PUBLIC EXPENDITURE TRACKING STUDY

HEALTH SECTOR

DRAFT REPORT

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TABLE OF CONTENT

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LIST OF ABBREVIATIONS

DD	District Directorate
EU	European Union
GDP	Gross Domestic Product
GP	General Practitioner
GOA	Government of Albania
HC	Helicopter Center
HCI	Health Care Institution
HII	Health Insurance Institute
IMF	International Monetary Fund
IPH	Institute of Public Health
INSTAT	Albanian Institute of Statistics
LGs	Local Governments
MCs	Municipalities and Communes
MOF	Ministry of Finance
MOH	Ministry of Health
MOLGD	Ministry of Local Government and Decentralization
NBEC	National Biomedical Engineering Center
NBTC	National Blood Transfusion Center
NWDRCC	National Well-being and Development of Children Center
NGO	Nongovernmental Organization
NHA	National Health Accounts
PCU	Project Coordination Unit
PHC	Primary health care
RD	Regional Directorate
SII	Social Insurance Institute
TRHA	Tirana Region Health Authority
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VIPC	VIP Clinic
WB	World Bank
WHO	World Health Organization

INTRODUCTION

The objective of this study is to carry out an abbreviated public expenditure tracking exercise and analyze the flow of funds in the health sector. The scope of the study includes the TRHA region, Dürres, and a 'control' municipality outside of Tirana and Dürres. All sources (i.e. Health Insurance Institute, Ministry of Health, local governments and out-of-pocket payments) and all levels (i.e. central government, local government, Tirana Regional Health Authority, and health facilities themselves) should be examined, and 'uses' should be examined both vis-à-vis different types of facility (hospital, health center, pharmacy etc.) and different kinds of expenditure (salaries, supplies, administrative costs, etc.).

1. HEALTH SECTOR ORGANIZATION AND MANAGEMENT

For administrative purposes, the country is divided in twelve Prefectures (regions), including Tirana Prefecture, plus Tirana Municipality. Each Prefecture is sub-divided into three Districts, while Tirana Municipality has only one district (Tirana City). In all, there are 37 Districts. Prefectures and Districts are deconcentrated levels of the central Government. All Prefectures and Districts are staffed by civil servants.

Local Governments are composed of Municipalities (69) and Communes (315) and are staffed by elected officials.

1.1 HEALTH CARE INSTITUTIONS

1.1.1 Health Care Public Institutions

The network of Public Health Care Institutions, in charge of diagnostic and curative health services is organized around three levels (see Graph 1):

- Primary Health Care;
- Secondary Hospitals; and
- Tertiary Hospitals and Specialized Institutions.

At national level, the network also includes the Public Health Institute.

Primary Health Care

Primary health care is provided in Primary Health Centers located in the main cities of each municipality and commune[1], Primary Health Posts located in a number of municipalities and communes, General Polyclinics and Dental Clinics in the main city of the 36 districts, and Specialized Polyclinics in Tirana. All polyclinics, except those in Tirana are under the responsibility of District Hospitals (see below), are headed by the district hospital director and use hospital staff.

In 2003, excluding Tirana, there were 582 PHCs, out of which only 316 or 54% were functional, 1501 PHPs, out of which approximately 700 or about 47% were functional, 35 general Polyclinics and 35 Dental Clinics. In Tirana (municipality and province), there were 24 PHCs, 69 PHPs (for 162 villages), 10 Polyclinics, 3 Specialized Polyclinics, 1 Dispensary and 1 Urgency.

[1] There should be at least one Public Health Center per commune

Approximately 1444 general practitioners, 900 specialized physicians with full or part time assignment and 5930 midwives, nurses and midwives-nurses currently were working in PHCs, including TRHA, during 2003. General practitioners offer diagnostic, curative, preventive, promotional and health educational services. They are paid by HII on the basis of a combination of basic salary and "per capita" system.

Dental services in Albania have a curative and preventive character. They are mainly private (approximately 70-80%), while the public sector includes free service offered to children until the age of 18 and emergencies. Public service is offered in 8-year elementary schools and high schools as well in the centres of each district. There are currently 310 dental clinics in which approximately 1200 licensed doctors work (283 in the public sector).

Public health and promotion services are provided in Public Health Centers within the framework of Primary Health Care and are supervised by the Institute of Public Health (see below). There are 35 PH Centers. Based on the recommendations of the conference of Alma Ata, public health services are integrated within primary health care institutions. The highest technical institution in the public health sector is the Institute of Public Health, which is a national institution directly independent from the Ministry of Health (see below).

Maternity consultations as well as centers of family planning operate within the Primary Health Care structure. There are currently 108 such centers.

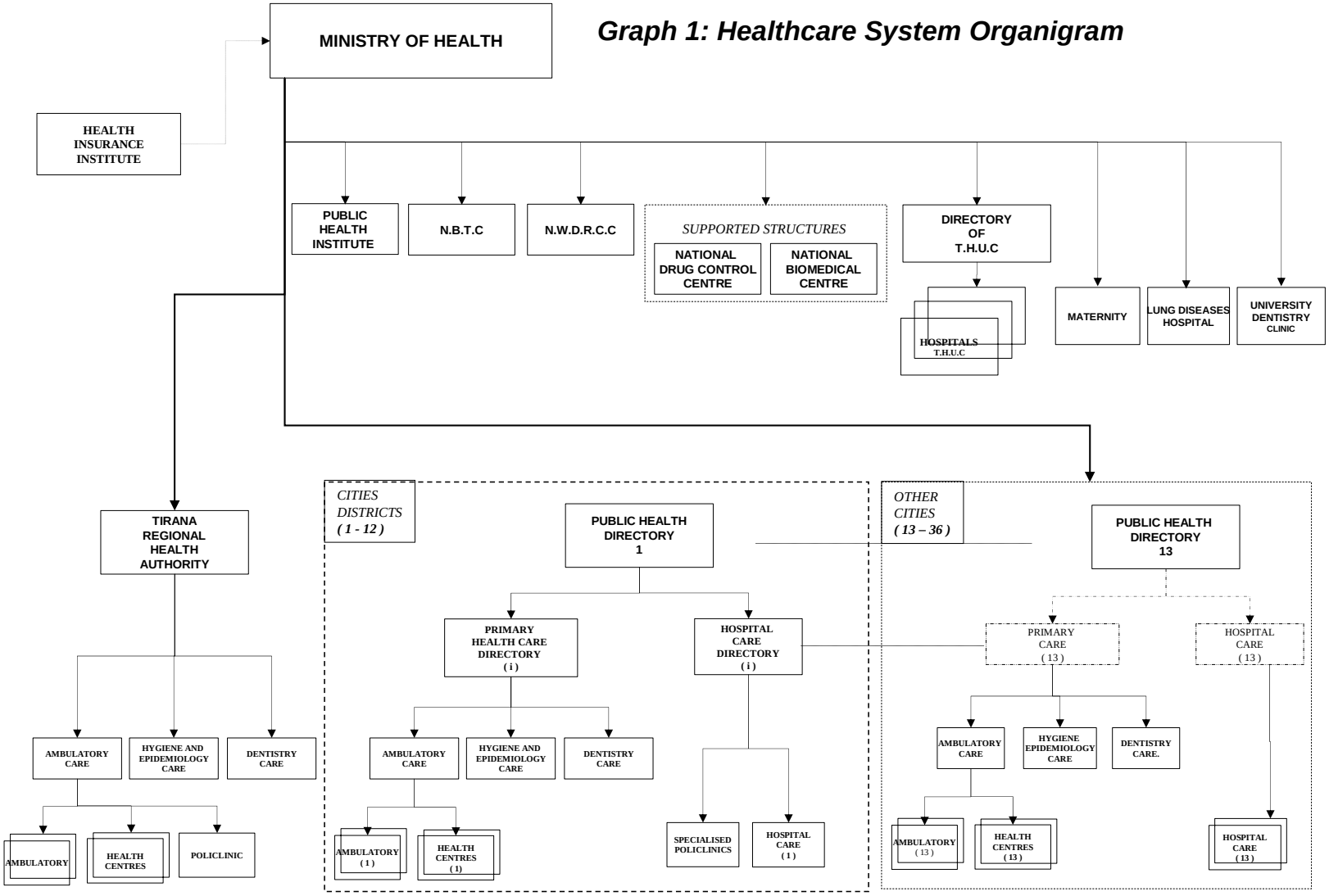
Children consultations are also part of the Primary Health Care network. There are currently 177 such centers.

