector and they fulfill the patient's needs, while 56.7% considered the number as insufficient.

- According to the survey only 6% of the interviewees consider that the number is enough. Meanwhile for all the others the number is not enough or are insufficient doctors of different specialties.
On contrary has resulted with the number of nurses, where 60% considered that the number of nurses is enough. There are problems with administrative and assistant staff. Only for 37% of interviews the assistant staff number is enough.
- From 6 interviewed hospitals only one of them declared that the staff is not enough. Also seems that needs for doctors in hospitals, in great part of them (82%) are in a satisfactory level.
More optimistic seems to be the situation to assistant staff and nurses where only in one case their number is insufficient. 100% of interviewees consider that the needs about administrative and assistant staff are fulfilled.
- Almost 100% of hospital's directors were changed once in 4 years. It shows the inconstancy of administrative staff is close related in the same time with politicization of humane resources, due to the fact that in every four years there are new parliamentary elections. The changes of doctors and nurses staff seem to not follow the same trend because 13% of interviewees are pronounced that the period of changes is from 5 to 7 years. At the hospitals, replacing doctors has the same tendency as at the primary service. 10 out of 12 interviewees assert that the chiefs move once in 2-4 years.
- According to the level of wages, the employees of Prime Health Care do not feel as the most favor one, compared with employees in other public sectors. 50% of them think that wages are equally, 47% think are lower and much lower.
The absence of the wage's motivation reflects in the level of management of institutions and in the level of patient's service. This factor and other have increased the mistrust in Prime Health Care service.
- The survey shows the existence of dismiss in the health system. 23% are pronouncing that in 2007 have been dismissed 1-6 persons. Over 30% of interviewees pronounced that during the last year 1-9 persons quitted voluntary from their institutions. This factor must be analyzed closely with both, obligation of duty and migration of population into urban areas.
- Even at the hospital services cases of dismisses people are present. 75% of them declared that they are 1-10 persons who have been dismissed from their hospitals. During 2007 there are many cases of transferred persons. In 57% of cases 10-20 persons have been transferred and 91,6% of interviewees pronounced that 3-20 persons quitted voluntary.

- The performances of health sector employees hang on their trainings. The survey finds that about 85% of interviewees have not complete vocational training. Increasing of their performance has influenced the engagement of doctors in private centers as owners or as employees. 50% of the respondents think that doctors from their institutions work in private health service centers.

Optimistic seems to be the situation in the training field where all interviewee's units received vocational training for their staff, in many cases the trainings have been provided to nurses, and only in 2 cases have been provided vocational training in the management field. Regarding the training of doctors, they have not been taken in consideration by the Ministry of Health. 50% of the interviewees are "unsatisfied" from the decision for trainings. The MoH's decision seems to be related with returning of doctors in old work place. Only in 25% of cases the doctors returned in the old work place after completing the training.

The survey shows on average 25% of doctors own private centers and 60% of them serve in private clinics, which affects negatively in their performance during their activity in public health sectors.

4.3. Health service delivery

- 51% of the client/beneficiaries' of health service declared that they pay the social and health insurance contributions, compared to 49% who not pay.
- The majority (67%) of the head directors and financial officers of the hospitals declare that none of their budget goes for covering the services of those who don't contribute through the social and health insurance scheme. There are also 33% of them who declare that from 1-20% goes for those who don't pay through the social and health insurance scheme.
- According to the hospital questionnaire results, it can be noticed a strong tendency to evaluate the management of health expenditures at an average level, 33.3% of the respondents evaluate the management of health expenditures in their institution at a very good and good level, 58.3% of them consider it as on an average level and 8.3% evaluate it on a low level. 58.3% of them think that the management of health expenditures is at a very good or good level in their district compared to 41.7% who says that the health management is at on an average level. Analyzing the management of

health expenditures at national level the respondents consider it at 33.3% at a very good or good level, 58.3% at on an average level and 8.35 of them think that the management is at a low level.

4.4. Public health sector expenditure distribution and management

- The same situation is identified also in the hospital system (Figure 25). Over 50% of them assert that (during) the consultations for the budget are based on the organic law of the state budget, 17% based on the directive of the Ministry of Finance and 33% on the Ministry of Health directive. As resulted, the line Ministries and especially the Health Ministry invest minor efforts to instruct the dependant institutions concerning the budget composition.

- Around 27% think that it should be taken more in consideration their requests, 20% admit assert that the outlined budget form the institutions of the primary health service is not considered from the higher instances. At about 13% of the interviewees assume that it should be planned a superior budget than the one we outline each year, 5% of them require the budget to have more analytical articles in the planning, and 5% believes that the budget should be more transparent since the planning, through the enlargement of the participation in the planning.

- 10% of the interviewees raise the problem to increase the group of interest's participation and only 10% of them think that the budget is composed from the others without taking into consideration the opinion of groups of local government units.

- After 2006, the local government institutions do not play any role and responsibility in the health sector and as a consequence they do not have a specific influence in the composition and implementation of the budget for this sector by influencing the efficiency and effectiveness of budget funds planning at the health sector.