Secondary Hospitals

Secondary care is offered in secondary, regional, district and rural hospitals, as well as in most national hospitals offering tertiary care (see below). There are 34 Secondary Hospitals, with 9 Rural Branches, and 2 Psychiatric Hospitals distributed and located as follows:

- 11 Regional Hospitals, located in the Prefecture centers, offering specialized services in ENT, Ophthalmology, Orthopedics, Trauma, Neuro-Psychiatry, Chest Medicine and Infectious Diseases, together with basic services;
- 23 District Hospitals, located in the District Centers, offering four basic services, Pediatrics, Obstetrics-Gynecology, Surgery and Pathology;
- 9 Rural Hospitals, directly dependent from District Hospitals and operating as an integral part of DH. Rural Hospitals offer Pathology and Pediatrics services;
- 2 Psychiatric Hospitals, located in Vlora and Elbasan, with 680 beds in total, specializing in the treatment of chronic and acute psychic patients.

Graph 1: Healthcare System Organigram



Tertiary Hospitals and Specialized Institutions

Tertiary care is limited and located mainly in Tirana. It is provided by 4 institutions:

- Tirana University Hospital, with around 1,527 beds, which offers secondary and tertiary care and includes the Clinic Stomatology University;
- Tirana Obstetric and Gynecology Hospital, with 287 beds, offering secondary and tertiary care;
- The Lung Disease Hospital, with 232 beds, offering secondary and tertiary care and long-term treatment for tuberculosis;
- The Military Hospital, under the Ministry of Defense, with 412 beds, specializing in traumatology and containing the university orthopedic department.

In addition to those tertiary hospitals, there are three specialized institutions:

- The National Center for the Well-Being and Development of Children;
- The VIP Clinic;
- The Helicopter Center.

Institute of Public Health and other National Institutions

Under MOH, the Institute of Public Health is responsible for health protection (especially the prevention and control of infectious diseases and the national vaccination program), environmental health and the monitoring of drinking water and air quality. It works mainly through the district public health centers.

National Institutions also include:

- The National Center of Blood Transfusion; and
- The National Center of Biomedical Engineering.

1.1.2 Health Care Private Institutions

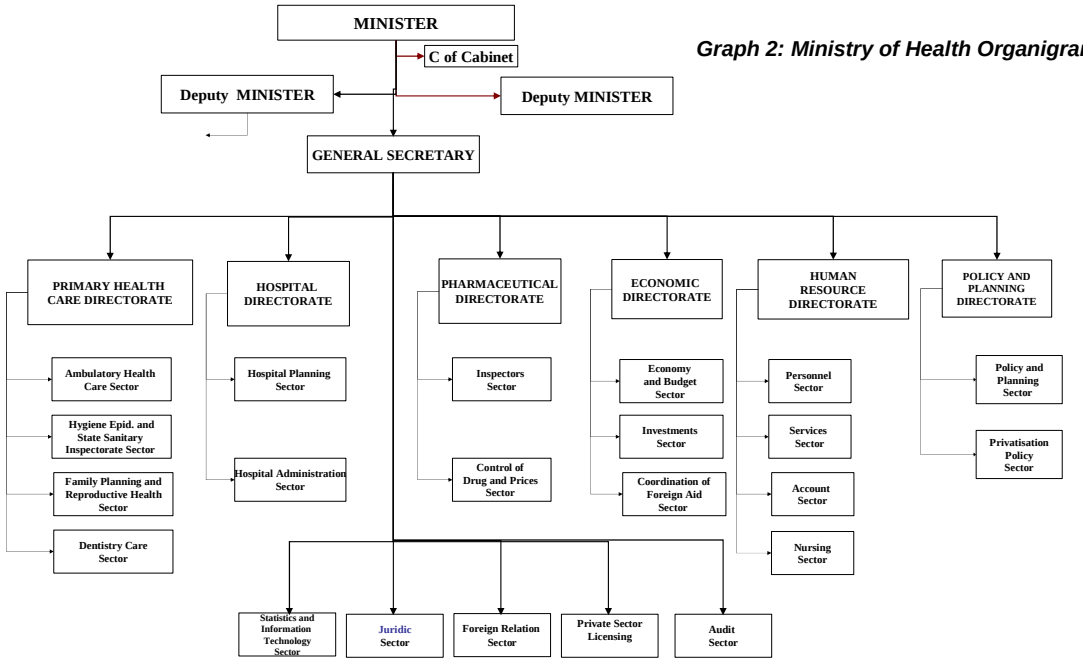
The network of Health Care Private Institutions is composed of:

- Private, general and specialized practitioners;
- Specialized polyclinics, including exam centers;
- Dental clinics;
- Laboratories;
- One 200-bed hospital, partly funded by the Catholic Church, which is not yet operational; and
- Pharmacies (all pharmacies, except hospital pharmacies are private). Pharmacies are monitored from the MOH through the Pharmacy Directorate and the National Center for the Control of Medicines, which is supported by three permanent commissions: the Commission of Drugs Nomenclature, the Verification of Manufacturing Conditions Commission and the Drugs Reimbursement List Commission. There are presently 157 agencies with pharmacist assistants, selling a limited number of drugs and 60 paramedics and nurses, which mean a limited and non-professional service.

1.2 HEALTH SECTOR MANAGEMENT INSTITUTIONS

The health sector is managed by:

- The Ministry of Health (see Graph 2). MOH which directly administers all National Hospitals, except the Military Hospital, the Institute of Public Health and all National Institutions. MOH is the owner of all Public Health Institutions, with the exception of Primary Care Centers and Posts, which are owned by municipalities and communes. A Policy and Planning Department has been created in MOH since 2000 with the objective of developing MOH capacity for designing and planning health policy and developing MOH capacity for a better use and coordination of donors intervention in accordance with its short- and medium-term strategies;
- The 12 MOH Regional Directorates and 24 District Directorates. Regional Directorates are organized in one Department of Primary Health Care and one Department of Hospital Care, while District Directorates have two Divisions of respectively Primary Care and Hospital Care. The Regional and District Directorates supervise all Primary Health Care Institutions within their jurisdiction and directly administer all secondary Hospitals and Centers of Public Health. Each PHC Directorate the following services: (a) Health education and promotion; (b) Hygiene/Epidemiology service and the State Sanitary Inspectorate; (c) Ambulatory Health Care Service; (d) Dental Service;
- The TRHA. TRHA is responsible for the planning and management of all Primary Health Care Posts, Centers, Polyclinics and Specialized Polyclinics in the Tirana Region.



Graph 2: Ministry of Health Organigram

2. FINANCING AND RESOURCE DISTRIBUTION

2.1 THE SCOPE OF HEALTH EXPENDITURE

Health expenditures include:

- Recurrent and capital expenditure of all Public Institutions managing and/or funding the health sector and/or health care institutions, as follows: (a) MOH and its regional and district directorates; (b) TRHA; (c) HII and its regional directorates, agencies and branches (see below);
- Recurrent and capital expenditure of all Public Health Care Institutions: (a) Primary Health Care Centers and Posts; (b) General and Specialized Polyclinics; (c) Dental Clinics; (d) District, Regional and National Hospitals; (e) Public Health Institutes and Centers; (f) Other National Institutions belonging to the health sector;
- All household direct payments to public and private health care institutions, such as user fees paid by non-licensed patients asking for diagnosis and treatment in public Health Care Institutions, outpatient fees (including under the table payments), drug co-payments, and contributions to the HII. In the LSMS survey, transportation costs to/from health care institutions were also included in health expenditure.

Private Health Care Institutions recurrent expenditure and amortization of capital expenditure are assumed to be balanced by household direct payments.

2.2 FINANCING HEALTH EXPENDITURE

The financing of health expenses is closely linked to the organization structure of the health sector. It is performed as follows (see Appendix I for detailed tables and presentation).

2.2.1 Allocation of Resources from the Central Level to the Health Sector

Under the responsibility of the Prime Minister, MOF allocates funds to MOH within the framework of the budget process. MOH budget includes resources for administration and management, PHCs and PHPs excluding Tirana Region, Hospitals and Public Health Institutions. MOH budget also includes resources allocated by MOF to HII for health expenses of the dependent population (see below). Finally, MOF allocates Block Grants to M&Cs which, until 2003 were supposed to use part of their BG to fund Primary Health Care Institutions O&M and small repairs (see below). Central Government resources are funded by taxpayers (households and firms) and grants (internal, external), while domestic borrowing and long-term external loans contribute to balancing the annual budget (see Appendix II).

MOH budget (see Appendix I), which is structured by program, chapter and source of funds since 2002, is designed as follows:

- Planning, Management and Administration Program. This program corresponds to MOH recurrent and capital budget, including MOH regional and District Directorates;
- Primary Health Care Centers/Posts, including School Health, Polyclinics and Specialized Polyclinics, Dental Clinics and Urgencies. Under this program are the following expenses: (a) Primary health care staff costs excluding GPs in all regions excluding TRHA; (b) administrative, school health and urgencies staff within TRHA; (c) since 2004, all non-salary recurrent costs of primary health care centers in all regions excluding TRHA; (d) MOF contribution to HII for dependent people, which appears as a transfer under chapter 604 (see above); and (e) all investment costs funded

from central sources, including donors for primary health care providers, including Tirana Region;

- Hospitals. Total, recurrent and capital budgets of all national, regional and district hospitals under MOH control (39 presently), except Dürres, and all national institutions such as NBEC, NBTC and NWDRCC;
- Public Health institutes and centers. Total, recurrent and capital budgets of all public health institutes and centers.

Over the 2002-2004 period, leaving aside MOF transfers to HII for dependent people, MOH recurrent budget (see Appendix II) depends to a large extent on staff costs, which represent nearly two thirds of the total, with minor variations linked to salary increases on the one hand and the funding of primary health care non-salary recurrent expenses through MOH budget since 2004, as well as the late increase of such expenses for hospitals on the other hand (see below). The issue of staff size and staff utilization still looms large in the reform of the health sector.

From 2002 to 2004, MOH budget has increased by 9.4% in current prices, essentially for the following reasons:

- Salary raises: expenditure under chapters 600 and 601 have increased by Lek 1,843 million, without any significant staff variation;
- Increase in non-salary recurrent expenses for hospitals and inclusion of such expenses for primary health care institutions in MOH budget since 2004. In total, these changes induced an increase of around Lek 920 million in chapter 602;
- Increased MOF allocation to HII for dependent people (chapter 604; see below) which amounted to Lek 535 million;
- On the other hand, investments declined approximately by Lek 1,840 million.

2.2.2 Allocation of Resources from the Local Level to the Health Sector

Under the **Law on Local Governments**, MCs have either 'shared responsibilities' or 'full responsibilities' over various functions, Health belonging to the former category. Municipalities and communes receive annually an unconditional block grant from the Central Government through MOF and MOLGD to fund those expenditures for which they are responsible within their jurisdiction. The grant is not earmarked and MCs are free to use it as they see fit, not necessarily according to national objectives and priorities. The amount allocated to each MC is based on population, area, and urbanization coefficient. Although local authorities have the possibility to increase their budgets with their own revenue collection, these local resources are generally very limited, except in a few big cities such as Tirana. Since health belongs to the shared responsibility category, MCs are supposed to finance the operation, maintenance and minor repairs of all Primary Health Centers and Posts, Polyclinics, Dental Clinics and Public Health Centers within their jurisdiction. Such funding was discontinued in 2004 since MCs were giving a low priority to health expenditure and there were significant disparities across MCs in the funding of O&M. Since 2004, those expenses are now funded by MOH.

2.2.3 Users' contributions: the role of HII

The Health Insurance Institute is a national autonomous body established in 1995 and accountable to the Parliament. HII has 12 Regional Directorates (RD), 2 Branches with the same functions as RDs and 22 Regional Agencies (RA; see Organigram 3). HII RDs are located in the main city of the Prefectures/Regions, while Branches are to be found in districts with extreme geographical positions, such as Sarane and Tropoje. Regional Agencies depend from RDs and are

located in districts distinct from the one which is the Prefecture center. RDs have executive functions, while RAs have control functions and do not implement any financial activity.

HII is funded out of employer/employee contributions amounting to 3.5 percent of salaries or wages up to a maximum of three times the annual average personal taxable income, split equally between employers and employees. Based on an annual decision of the Council of Ministers, the self-employed contribute a percentage assessed over the minimum salary which is of 7% in cities and 3-5% in villages. Farmers pay lower rates, since they cannot afford to pay both health and social insurance contributions. Employees' contributions are collected by employers as payroll deductions and employers pay the overall contribution to the Social Insurance Institute, which transfers it to HII. Finally, MOF includes in MOH budget a contribution to HII which is supposed to cover the contribution for the dependent population. The dependent population includes all children under one year, pregnant women and women working at home, war veterans, people with cancer or TBC, people under compulsory military service and the elderly, all of them being in principle directly insured by the State.

The health insurance buys a limited package of health services and drugs. Initially, only PHC general practitioners' salaries were covered, while a limited list of drugs was partially or totally subsidized. The coverage was then progressively extended: (a) the list of subsidized pharmaceuticals was expanded to 278, then 308 and now 344 in total, with about 709 different drugs; (b) all general practitioners' salaries, including in TRHA; (c) in Tirana Municipality (TRHA), HII now covers all outpatient primary health care services, including specialist doctors, nurses and midwives, non-salary recurrent costs and tertiary exams; (d) since 2001, HII has also started funding Dürres hospital as a pilot scheme aiming at testing the direct funding of secondary hospital services through HII.