- As a result, 30% of the interviewees admit that for the distribution of the investments should be taken in consideration the number of population, which would definitely require the use of this criterion by a specific formula for the budget composition. Only 20% of the interviewees said that the budget should be bigger and more detailed, as well as other 20% assumed that if the budget would be bigger even

the planning would be easier. Moreover, 10% of them declared that the budget is insufficient and this deficiency come into fore since the moment when quotas are being discussed. As a conclusion, both target groups in principle raise the problem of the low quota deriving from the Ministry, which leave few opportunities for a planning according to the needs.

- Concerning the investments, approximately 40% of the interviewees ask for more investments in both equipments and apparatus. Moreover, 30% of them think that the investments should be more in the health sector. These findings explain the fact that in Albania the health service still does not offer qualified services, which force the citizens to provide capable health services in the other countries. In addition, 20% of the interviewees require that the planning of competitive grants should be done according to clear and transparency criteria and procedures and 10% of them suggest that grants should be given more to the communes.

- The biggest part of the budget is addressed to payments and social insurances. Part of the budget is directed to those who do not pay. This clearly shows a weakness of the system itself, in which apart problems of organization there are also social problems, evasion in the contribute payments and benefits from the sector without contributing.

- Referring to the analyze of the survey, it results that the majority of the primary health service institutions use the 70% of the budget for operative spending and 30% for capital expenditures. The rest of the institutions have a deeper rapport of the above mentioned, where the operative spending occupy 90-95% and the capital ones 5-10%. These indicators emphasized the fact that a considerable part of the institutions of this service do not undertake progressive policies through investments.

- Since 2003 in Albania is applied the Middle-term budget planning composition method. This methodology is wide spread in the majority of central institutions, and consequently these last should extend it to the institutions and agencies on their dependence. As interviewed, 58% of the hospital service institutions have approved that they do not know this procedure, moreover a considerable part of them do not have information who approve this budget or rather affirm that is the parliament who ratifies it while is the Council of Ministers. This clearly shows that still the middle-term planning institutions remain weak and not efficient.

- In order to raise efficiency and effectiveness to reach priorities and budget planning is necessary to publish these data in order to discuss and drawn suggestions within a wider group of participants. The interviewees of the hospital service were asked in this issue and they provided us with this information: 25% assert that the data of the Ministry of Health is made public, 33% of them admit that those are made public from the health care institutions. In both cases, it results that although the budgets were made public, the method used to deliver the information made impossible the public or group of interests to utilize them. Therefore, the planning of funds is initially lacking transparency, by diminishing in this term the planning quality as well as can influence the drop of efficiency in the public funds utilization.

- The differences between the contributors and beneficiaries have caused premises for a considerable fiscal evasion. Therefore, the contribute coming from the general taxation for the primary health service is being increased year after year. In this case, this should be considered the reason for stimulating in an indirect way the bribe and other corruptive elements in this sector. As such, around 61% of the interviewees who benefit from the service declare that after the visit to the doctor have paid to him of to the nurse different amount as a bribe. The majority of them affirm that the minimal amount paid was 500 Lek and 30% paid 1000 Lek.

- The implementation of the budget is strongly linked with its quality prediction. The latest, is affected by the quality of the process in budget composition, by the participation and contribution of the interested actors and broadly. Certainly, this phenomenon is present even at the health sector. The interviewees of the primary health service assert that often shifts of budget expenditures destination occurred during fiscal years. Regarding, 30% of them declares that during the budgetary year funds are differently reallocated. The amount of funds destination allocation varies from 10 – 30% of the institution budget. At the hospital service, this phenomenon is more observable. Hence, 58% of the interviewees attest that during the budgetary year there are changes of use and destination of budgetary funds. As such, this phenomenon not only reflects the low level in the scheduling of budgetary priorities, bur also is likely to be influenced from the politics in different regions and areas, or by the abusing preferences of the administration which held the authority to propose the shift of funds in any time of the year.

- The shift of destination in the utilization of the budgetary funds creates effects even in the realization or consumption of budgetary funds within the fiscal year. In various cases, the intensity of changes is during the third and forth trimester. As a result, these changes or tentative for changes are time consuming and bureaucracy by influencing that funds are not consuming within the fiscal year. Due to the survey for the respective periods 2005-2007 at the hospital service, results that the majority part of these budgetary institutions have a budget realization from 75- 90% of the fiscal year budget.

When comparing these indicators with needs carried out by this service, than they become more serious to be realized and adjusted. The unified distribution of expenditures during the year would be in accordance even with the objectives of the monetary policy in order to maintain a stable level of prices. If referring to the figures, we notice a disproportion in the accomplishment of these expenditures. A considerable part of them is achieved during the last period of the year by influencing the inflation, which is higher during this period due to other factors of the season.

Further analyzing the budget execution for these institutions, we notice that the execution of capital expenditures did not have mensural. Naturally, is common the trend to repay the obligations at the end of the year, but to this extent at the end of the year it could not be guaranted the affectivity of the utilization of financial resources of the budget.

According to PETS, 36.3% of budget expenditure is made in the last trimester, which testifies that this is affected from the shifts of destination or other subjective delays in the procurement and realization of public investments. Based on the yearly directive of the Minister of Finance for budget implementation, all non procurator budget funds of investments until 1 of November are not used from the institution which disposes them. Based on this financial discipline established from the financial authorities, the budgetary expenditures in the fourth trimester should have been insignificant.