Users' contributions

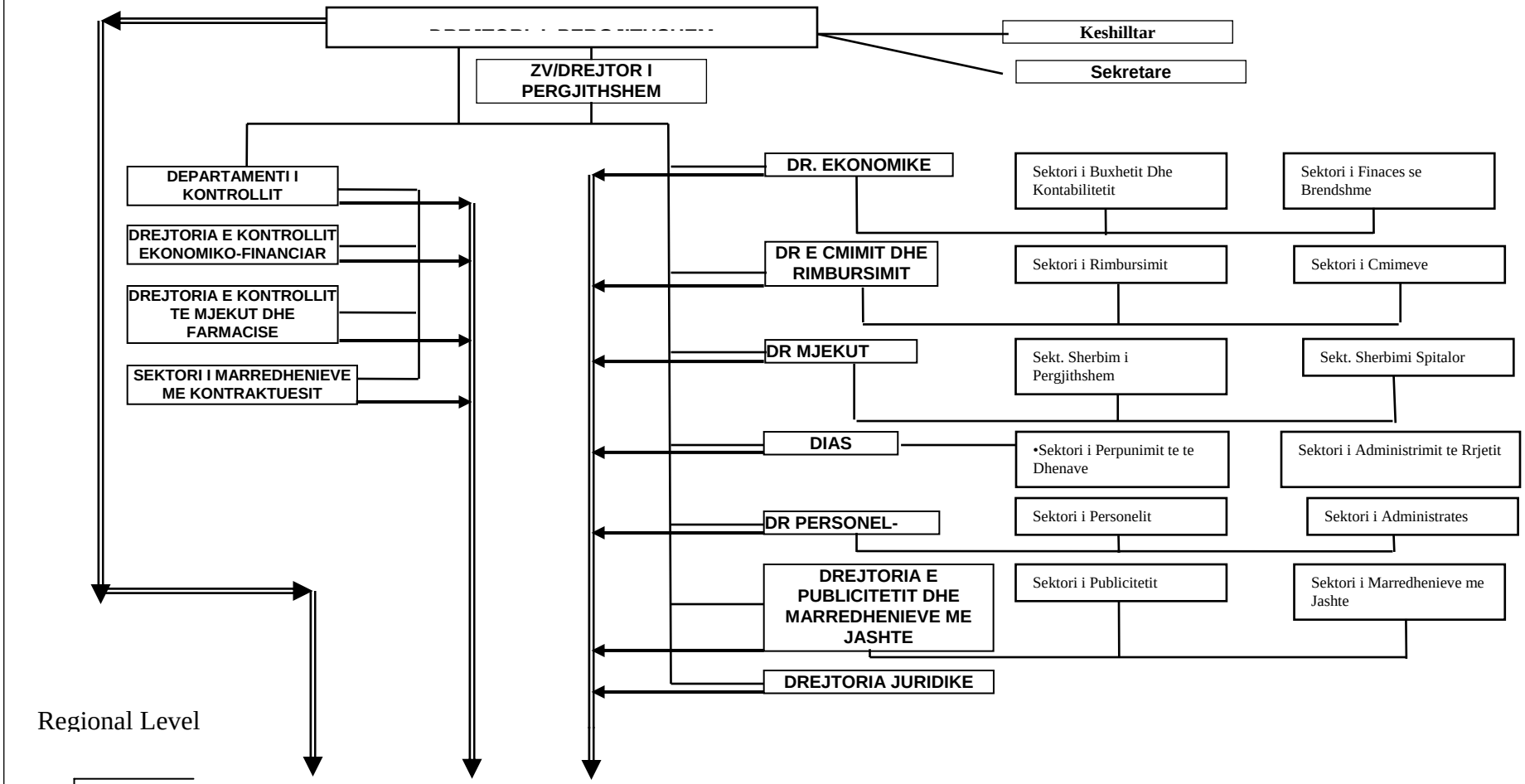
The total number of contributors, excluding those directly insured by the State, was of 507,867 in 2004, down from 574,637 in 2003 essentially because the number of farmers participating to the scheme declined by over 70,000 from 2003 to 2004, without any apparent reason (see Table 1). With the streamlining of the public sector, the number of civil servants contributing to the scheme fell down to 132,300 in 2004 (26.1% of the total number of contributors) from nearly 148,900 in 1995 (39.0% of the total) and the number of employees of former public firms, now privatized is down to 52,800 people (10.4% of the total) from 109,100 in 1995 (28.6% of the total). Although their number has increased recently, self-employed are not yet very much represented. Nearly half of the contributions are paid by civil servants and the average contribution per farmer is extremely low, when compared to all other categories of contributors (see Tables 2, 3 and 4).

Actual coverage still remains limited. In the LSMS survey, only about 39 percent of the total population reported having health insurance license[2]. Coverage varies to a large extent according to location (people in urban areas, especially Tirana are much more likely to have a license than in rural areas, and people in the Mountain region are much less represented than elsewhere), activity (farmers were under-represented until 2003 when their number in the scheme increased significantly) and dependence.

[2] 'Albania Poverty Assessment' the World Bank, Report N°. 26213-AL, November 5, 2003

ORGANIGRAM 3: HII

National Level



Regional Level

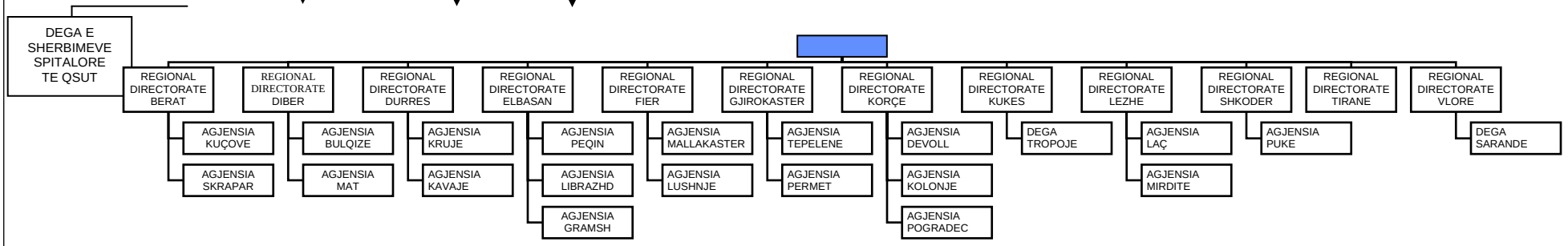


TABLE 1: CONTRIBUTOR NUMBERS, HII										
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Public Sector	148 887	145083	136396	144907	146603	145674	136354	132810	135015	132345
Former Public Firms	109 154	92932	78439	73684	59530	59252	63620	61452	57436	52845
Private Firms	47 764	49482	50041	54091	53743	64038	72089	88339	90369	91512
Self Employed	32 178	22172	13662	13968	13815	19971	26507	28205	30355	40237
Farmers	43 881	32563	26723	38537	113894	171994	160645	126559	261462	190778
Voluntarily Insured										150
TOTAL	381 864	342232	305261	325187	387585	460929	459215	437365	574637	507867

TABLE 2: CONTRIBUTIONS, HII (Lek 1000)										
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Public Sector	234350	425198	516346	627618	701996	768138	837161	966813	1167679	1156000
Former Public Firms	183373	174120	235878	288099	280899	288623	330182	332148	385861	429000
Private Firms	37366	120714	125320	177255	210013	259919	315001	393670	491070	540500
Self Employed	33549	118243	57799	73717	93539	117868	172590	171227	253749	321000
Farmers	7017	115069	11625	10146	24624	23829	39930	38291	50424	107500
Voluntarily Insured										1500
TOTAL	495655	953344	946968	1176835	1311071	1458377	1694864	1902149	2348783	2555500

TABLE 3: AVERAGE CONTRIBUTION PER CONTRIBUTOR, HII (Lek)										
	1995	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Public Sector	1574	2931	3786	4331	4788	5273	6140	7280	8649	8735
Former Public Firms	1680	1874	3007	3910	4719	4871	5190	5405	6718	8118
Private Firms	782	2440	2504	3277	3908	4059	4370	4456	5434	5906
Self Employed	1043	5333	4231	5278	6771	5902	6511	6071	8359	7978
Farmers	160	3534	435	263	216	139	249	303	193	563
Voluntarily Insured										10000
TOTAL	1298	2786	3102	3619	3383	3164	3691	4349	4087	5032

TABLE 4: CONTRIBUTIONS TO HII BY ORIGIN (%)

	1 996	1 996	1 998	1999	2000	2001	2002	2003	2004
State contribution	34,2%	45,0%	46,6%	49,0%	46,0%	48,7%	44,8%	45,2%	46,4%
Public & private firms	48,6%	50,0%	47,6%	44,9%	46,6%	43,0%	46,9%	44,0%	42,1%
Self employed, farmers & vol. ins.	15,7%	4,0%	3,6%	4,5%	5,0%	6,2%	5,8%	6,5%	8,5%
Interests	1,5%	1,0%	2,2%	1,6%	2,4%	2,2%	2,5%	4,3%	2,9%
TOTAL	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%

State contribution

MOF does not determines this contribution on the basis of the number of dependent people and their expected health expenses but mostly as a contribution taking into account HII expenditure and resources, as shown in the 2005 budget proposal[3] sent by HII to MOF, based on MOF ceilings (edited translation):

'The State contribution to HII is meant to cover:

- The reimbursement of health expenditure of the dependent population (drugs, general practitioners and tertiary examinations and treatments); and
- TRHA and Dürres hospital expenses.

The total population is estimated at 4 078 048, distributed as follows:

- Active: 1 260 117
- Non-active: 2 817 931

The non-active population is composed of:

- Retired people: 554 140
- Registered unemployment: 188 063
- People in need of assistance: 585 175
- Military people: 8 700
- Children, pupils & students: 1 481 853'

[It is worth noting that the April 2001 demographic census estimated the total population at 3 087 159, while INSTAT population projections for 2000, based on the previous, 1989 census were of 3 961 400, the difference being related to the combined impact of sustained external migration and strong fertility decline. It is simply impossible for the 2005 population to reach the total referred to in HII budget document, which is most probably based on the 1989 census].

2005 expenses are then projected by item (drugs for active and non-active population, GP salaries, tertiary examinations and treatments, TRHA and Dürres hospital).

[Drug expenses for dependent people are projected based on HII data classified by category of patients, as indicated in Table 5].

'The funding of drugs, general practitioners, tertiary examinations and treatments, TRHA and Dürres hospital expenses is decided by MOF as follows (see Table 6):

- Part of the expenses must be borne by HII as its contribution to the solidarity goal; and
- Part of the expenses is funded by MOF as State contribution'.

In 2003, the state contribution just covered drug expenses for the dependent population and did not take into consideration estimated GP salaries for dependent people and Dürres hospital expenses, while all other hospital expenses are funded by the State through MOH budget. Indicative figures for 2006 and 2007 show that MOF plans to significantly increase its contribution to HII (see Table 6).

[3] 'Relacion Per Hartimin E Projektbuxhetit Te Vitit 2005', Instituti Sigurimeve Te Kudjesit Shendetesor, Drejtoria Ekonomike

TABLE 5: DRUG EXPENSES BY CATEGORY OF PATIENTS (Lek 1000)			
	2002	**2003**	**2004 (9 months)**
Less than one year old	42998	30614	17530
Disabled people	394875	608574	630022
Partially disabled people	31167	41095	26255
War disabled	6790	8423	8029
Cancer	97315	231848	242581
Veterans	146022	222578	209936
Pupils/students	151819	159742	91289
Retired people	580259	807340	1207174
Mentally disabled	3618	9472	7808
Unemployed	146659	156162	109931
Pregnant women	630	820	132
Soldiers	31	35	23
Total non-active population	**1602183**	**2276703**	**2550710**
Active population	**166769**	**207206**	**184165**
Grand Total	**1768952**	**2483909**	**2734875**

Source: HII

TABLE 6: Assessment of State Contribution to HII (Lek million)

	2003	2004	2005	2006	2007
Expenses with state contribution					
1. Total Drugs	2248.7	2746.1	4569.5	5072.1	5634.7
Of which supported by the state budget	2056.7	2546.0	4251.1	4676.2	5143.8
2. GPs	992.4	1110.0	1242.0	1307.9	1377.4
Of which supported by the state budget	907.7	1029.1	1155.5	1205.8	1257.5
3. Tertiary exams & treatments	0	40.0	370.0	1360.0	1360.0
Of which supported by the state budget	0	40.0	344.2	1253.9	1241.5
4. TRHA & Dürres hospital	688.3	800.0	945.5	1029.8	1121.6
Of which supported by the state budget	688.3	800.0	945.5	1029.8	1121.6
Total expenses to be supported by the state budget	**3652.7**	**4415.1**	**6696.3**	**8165.6**	**8764.4**
HII contribution to the solidarity goal	1552.7	2065.1	2293.3	2286.0	2358.9
Contribution from the state budget	2100.0	2350.0	4410.7	5879.6	6405.6

Source: HII, 'Relacion Per Hartimin E Projektbuxhetit Te Vitit 2005', Instituti Sigurimeve Te Kudjesit Shendetesor, Drejtoria Ekonomike

For year 2005, as shown by HII report to MOF, HII financial situation is rather problematic since the financial gap is foreseen at 1,825 Lek million (see Table 7):

TABLE 7: HII Projected Resources and Expenditure – 2005 (Lek million)

HII foreseen income	
Health insurance contributions	3 169
State contribution for dependent people	2 583
Miscellaneous	150
Total Income	**5 901**
HII foreseen expenditure	
Drug Reimbursement	4 569
GP salaries	1 242
Administrative expenditure	446
Training	3
Investments	150
Tertiary examination and treatment	370
TRHA and Durres Hospital	945
Total Expenditure	**7 726**
Financial Gap	**1 825**

Most probably, HII projected budget for 2005 is based on the expectation that the new law on health financing will be adopted soon (see below), but prospects are not clear since health contributions are supposed to double, while payments to all primary, secondary and tertiary health providers should be under the responsibility of HII and all providers should be granted autonomy.

2.2.4 Patients' Payments and Total Health Expenditure

By law, inpatient services in hospitals including drugs are free of charge for the entire population, whether patients are insured or not. This also applies to long term treatments.

Outpatient services involve patient co-payments which are set at a low level and are publicized in principle. All fees thus collected stay within the institution delivering the services. 70% of the fees go to the staff, 15% to non-salary recurrent expenses and 15% to investments, including small repairs.

Informal payments seem to be rather widespread according to the LSMS survey, which seems to contradict the free character of inpatient services in hospitals, since answers specifically refer to 'individuals reporting a hospital stay in the year before the interview'[4] (see Table 8). This contradiction is reinforced by one comment in the 'Poverty Assessment' study which reads as follows: 'the problem of informal payments in hospital care seems to be a large one (all hospital services are supposedly free), and more important than the problem in outpatient care facilities' (see Table 9).

[4] 'Albania Poverty Assessment', Report N°. 26213-AL, November 5, 2003, the World Bank

TABLE 8: Yearly Hospital Expenditure (Lek)

	Not-Poor	Poor	Total
Tirana	34 013	18 315	29 192
Urban	22 410	17 315	21 381
Rural	21 540	14 569	19 573
Total	22 605	15 555	20 787

Source: 'Albania Poverty Assessment', Report N°. 26213-AL, November 5, 2003, the World Bank

In total, 2002 household health expenditure have been estimated at Lek 673 per month, with large differences across consumption quintiles (health expenditure per household are twice higher in the highest quintile than in the lowest one, see Table 10).