- The question addressed to the directors of the hospital service if there is any rule in their institution concerning the budget implementation, 92% of them replied positively confirming that there are regulations and directives for the budget implementation, while to the question if there is any sancion if they do not spend their budget, 67% answered that there is not any. In reality, there is no sanction concerning the non consuming of it clearly stated. According to the

yearly Directive of the Minister of Finance, to implement the state budget each institution is obliged to report for the financial indications and explain the reasons of failing to execute the budget in a periodical way. On the basis of this raport, the work performance of each institution is measured in a vertical way, which means that in the same vertical way even at the horizontal at the health service administration should be made evident the rensponsability of each for the non realisation of the budget and this latest accompanied with different sanctions.

- In accordance with the managment of the budget as a whole, actors who execute this duty were asked. As such, from the answers made to the primary health service results that communes and municipalites are evaluated with a coeeficient 4.8, Health Care Institution – 7 and their institutions approximately 8. These institutions are asked concerning their budget implementation and around 50% of them declares that their budget implementatio has problems from the burocratic ones to the measurement of the performance by inputs and no outputs. The institutions of the hospital service were asked as well and confirms that the Ministry of Health evaluates with 7.2, the Public Health Institute with 7.2 while their institutions with 8.2. To the question related with the level of funds menagement during last 5 years, the majority asserts that funds are managed at the middle level.

- The institutions itselves consider the funds managment better to do in their institutions rather than from the other outside of them. Despite the subjectivism in the evaluation and self evaluation all assert that there are problems in all the system as far as budgetary and not budgetary funds managment are concerned. Although, the audit is accomplished yearly or over two years and less audit are done in periods of 3-4 months.

- Concerning the assesment on investments, the majority of communes and municipalities do the evaluation 4-8. It clearly shows a lack of coordination within these units, enterpreneurs and institutions of primarly health service related with the standarts of workings from the competitive grant funds for investment in this sector. As a conclusion, all the interiewees replied that there is a need for more investments in medical equipments and medicaments. As well as, regarding their addressed requests for the 2007 budget, they declares that onyl 70% have been aceepted.

- The hospital service was asked on how the budget of 2008 is presented in report with the one of 2007 identify these results: 66% of them declares that there is 10% of increase, 8.3% assess that the raise is of 20% of budget and last said is no raise made. Overall, there is an increase of it of +10% in the majority of the institutions which is standart for each year taking into consideration the economic growth of 6% and inflation around 4%. As seen, there is few garancies in the budget needs fulfillment of institutions with this little budgetary raise.

- The interviewees at the primary health sector generally declare that the level of decentralisation in this sector is still low, meaning that the problems of budgetary funds are almost centralised from their cheifs at the Ministry of health or Health care Institute. Only 13.3% assesses that the decentralisation is not bad. All the rest declares that there is no decentralisation or it is low level.

The local power asked concerning the collaboration degee between local government units and Ministry of health, declares in disfavor of this collaboration. As such, 10% said that the level of cooperation is high, and the rest evaluates it as on the average, low, and ver low. This situation arise even because of the fact that decentralisation of that sector in relation with the Ministry of Health and local government is still at low level.
- The primary health service interviewees declares that they are not happy with the actual system. Only 1% said it is very good and 7% more or less good, and the rest said it is on the avarage, bad and very bad.

4.5. Notes about the implementation of PETS in Albania

The main goal of implementing PETS project in Albania is the improvement of the effectiveness of the allocation and use of the public budget in the Albanian primary health sector through monitoring and analyzing the expenditure with the appropriate institutions. Until now, it was concluded the first phase of the project representing the implementation of PETS and have begin the preparation for the second phase consisting in the results' dissemination.

Implementing PETS in Albania was a difficult task, not only because it is the first time, but due to the large spectrum of dimensions. In Albania, notwithstanding a number of initiatives directed to the

consolidation of the Health System, and the existence of projects designed to provide evidence for the health policy, there is no governmental initiatives related to measure the performance and the burden of those changes on the performance of the health system, as a whole.

In our work we tried to develop a methodology wide enough to address all these issues, based on Brookings and Results for Development Institutes recommendations and on literature review related to PETS.

At the end of this process the main advantages of implementing PETS in Albania are:

- Confirmation of the hypothesis by the survey's results that a sizeable share of the funds intended for health care services/facilities does not reach their intended destination.
- Clarification of the technicalities of budget readings that harms the transparency of legislative and procedural budget formulation in health sector
- Assessing the role of the Local Government Units as a partner in the primary health service. Their role is insignificant even after the decentralization process.
- Confirmation with results and arguments that the methods used for budget planning in Albania are based on historical trends, without considering specific programs and policies and Local Government is not considered as a partner.
- Effectiveness of the health service is affected by different factors that implementation of PETS can contribute for their argumentation.
- PETS can contribute with results in the argumentation that
    - the existing monitoring mechanisms need to be enhanced and policy changes are needed to make the process more transparent.
    - rather than being a function of specific policies and programs, budget allocations largely follow historical trends;
    - despite some recent efforts to institute participatory processes around budget formulation, the budget itself remains the business of a handful of experts.
    - Te planning and implementing phases are considered as two separated processes not necessary linked with each other.

Some of the disadvantages of implementing PETS in Albania are:

- The methodology needs to be improved according to local conditions.