TABLE 9: Average Informal Payments in Outpatient Care Among Those Making Informal Payments (Lek)

Coastal	Central	Mountain	Tirana
576.4	587.5	722.0	337.5

Source: 'Albania Poverty Assessment', Report N°. 26213-AL, November 5, 2003, the World Bank

TABLE 10: Per capita monthly health expenditure and share of health expenditure on total household per capita expenditure across consumption quintiles (Expenditure in Lek)

	Quintiles					Total
	I	II	III	IV	V	
Per capita health expenditure	449.8	544.4	618.5	691.4	892.9	672.9
% Share of total expenditure [a]						
Total health exp.	9.1	7.9	7.1	6.1	4.9	6.7
Hospital exp.	1.3	1.2	0.8	0.8	0.4	0.8
Outpatient care exp.	6.2	5.3	5.0	4.0	3.3	4.6
Exp. On drugs [b]	4.9	4.1	3.8	3.2	2.5	3.5
% Share of permanent income (*Total per capita expenditure excluding health expenditure)*						
Total health exp.	12.7	10.6	9.2	7.8	6.1	8.8
Hospital exp.	1.8	1.7	1.1	1.0	0.5	1.1
Outpatient care exp.	9.0	7.4	6.6	5.2	4.2	6.1
Exp. On drugs	6.6	5.2	4.9	3.9	3.1	4.5

Source: 'Albania Poverty Assessment', Report N°. 26213-AL, November 5, 2003, the World Bank

[a] *Total health expenditure was added to total per capita household expenditure to compute these shares. However, the consumption quintile distribution does not include health expenditure*

[b] *Includes medicines prescribed in outpatient care services, hospitalizations and non-prescribed medicines*

2.2.5 Donors and NGOs Financing of Health Expenditure

Bilateral (France, Germany, Greece, Italy, Switzerland, The Netherlands, The United Kingdom, etc.) and multilateral projects (World Bank, OPEC Fund, Islamic Bank, EC, ECHO, UNICEF, UNFPA, WHO, etc.) have financed the health sector since 1993, under the form of soft grants and loans, with a period of strong increase starting in 1996, and especially in 1998/99 during the

aftermath of the Pyramid scheme and the Kosovo crisis. Since 2000, external assistance is focusing on priority development programs. Foreign funds financed on average 15% of total public expenditure on health over the past 5 years. External funding was mostly targeted to hospitals (60%), primary health care (25%) and special public health programs.

There are many NGOs and professional organizations active in the health sector. The Albanian Red Cross has branches and volunteers in every district of the country. Most NGO financing originates from foreign bilateral and multilateral agencies. NGOs mostly fund public health programs and Primary Health Care Institutions.

2.3 PAYMENTS TO HEALTH CARE PROVIDERS

Payments are made to Health Care providers by two institutions: the MOH and HII.

2.3.1 Ministry of Health

The budget preparation process starts in June/July, when MOF sends a note setting financial ceilings to each ministry for their total budget. MOH send in turn guidelines to each health care institution specifying how expenses should be assessed and setting ceilings for each chapter based on MOF instructions and ceilings. Even for hospitals, no objectives or targets are specified since MOH does not buy medical services and there are still no medical protocols jointly established by MOH hospital and economic departments. The old traditional budget preparation processes are still used, where new budgets are based on actual expenses of past year and percentage increases deriving from MOF guidelines and ceilings. Once each institution has prepared and justified its draft budget, institutional budgets are assessed and consolidated by MOH hospital and economic departments and finally submitted to MOF which must approve it by institution and chapter. The national budgets must be approved by the Parliament, generally by end December and expenses on the new budget may start as soon as January.

Funds for primary health care institutions, excluding TRHA, are transferred by MOH either to the Directorate of Primary Health Care of the District, when dealing with Primary health care institutions located in the main municipality of the District, or to the municipality/commune, for Primary health care institutions located in all other MCs of the District. In such case, those funds belong to a budget distinct from the MC budget. Payments are made by the Treasury since PHCs/PHPs do not have a bank account and do not manipulate funds. A similar process is used for hospitals, with funds transferred to the Hospital Care Directorate of the region or district.

All primary health care institution and hospital submit an expenditure report to MOH, and their expenses are controlled once a year by MOH audit department. Since payments are supervised and authorized by Treasury District offices, there is no further control by MOF over health care institutions expenses.

2.3.2 Health Insurance Institute

Payment of General Practitioners

Currently in the territory of Albania 1444 contracted general doctors are paid directly from HII funds. The payment of doctors is made according to a compound system “Compensation for compensation” and “compensation for inhabitants”. Other criteria such as years of work, specialisation, functional duty and geographical difficulty are also taken into consideration. TRHA GPs are paid according to slightly different regulations.

The drug subsidy scheme

Each year, HII publishes the list and prices of drugs which are partly or totally subsidized. These drugs are grouped under 15 main categories based on the typology of functional illnesses they should be prescribed for. Each category is in turn subdivided into subgroups until reaching the molecule level, under which various options may be found. This publication is associated with a Decree specifying for each main sub-category of drugs the percentage of the cost which is subsidized (those percentages apply to the price of the cheapest drug in each basic category).

There are 6 subsidy levels, from 100% to 50%, but the subsidy applies to the lowest cost of the molecules which are proposed in the list. The Decree specifies subsidies in the following way[5]:

- 100% subsidy: J04, L01, L02, L03, L04, M05, V03;
- Subsidy between 85% and 95%: A09, A10, B01, B03, H01, H05, M04, N03, N04, N07;
- Subsidy between 75% and 85%: C01, C02, C04, C08, C09, H03, J05, N05, R03;
- Subsidy between 65% and 75%: A02, A07, B05, C03, C07, C10, G02, G04, H02, N02, N06;
- Subsidy between 55% and 65%: A03, A05, A11, B02, C05, G03, J01, J02, M01, P02, R05, S01;
- 50% subsidy: D01, D06, D07, R01, R06, V07.

Those levels of subsidy apply to all categories of patients except belonging to the dependent category who benefit from a 100% subsidy for all drugs, based again on the lowest cost of the molecule in the category since October 2003.

Patients with a prescription from a physician agreed by HII buy their drugs at pharmacies under contract with HII and are charged the difference between the total cost and the subsidy, while pharmacies are refunded by HII based on the prescriptions they submit.

While there are three main Albanian firms producing drugs (including Profarma and Prodentalfarma), most drugs are imported from various countries including India.

TRHA

There is a budget for each PHC, polyclinic and specialized polyclinic which is prepared by TRHA and negotiated with HII, regarding recurrent expenses, while investment budgets are negotiated with MOH. Budgets are prepared in a traditional manner, based on projected expenses for each chapter (600; 601; 602; 230 and 231). Salaries and contributions are assessed for next year, based the institution staff, which is not supposed to vary and salary regulations; while contributions are determined based on social and health insurance regulations. All expenditures under the 602 chapter (non-salary recurrent expenses) such as operation and maintenance, supplies, etc. are finally budgeted, based on past year actual expenditure.

All PHCs and polyclinics get secondary income from non-insured patients. For the 13 polyclinics in Tirana city, total secondary income amounts to approximately 16.8 million Lek per year or 0.17 million US$. Secondary income stay within the institution: 70% goes to the staff, 15% to operation and maintenance and 15% to investments including rehabilitation and repairs.