- The questionnaires are long and exhaustive with many questions that sometimes are difficult to understand, it is necessary that they should be shortening in future projects. Shortening of these questions would increase the responsibility level of interviewees in the giving the answers. Since there are too many options they tend to shoot an answer just to get rid of.
- Because a lengthy questionnaire creates an exhausted environment for the interviewees and the use of a sophisticated terminology slows the organization of work, their rehabilitation would be of a significant help.
- A particular attention should be addressed to the choice of the percentage of the open questions to be included in the questionnaire.
- The sample was small; a higher percentage of each category of institutions can contribute for better results.

- An analysis of the Albanian population's health status and the main health challenges is rendered difficult by data limitations. The available data on the population's health status are scarce and often of questionable reliability.
- There was a big problem during the implementation of PETS which revealed to be an important conclusion that the record keeping and record filing systems are sometimes inexistent. People who kept records often had no relevant training. Records were often filed at different places and kept by different people. There was very little institutional memory. We had great difficulties to collect information in hospitals and primary health service where we asked more than three persons to collect all the data needed for the survey.

This study represents a first pilot case of a public expenditure tracking survey for Albania. It is important to note that assessment of health systems is a long and permanent process, and one has to make allowances to successive and continuous adjustments.

A Public Expenditure Tracking Study in the health sector was conducted in 2004 by the international consultant Claude Tibi with the support of World Bank in collaboration with Albania's Ministry of Health.

The Tibi's study contains relevant information on organization and management, financing and resource distribution in the health sector, health care providers activity and expenditure in Albania only based on institutional data and statistics, without carrying out surveys on beneficiaries, hospitals, primary health care and municipality and communes as 2A Consortium did in 2008.

There is not only a distinction in the approach of the study and methodology, but the in 2004 study was not used any tracking of funds from the governmental institutions to the last beneficiary.

Our study has been fundamentally based on primary data and secondary data collected through questionnaires, focus groups and direct observations, in order to track the flows and use of public expenditures during the period 2005 to 2007.

The other studies on the health sector conducted in Albania, including Tibi's study, have been aimed to analyze the system, have not used so many types of collecting information and no study was implemented until now at national base.

A particular focus in our study has been the role and responsibilities of muncipalities and communes in the health sector, which have not attracted a particular attention in other studies. We consider that this area will be the focus of other studies in the health sector in relation with the decentralization process.

2A Consortium in implementation of PETS in the health sector in Albania has prepared a comprehensive report with findings and recommendations which have used for the dissemination of the results to the proper institutions through different channels of information, which is a new approach compared to other studies already implemented.

Taking in consideration the methodology, including the dissemination of results, and based on the fact that there is no perception from hospital, primary health care institutions, municipalities/communes and beneficiaries in other studies as 2A Consortium has undertaken in 2008, we can say that we have implemented the first PETS in the health sector in Albania.

4.6. Similarities and peculiarities of PETS with other countries

After a literature review that the 2A expert team has conducted, we noticed that similar results or tendencies have been ascertained by different countries in implementation of PETS:

- delays in public funding;
- leakage and shortfalls in public funding;
- inefficient resource distributions;
- lack of transparency;
- need for improvement of information on the health care system and finances;
- lack of cost efficiency calculation methods;
- inefficient level of decentralization;
- wrong used criteria in allocation of funds;
- lack of motivation of staff;
- lack of proper conditions and management of health facilities;
- inappropriate monitoring systems
- lack of coordination in the planning and implementing of budget processes;

Although the evaluation methodology here presented was based mainly on elements of PETS literature review and Brookings & Results for Development Institutes recommendations, important differences exist:

- Despite the fact that the implementation of PETS have the same objective, different approaches have used in different countries according to the health system organization. A toolkit for PETS will be necessary to improve the standards of implementation.
- According to different authors, we can say that there is no agreement at all, among the authors on the most appropriate comprehension of what is health system, which depends on what is health and which is the role of the State in relation to the health of populations. It may be said that the way health problems are perceived is crucial to determine what should be held as relevant or not. The different definitions and perceptions of the health system contribute on the different implementation of PETS.
- PETS can produce different results which can be affected by the different levels of development of the countries.
- Different countries define different frameworks (objectives and goals) and different performance dimensions (mostly in relation

to quality and efficiency) which also effect the PETS implementation.

- Level of institutions participated in the process of implementation of PETS differ from country to country.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. National based conclusions

1. Public sector expenditures on health as a share of GDP have risen only slightly in the last 5 years, from about 2.2 percent in 2000 to an expected 2.79 percent and remain substantially below European and middle income country averages.

2. General revenues account for over 90 percent of public sector funding, despite a mandatory contributory health insurance system. The big problem continues remain the non-budgetary sector employers as farmers and self-employed.

3. The Albania Poverty Assessment has shown that health expenditures have a strong impact on poverty, with the poverty incidence increasing from 25 to 34 percent if out-of-pocket health expenditure is subtracted from household income. Outpatient care expenditures have a greater impact on poverty than hospital expenditures, owing to their more frequent occurrence.

4. An analysis of the Albanian population's health status and the main health challenges is rendered difficult by data limitations. The available data on the population's health status are scarce and often of questionable reliability.

5. Sectoral funding remains fragmented and financing responsibilities have changed often. The main source of public sector funding is the state budget. Public sector spending on health per capita varies markedly by district and region. Even when Tirana, where the country's tertiary care facilities which serve the entire country are located is excluded, public sector recurrent expenditures on health care per capita vary by a factor of two between Albania, have publicly financed and administered health insurance programs.

6. Hospital expenditures dominate public sector spending on health. Albania allocates a higher share of total public sector spending to hospital care than do OECD or EU-8 countries. Hospital expenditures account for about half of all public sectors spending on

healthcare in Albania compared to an OECD average of about 38 percent.

7. The budget mainly is planned based on the historical trends. Therefore, the requests of depending institutions are not taken in consideration from the high institutions. The primary health service institutions were asked on this problem and declares that: 27% think that it should be taken more in consideration their requests, 20% asserts that the outlined budget form the institutions of the primary health service is not considered from the higher instances. At about 13% of the interviewees assume that it should be planned a superior budget than the one we outline each year, 5% of them require the budget to have more analytical articles in the planning, and 5% believes that the budget should be more transparent since the planning, through the enlargement of the participation in the planning.

8. In the framework of reforming the sector of health, the decentralization is important within the sector, as well as for sharing responsibilities, competences and functions with the organs of the local power. The actual experience is not very positive. It has been characterized by frequent changes and reciprocal mistrust.

9. At the health sector there is still centralization of tasks and budgetary competences from the Ministries and central institutions, which has badly influenced in the composition and administration of the public funds. It is worthy to underline that after 2006 the local government units do not have any role and responsibility in the health sector and as a consequence do not play a specific role in the composition and implementation of the budget in this sector.

10. As analyzed even at the composition and implementing part of the budget, the local power role is not considerable. It does not have a primary role in the investments policies, only if asked. Moreover, it does not play any role in the service performance measuring, while the citizens address their request and objections against the services to the local authorities. A survey made from USAID/LGDA pose a question to the citizens related to what do they think for the primary health service, 90% of them inculpate the local power because under their perceptions this service is under their authority.

11. The investment at the primarily health services (health centre, ambulances etc) can be decentralized in municipalities at a larger

scale and the rest of the local power at the districts level as it was before. The districts have as a main competency the composition of development policies for the region always in accordance with the local commune and municipality's policies and national development policies. In this context, the scheme would be more decentralized by insuring more involvement, transparency and efficiency in the utilization of public funds. Moreover, by including the local government in the composition of the MBA it is possible that the fragmentation of the investments funds as the main concern of the MoH could decrease roughly.

12. The distribution of funds from the state budget to the Districts can be achieved through different criteria and calculations. As such, on of the criteria could be the poorness or the development coefficient made by UNDP and some World Bank studies. Other criterion can be attached to the above one such as: the infrastructure level, the government policy for health sector, the level and perspectives of human resources development. In addition, another criteria could be the assessment that INSTA made to 12 districts according to the theory of Washington for sustainable development based on 5 components: i) the level of human capital, ii)level of social capital, iii)physical capital, iv) financial capital and v)natural capital.

5.2. Sectorial based conclusions

13. Hospital capacity has continued to increase over the past decade, despite falling admissions and shorter lengths of stay. Over the past 3 years, the main hospital performance indicators including admission rates, ALOS, bed occupancy and bed turnover rates have more or less remained on a similar low level, pointing towards inefficiencies in production and idle resources in hospitals. Compared to other European countries, Albanian hospitals report relatively low rates for hospital admissions, surgeries, and bed occupancy.

14. The majority of the interviewed at he primary health service and hospital service, express concerns in relation with the budget planning at the health sector. They affirm that the process is not opened, transparent and as a result influence in the bad adminstration of funds.

15. Albania's hospital capacity (3.04 beds per 1,000 populations) compares favorably to that of many other lower middle-income countries, but is on the lower end of the European scale.

16. At the same time smaller hospitals have low occupancy rates and a significantly higher ratio of staff per utilized bed than larger facilities, pointing to inefficient use of scarce resources. Hospitals with less than 100 beds report occupancy rates that are substantially below those of larger hospitals. This reflects patients' failure to trust that these facilities can provide adequate quality of care. Hospitals with less than 50 beds have almost four staff per occupied bed and occupancy rates below 30 percent, pointing to high staff costs and low productivity. This compares to an average of about 2.5 staff for hospitals with 200 or more beds.

17. Consolidation of hospital departments would allow for efficiency gains. Several hospitals in Albania have identical departments within the same hospital or within close proximity.

18. Currently, investment decisions in the sector are not guided by an overall vision of the sector's structure. This often leads to questionable investments, particularly in the hospital sector. Overall, the needs for investment in the sector remain substantial, as many facilities are in poor condition and lack basic equipment. Therefore, the need to make the most effective use of the country's limited resources for sectoral investments is pressing.

19. The biggest part of the budget is addressed to payments and operative expenditures and a minor part goes for investmens. From this questionnaire it results that 60.2 % of the budget is foreseen for payments and social insurances, 27.9% for medicaments and 8.4% for services towards those who do not pay. This clearly shows a weakness of the system itself, in which apart problems of organization there are also social problems, evasion in the contribute payments and benefits from the sector without contributing.