[5] For more details on therapeutic groups, refer to ‘Lista E Barnave Që Rimbursohen Nga’ HII, Tirana, 2004

PHC and polyclinic budgets are managed by HII, while TRHA actually pays the bills based on staff lists established twice per month by the HCIs and certified by the institution head and the head nurse. No expenses are paid directly by primary health care institutions.

Dürres Hospital

Dürres is a large and rather well kept hospital with significant expansion plans and service reorganization. There are plans to build two towers which will include 170 beds and allow for the regrouping of pathology, surgery and internal medicine departments. The maternity department will also be reconstructed. Such developments, which are aiming at transferring and improving services rather than expanding capacity, will take place without significant staff changes because of present overstaffing.

The hospital receives patients from Dürres and other districts. Patients not belonging to Dürres district are usually admitted only in case of emergency, but there are exceptions to the rule. Inpatients do not pay any charge, even when they are not licensed, while outpatients pay fees for ambulatory services.

Dürres hospital is an autonomous institution with an account at the National Bank of Albania, while all other hospitals only have one at the Treasury. HII transfers its budget to its account and Dürres is entitled to prepare and sign tenders in line with regulations, decide about the best offers and directly pay its suppliers, once the hospital financial officer has controlled the invoices. A similar process is used to buy drugs for the three warehouses and the hospital pharmacy.

Dürres expenditures are categorized by cost center (services), opening the way in the future to the assessment of costs, once medical procedures are established (see Tables). Dürres hospital budget is prepared in the same way as other health care institutions and is based on demands made by each service concerning staff and non-salary recurrent expenses which are consolidated by the hospital direction. The hospital is entitled to reallocate funds within the budget after approval by its Board.

Control of expenditure is carried out by HII regarding recurrent expenses and MOH for investments. There is also the State control exercised by the National Audit Institution.

HII Resources and Expenses

HII expenses are determined to a large extent by drug subsidies. Changes in the structure of expenses over time are mostly explained by the following factors:

- Increase in the number of GPs and their salaries;
- Funding of Dürres hospital and TRHA expenses by HII since 2001; and
- Increase in drug subsidies related to the full reimbursement of drugs to retired people since October 2003, the increased incidence of some illnesses and the increased number of subsidized drugs.

While HII has generally shown a positive balance (see Table 13, and Appendix II), there is a clear deterioration of its accounts which is foreseen in 2004, with an expected deficit of Lek 756 million. This trend is mostly due to the fast increase of drug reimbursements and it is rather urgent to reform the health sector financing and HII funding.

TABLE 11: HII EXPENDITURE (Lek million)									
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Drugs	867	1202	1783	1941	1705	1681	1697	2249	3430
GPs	320	343	432	475	529	601	876	992	1078
Tertiary Exams	0	0	0	0	0	0	0	0	40
Dürres Hospital & TRHA	0	0	0	0	0	440	653	688	800
Administration	64	75	137	154	176	222	300	315	351
Investments	19	3	28	22	26	23	78	121	100
TOTAL	**1270**	**1623**	**2380**	**2592**	**2437**	**2967**	**3604**	**4366**	**5799**

TABLE 12: HII EXPENDITURE (%)									
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
Drugs	68,3%	74,1%	74,9%	74,9%	70,0%	56,7%	47,1%	51,5%	59,1%
GPs	25,2%	21,1%	18,2%	18,3%	21,7%	20,3%	24,3%	22,7%	18,6%
Tertiary Exams	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,0%	0,7%
Dürres Hospital & TRHA	0,0%	0,0%	0,0%	0,0%	0,0%	14,8%	18,1%	15,8%	13,8%
Administration	5,0%	4,6%	5,8%	5,9%	7,2%	7,5%	8,3%	7,2%	6,1%
Investments	1,5%	0,2%	1,2%	0,9%	1,1%	0,8%	2,2%	2,8%	1,7%
TOTAL	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%

TABLE 13: HII RESOURCES, EXPENDITURE AND SURPLUS/DEFICIT (Lek million)									
	1996	**1997**	**1998**	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**
RESOURCES	1482,0	1754,0	2298,0	2654,6	2826,4	3447,0	3611,0	4647,1	5043,0
EXPENDITURE	1270,0	1623,0	2380,0	2592,0	2436,7	2966,6	3604,0	4365,5	5799,0
SURPLUS/DEFICIT (-)	212,0	131,0	-82,0	62,6	389,7	480,4	7,0	281,6	-756,0

2.4 New Law on Health Financing

A new law on 'Financing Health Services through Health Insurance' has been drafted but not yet submitted to the Parliament (see Appendix III). The draft law is promoting six key changes:

- **MOH role is re-directed from funding health care institutions to policy, planning, monitoring and control**. MOH responsibilities will include: (a) prevention; (b) first-aid emergency services; (c) investments; (d) education and research; and (e) other activities as defined by special law. The Ministry of Health shall be responsible for: licensing of health service providers; registration of public health service providers; monitoring health service providers; negotiating proposals of health services costs and submitting them for approval to the Council of Ministers; supervising the quality of health services; and planning the development of public health services. The Ministry of Health shall create professional advisory boards including a representative of the Health Insurance Fund to assist in formulating policy aims and cost proposals;
- **Compulsory insurance is extended**. All economically active persons permanently residing in Albania are obliged to register with the HII and will not be able to opt out;
- **Contributions to HII are significantly increased**. The employer/employee contribution is raised to 7.5% of the assessment base, instead of 3.5% presently for employed persons. The basis for calculation of the contribution shall be the taxable personal income of the insured person up to a maximum of three times the annual average personal taxable income. The minimum assessment base shall be the minimum wage, as set by the Council of Ministers. The assessment base for non-economically active insured persons shall be the minimum living level as defined by the Council of Ministers. In the future, contributions should be collected by the General Directorate of Taxes;
- **Health care services reimbursed to patients are extended**. They will include: (a) primary care; (b) specialist care; (c) hospital care; (d) drugs and appliances; and (e) transportation; as defined in the Health Care Act, Hospital Act and the Drugs Act. It is further specified that the size of reimbursement of health services providers, including the size of reimbursement for essential drugs shall be defined annually by the Council of Ministers on the proposal of the Minister of Health, after consultation with the Health Insurance Fund and the competent professional medical organizations. Insured persons may be requested to participate in the cost of health care provided to them. The size of such participation shall be decided by the Council of Ministers;
- **New financing relations between HII and health service providers are promoted**: Health service providers that conclude a contract with the Health insurance Fund shall be entitled to reimbursement of the cost of provided services in accordance with the Health Insurance Fund Act. Health service providers that have not concluded a contract with the Health Insurance Fund shall collect the fees and other costs from the patient. In such cases patients shall be entitled to reimbursement from the Health Insurance Fund up to an amount to which the contracted providers are entitled to under the Health Insurance Fund Act. The Fund shall reimburse only health care provided by licensed health service providers, registered with the Ministry of Health;
- **Autonomy is granted to all public health institutions** which shall be transformed into independent legal persons licensed and registered with the Ministry of Health and shall get an independent budget and a bank account by 1 January 2006.

3. HEALTH CARE PROVIDERS ACTIVITY AND EXPENDITURE

3.1 Primary Health Care (excluding TRHA)

PHC/PHP and Polyclinic expenditure funded by MOH (see tables 14 and 15) do not include general practitioner salaries which are paid by HII. While the staff has increased by 6% in the 35 polyclinics during the 2002-2004 period, it has declined by 1.5% in the 2083 PHCs/PHPs. Trends in recurrent expenses have been mostly determined by such staff changes, salary increases and the inclusion of O&M expenses for primary health care institutions in MOH budget since 2004.