20. The differences between the contributors and beneficiaries have caused premises for a considerable fiscal evasion, which influence in the raise of contributes from the general taxation. In this case, this should be considered the reason for stimulating in an indirect way the bribes and other corruptive elements in this sector. As such, around 61% of the interviewees who benefit from the service declare that after the visit to the doctor have paid to him of to the

nurse different amount as a bribe. The majority of them affirm that the minimal amount paid was 500 Leke and 30% mentioned the amount of 1000 Leke.

21. The structure of the budget among the years asserts that the budget of investments occupies a relatively low position comparing to the operative budget. This indicator emphasizes once more the fact that the sector suffers the lack of reformations and having development strategies. In 2006, 13% of the health system budget (Ministry of Health) was used for investments and 87% as occuring expenditures. Whilst in 2007, 12% goes to expenditures for investments and 82% as korrent expenditures. In 2008, this balance seems improved as 20% are planned for investments and 80% for korrent expenditures (salaries, insurances, operatives and maintenance).

22. From the accomplished analyses, changes and continues shifts of destination in the budget utilization are being observed. The requests start in January-February when the budget implementation begins. These facts are a clear testimony of a lack of responsibility from the institutions which draft the budget and accomplish budgetary policies.

23. The implememtationof the budget presents problems in almost all interviewed health institutions. As such, from the answers made to the primary health service results that communes and municipalites are evaluated with a coeeficient 4.8, Health Care Institution – 7 and their institutions approximately 8 (evaluation from 1-10).

24. In general, the budget from year to year increase together with the historical trend. As such, the respondents of the hospital service were asked on how is the budget of 2008 comparing with the 2007 one. 66% of them said that there is an increase of 10% comparig with one year before, 8.3% affirm an increase of 20% of budget and the rest declare that there is no raise in the budget at all.

5.3. Internal management conclusions

25. The interviewed replied that needs for doctors are still uncompleted, but the contrary results with the number of nurses, where 60% considered that the number of nurses is sufficient.

Therefore, the overall conclusion is that there are problems with the administrative and assistant staff. Only for 37% of respondents the assistant staff number is an adequate amount.

26. The lack of motivation in the salary reflects to the management level of the institutions, as well as in the patient's standards of service. Therefore, the primary health service employees do not fill more favored comparing to the other employees of public sectors at the wage term. As such, 50% think that the salaries are the same and 47% asserts them as lower and lowest.

27. Analyzing the level of changes occurred on the quality of the services in the medical center during the last 3 years, 66% of the clients declare that they have noticed little, very little, or not any changes in the quality of the services.

28. Perception among 72% of the clients on the dissemination channel of information (posters, leaflets, others) regarding the diseases and services are that little, very little or nothing has been done to spread the information regarding the diseases and services provided by the medical center/ambulance. 22% of the respondents consider that the information is spread on an average level and only 6% consider that the information is very much spread to the respondents.

29. 61% of the clients has paid money to the doctor/nurse for the visit they made. From the clients who paid money they declare that 43% of them paid because the doctor/nurse made her/him understand to do in that way. 22% of the respondents declare that they have been asked to pay. There are also 35% of the respondents who paid voluntary.

30. Analyzing the head of hospitals and their financial managers' perception on planning the visit of patients in their unit it results that 42% of them consider that the visits of the patients are not planned or are planned very rarely. There are also 25% of them who believe that the visits are planned often or even 33% who believe that the visits are very often planned.

5.4. Recommendations

Training. There is a need to be more open-minded and to adapt new training forms or approaches in the field of health management and

administration in Albania in order to consolidate the capacities in key institutions like the Ministry of Health, Institute of Public Health, and Institute of Health Insurance.

Foreign technical assistance. Foreign technical assistance was and still is present – and important – in helping Albania manage its reform, but such foreign assistance will be effective only if it is reinforced by Albanian support. So, it is essential to build long-term capacities in the area of health administration and management, and especially in leadership.

Decentralisation. Giving more power to the regional and district levels through the decentralization of policy to the health directorates will require continuous strengthening of human management capacities.
At the present time, there is no school of public health administration and management in Albania, nor is there any institution in which to educate and train people in health policy making and implementation. New initiatives are need to plan the establishment of a local School of Public Health to help provide the capacities in health administration and management.

Optimize revenue collection. The sustainability of healthcare systems depends largely on the ability to generate sufficient revenues. Today Albania continue to face difficulties in raising revenues, due to high levels of unemployment, informal economic activity and poor collection mechanisms. The social health insurance system, the aging of the population will put increasing pressure on the sustainability of health financing both through increased demand for healthcare by the adult population and, most importantly, larger dependency ratios and a smaller contribution base. Albania should develop an explicit, comprehensive revenue collection strategy that considers all available methods, such as direct taxation, indirect taxation, social security contributions, voluntary health insurance, and user charges.

Rationalize the benefit package. Benefit packages are very comprehensive and, therefore, very costly. In order to eliminate the implicit rationing of health care stemming from an unaffordable benefit package – and the associated inefficiencies and inequities – it is necessary to align the services provided with the resources that are available. This process should involve a review of the size and scope of the package that takes into consideration international practices, national demographic and epidemiological characteristics and the expected future flow of revenues.

Modernize the healthcare delivery system. The introduction of a new primary healthcare model that emphasizes family medicine is proving to be successful in most countries, and is resulting in increased patient satisfaction. This should only be the first step, however, towards a more profound reorganization process is necessary. A reorientation of the delivery system towards preventive and primary care should be carried out in order to increase the efficiency of the hospital network by establishing infrastructure, equipment, staffing and service standards in each facility.

Engage the private sector. Involving the private sector in both the financing and provision of healthcare services needs to be further explored because of the potential efficiency gains and greater consumer choice it offers. Involvement can include the provision of private healthcare in public or private facilities, which will in turn require a stronger role for government in licensing, accreditation and quality assurance.

Strengthen human resource planning and training. As important as the financing and organizational reforms are, Albania needs to proceed quickly to upgrade the clinical management of care. To do so, two types of interventions are particularly important. First, providers' skills ought to be upgraded to reflect state-of-the art medical practice, which relies heavily on evidence-based medical and nursing practices. Second, new protocols ought to be developed since some of the existing protocols are outdated, especially with regard to the promotion of healthy lifestyles, the prevention of non-communicable diseases and outpatientbased methods of disease management. Continuing medical education, which has been introduced as part of the health system reforms in Albania, needs to be sustained.

Reform the payment system for health providers. The payment system inherited pays salaries that are based on coefficients defined by the Ministry of Health in collaboration with the Ministry of Finance. Changing the way healthcare providers are paid is the central pillar of reorienting the health system away from historical, line item budgeting towards a system that rewards outputs and quality, thereby increasing the efficiency of public spending and the sustainability of health financing. Reforming the payment system will, however, be a very difficult and lengthy process. Taking in consideration the changing natyre of provider payment mechanisms, it is crucial to consider individual incentives alongside institutional incentives. In addition, steps will need to be taken to reduce the volume of informal payments made to healthcare providers since they undermine the impact of

health reforms, siphon funds away from the health system and negatively affect the quality of service provided to those who cannot or do not make these payments.

Regulate the pharmaceutical sector. The drug expenditure is set to grow in Albania as it did in other countries, due to inevitable factors such as innovation, aging populations, increasing incomes and better access to health care. For the foreseeable future there will be a need for further capacity-building in the pharmaceutical sector, with a focus on increased oversight and higher professional standards, more efficient use of limited public resources, better drug pricing policies, equity in access and the rational use of medicines.

Improve data quality. The paucity of good data with which to track health care expenditure and revenue streams, and analyze liabilities, deficits and arrears, is a constraint on Albania' abilities to effectively manage its expenditures. An important first step could be to move towards institutionalizing systems of National Health Accounts, which would allow the analysis of expenditure by combinations of provider type, function and financing source. At the level of the individual institutions, the establishment of formal and regular financial reporting mechanisms is important. Regular household budget surveys with detailed health budget components would greatly enhance the measurement of private out-of-pocket health expenditures.

6. DISSEMINATION OF PETS PROJECT RESULTS

The aim of ACER and ASET dissemination activity is to raise awareness of the project and to publicize its activities, particularly its findings and results.

In this report we present the activities undertaken to disseminate the work which has been accomplished for the implementation of the project. The purpose of this dissemination report is to highlight the main achievements of the work done from the staff of ACER and ASET according to the work plan for the dissemination of finding. In this process, suggestions and remarks made during the seminar which took place in Washington were included.

In order to implement the dissemination program concerning the findings of the project, there are completed the following activities:

a) Meetings, round table, presentations and discussions at the central and local institution level with the participation of experts and groups of interest.

- Meeting with budgeting experts

At the meeting took part experts with a long working experience in leading positions of budget programming, monitoring and implementing, representatives of NGOs, "Order of Doctor", as well as researchers from the academia. This meeting was organized on 23.06.2008 at the ACER offices and lasted around 2 hours. The main objective of it was not only the dissemination of project findings, but especially the development of an active debate with experts of the field. This meeting was relevant as far it highlighted a different point of view from the one of the executive units in relation to problems and their solution possibilities. In this meeting participated members of the project staff: Dr. Zef Preci, Prof. Fatmir Memaj, Mr. Fran Brahimaj, Mr. Klodjan Seferaj, Mrs. Mimoza Kasimati and Mrs. Jolanda Memaj and experts of the budgeting: Mr. Arben Malaj, Mrs. Adriana Berberi, Mr. Gjergji Teneqexhi, Mr. Remzi Sula and Mr. Xhafer Baloshi. From the NGOs, it was present Mr. Minella Borova and a representative from the "Order of Doctors" and academia, Mr. Beshir Ciceri, Mr. Lavdosh Zaho and Mr. Drini Salko.

During the meeting it was discussed mainly over technical problems which deals with the process of budgeting as a whole, as well as public funds in the health sector (concerning, it was suggested the need for a legal framework at the level of Council of Ministers Decision). After a brief presentation regarding the project activity presented from Dr. Zef Preci and main findings presented from Prof. Fatmir Memaj, the participants exchange opinions on the methods and possibilities to raise transparency in the budgeting process, as well as the monitoring of its implementation and considering the suggestions of the groups of interest in every phase of it. The presented problems emphasized the necessity to take measures not only in a short-term, but also to encourage initiatives in middle – terms (the case of adopting the law for the state budget).

- Round table with the technical staff of the Economic Department of the Ministry of Health.

The project staff was composed by Dr. Zef Preci, Prof. Fatmir Memaj, Mr. Fran Brahimaj, Mr. Klodjan Seferaj and Mrs. Mimoza Kasimati.

The round table was organized on 01.07.2008 at the environments of the Ministry of Health. From the technical staff of the Economic Department of the Ministry were present the Director, Mr. Saimir Kadiu and three other specialist of it. The discussions lasted approximately two hours.

It is worthy to mention that the presentation was focused mainly in technical details of the research findings and in their presentation in a technical way. Also, the questions and answers were more concentrated on technicalities. In support of the discussed problems, possibilities to undertake concrete measures to improve the state of affairs were considered. The round table was focused in the technical steps to be carried out in a vertical line from the Ministry staff to the Government and the Parliament. The latest would play a major role in approving different legal acts in order to improve the situation in accordance to the arisen problems. It was positively considered the possibility to sanction with the Council of Ministers Decision the process of establishing opportunities and analysis during the implementation of the budget in the health sector.

- Presentation at the Parliamentary Commission of Health

This meeting was organized on 12.07.2008 at the environments of the Albanian Parliament and lasted 1 hour. In the meeting took part

representatives from the project staff, Dr. Zef Preci, Prof. Fatmir Memaj, and Mr. Klodjan Seferaj. The Parliamentary Commission was represented by key stakeholders as Mr. Tritan Shehu (Head), Mr. Leonard Solis and Mr. Engjell Bejtaj. Firstly, it was made known a brief summary of the research, emphasizing the main findings of the PETS study for the Albanian health sector and recommendations. During the meeting, it was evaluated the support given from the Brookings Institution (USA) in the realization of this research study. Moreover, there were given valuable ideas on how should be performed in the near future. The discussions were focused on the below topics:

- *health facilities conditions and management,*
- *human capacities conditions,*
- *health service delivery,*
- *the system of public expenditure distribution and management in the health sector,*
- *Advantages & disadvantages of the implementation of PETS in Albania and similarities and peculiarities of PETS with other countries.*

The members of the Health Commission expressed their willingness to support with legal initiatives the improvement of the situation in the health sector.

- Based on the dissemination plan, the next meeting was organized with the Minister of Health, Mr. Nard Ndoka.

At the meeting were present the project staff composed by Dr. Zef Preci and Prof. Fatmir Memaj. Also in this meeting was present the General Secretary of this Ministry, Mr. Defrim Krasniqi as a key Ministry official. The meeting was held at the offices of the Ministry of Health and lasted around 40 minutes.

Firstly, the Minister of Health, Mr. Nard Ndoka was informed regarding the previous meetings and about the results achieved from them. Next, it was made a brief presentation of the main findings from the project and following of the main conclusions and respective recommendations.

After some brief questions and respective answers, it was discussed over some major recommendations. Mr. Ndoka thanked the working group for the implementation of the project as well as the Brookings Institution (USA) for the assistance given on this purpose. At the end of the meeting, the participants of the meeting reached agreement and the Minister sustained the idea to establish a National Health Committee through a Council of

Ministers Decision, as a consultative unit of the Minister of Health in regards to the implementation problems of the Government program in the Health Sector (attached the Draft Decision in the Albanian Version).

b) In addition, the working group paid a particular attention to wide media coverage of the most developed problematic in the PETS report.

Publications at the written media were delivered according to a division of topics developed in the PETS report, with the prior intention to cover all findings and recommendations. This was accompanied with the selection of those newspapers with major printing in the country and publishing the articles at the economic rubric of each of them.

There were published the following articles:

1. **"Public Expenditures in Albania**" published at the "Gazeta Shqiptare". In a summarized way, it is discussed the survey methodology and main finding of PETS.
2. **"Decentralization and Health Service efficiency"**, published at "Standard". In the article it is emphasized the need for a real decentralization of public funds and the results of findings from the survey in this field.
3. **"Negative effects in the Health System"**, published in the "Tema" newspaper. This article particularly discusses the human resource capacities in the health service and their qualification, as well as the efficiency in the utilization of health institutions.
4. **"PETS, a technique of observing transparency in the Health sector – The Albanian case"**, published at the "Economia". The author analysis in details the budget of the health sector and gives evaluations and recommendations according to results of PETS study.
5. **"PETS, a technique to assess and analyze the corruption in the health sector"**, in which despite the importance that PETS has in analyzing the phenomena of corruption, it is focused also over the similarities and peculiarities of the survey results of the other countries.
6. **"Increase or index of payments?"** published at "Agon", where it is emphasized the PETS results on the level of payments of health sector employees.
7. **"PETS, a tool for transparency"**, published at the "Metropol". After analyzing in general term the expenditures

of the health sector, the article highlights the survey results from the research study concerning the raise of transparency and efficiency to a better use of public funds on the benefit of the citizens.

Attached, there are copies of the newspapers with the published articles.

Finally, a publication in the audiovisual media was made possible

This is a wireless interview about the project, the findings and its recommendations delivered at the "Tirana" National Public Radio (attached a copy of the Audio CD).

In the main time, the staff of the project implementation is cooperating to organize a television program in one of the major television channels in Albania concerning *PETS in Albania: the project idea, the support of the Brookings Institution, the work done to organize the survey, results and its main findings*.

APENDIXES

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List of graphs

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