Not surprisingly, over 70% of the visits take place in PHCs while there are twice as many consultations at home from PHP staff (see Table 16).

TABLE14: PHC/PHP EXCLUDING TRHA – MOH FUNDED RECURRENT EXPENDITURE AND STAFF (Lek million)

	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	4598	876.4	290.0		1166.4
YEAR 2003	4576	888.3	301.7		1190.0
YEAR 2004	4529	1061.5	304.9	212.9	1579.3

TABLE 15: POLYCLINICS EXCLUDING TRHA – MOH FUNDED RECURRENT EXPENDITURE AND STAFF (Lek million)

	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	2599	486.0	155.3		641.3
YEAR 2003	2668	494.9	170.4		665.2
YEAR 2004	2754	613.1	175.4	333.4	1121.8

TABLE 16: PHC-PHP ACTIVITY AND STAFF (2003)			
	In Municipalities	In Communes	TOTAL
Primary Health Care Centers	**104**	**478**	**582**
Total Visits	1167737	966290	2134027
Less than 14 year	282196	321919	604115
Of which less than 1 year	55970	73558	129528
Over 14 year	860051	570776	1430827
Of which over 60 year	349624	243188	592812
Consultations at home	25490	73595	99085
Primary Health Care Posts	**152**	**1349**	**1501**
Total Visits	413867	453471	867338
Less than 14 year	66744	168479	235223
Of which less than 1 year	19707	41825	61532
Over 14 year	189480	219189	408669
Of which over 60 year	38890	116211	155101
Consultations at home	157643	65803	223446
Number of General Practitioners	**538**	**784**	**1322**
Number of Nurses and Midwives, PHCs	**723**	**1682**	**2405**
Number of Nurses and Midwives, PHPs	**419**	**2776**	**3195**

3.2 Dental Clinics and Public Health Centers

TABLE 17: DENTAL CLINICS: MOH FUNDED RECURRENT EXPENDITURE AND STAFF (Lek million)					
	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	399	79503	26356		105859
YEAR 2003	392	80213	26775		106988
YEAR 2004	396	94228	26886		121114

TABLE 18: PUBLIC HEALTH CENTERS: MOH FUNDED RECURRENT EXPENDITURE AND STAFF (Lek million)					
	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	824	165333	53511		218844
YEAR 2003	818	180116	51492		231608
YEAR 2004	816	195984	58687		254671

3.3 Primary Health Care (TRHA)

TRHA primary health care network includes 24 PHCs, with 65 PHPs, 10 Polyclinics, 3 specialized polyclinics, and 3 specific institutions (Urgencies; Dispensary and Blood Transfusion Center). Staff salaries still represent a very high share of recurrent expenditure in all primary health care institutions with a slight decline from 90% in 2003 to 89% in 2004 while expenses on supplies, drugs and repairs increase to a limited extent (see tables 19 and 20).

TABLE 19: PRIMARY HEALTH CARE RECURRENT EXPENDITURE, TRHA 2003 (Lek million)

	Cost item	PHC	Polyclinics	Specialized Polyclinics	TOTAL
I.1	Staff				
	Base salaries	71,16	112,32	94,81	278,28
	Health and pension contributions	20,56	32,73	29,84	83,13
	Wages & others	6,07	7,35	6,50	19,92
	Total Staff Costs	**97,79**	**152,40**	**131,14**	**381,34**
I.2	Utilities (electricity, water, phone)	8,56	13,21	7,49	29,26
I.3	Uniforms	0,00	0,00	0,13	0,13
I.4	Waste disposal	0,00	0,00	0,00	0,00
I.5	Furniture, equipment and repairs	1,47	0,53	1,11	3,11
I.6	Administrative supplies & others	1,40	1,76	3,41	6,57
I.7	Drugs	0,59	0,56	2,33	3,49
I.8	Cleaning materials	0,09	0,14	0,14	0,37
	Total Non Salary Recurrent Costs	**12,12**	**16,20**	**14,61**	**42,93**
	TOTAL	**109,91**	**168,60**	**145,76**	**424,27**

TABLE 20: PRIMARY HEALTH CARE RECURRENT BUDGET, TRHA 2004 (Lek million)

	PRIMARY HEALTH CARE RECURRENT BUDGET TRHA 2004 (Lek million)				
	Cost item	**PHC**	**Polyclinics**	**Specialized Polyclinics**	**TOTAL**
I.1	Staff				
	Base salaries	77,37	127,59	122,89	327,86
	Health and pension contributions	23,21	38,28	36,87	98,36
	Wages & others	8,54	8,04	7,53	24,11
	Total Staff Costs	**105,80**	**160,95**	**154,10**	**420,86**
I.2	Utilities (electricity, water, phone)	3,68	7,30	4,89	15,86
I.3	Uniforms	0,00	0,00	0,14	0,14
I.4	Waste disposal	0,00	0,00	0,00	0,00
I.5	Furniture, equipment and repairs	4,44	0,70	3,97	9,10
I.6	Administrative supplies & others	3,72	4,07	3,53	11,31
I.7	Drugs	3,74	5,61	5,35	14,70
I.8	Cleaning materials	1,22	1,83	1,08	4,12
	Total Non Salary Recurrent Costs	**16,78**	**19,51**	**18,95**	**55,24**
	TOTAL	**122,58**	**180,46**	**171,17**	**474,21**

TABLE 21: Staff in TRHA Primary Health Care Network (2004)

	Polyclinics	Specialized Polyclinics	Health Centers	TOTAL
Family Physicians	215	0	122	337
Special. Physicians	89	127	33	249
School Physicians	43	0	3	46
Nurses	442	103	330	875
Others	71	66	30	167
TOTAL	**860**	**296**	**518**	**1674**

3.4 Payment of General Practitioners by HII

GP salaries and contributions are recorded in Table 22. They have doubled over the 2000-2004 period.

TABLE 22: HII EXPENDITURE (Lek million)

	1996	1997	1998	1999	2000	2001	2002	2003
Drugs	867	1202	1783	1941	1705	1681	1697	2249
GPs	320	343	432	475	529	601	876	992

3.5 Reimbursement of Drug Subsidies to Pharmacies by HII

Drug total reimbursements did not vary much from 1998 to 2002, and then more or less doubled during the following two years (based on planned reimbursements for 2004). Two factors explain to a large extent this very significant trend (see Table 22):

- The fact that retired people are fully reimbursed starting from October 2003;
- The increased incidence of specific illnesses such as cancer;

In addition, changes in the number of licensed patients, price increases between 2001 and 2004 and the increase in the number of drugs which are reimbursed may also have had some limited impact on drug reimbursements.

HII controls drug reimbursements in various ways: (a) prescriptions by GPs are controlled based on patients' files; (b) HII also controls pharmacies for drugs delivered and check drugs taken from pharmacies with some patients; (c) patients must sign the prescription which shows the amount they paid.

According to the strategy for the health sector drafted by MOH, there are however significant problems in the pharmaceutical sector: 'There is an insufficient number of inspectors in the structures of the pharmaceutical sector, which has to assure regular and permanent inspection of pharmaceutical products. Approximately 60% of the territory is not covered from regional inspectors and as a consequence the complete control of market can not be carried out, while problems such as smuggling of drugs, the sale of humanitarian aids especially during crisis periods and the non-observance of the margins of trade have greatly increased. Medicine registration is an acute problem. Not only the existence of drugs that come from smuggling but also non-effective ones have been registered, and there have been many complaints from patients, doctors and pharmacists. Other problems include the lack of drug prices transparency, missing

prices in the label of the product, lack of a drug information system in the sector, which includes all links of inspection, registration, drug's information, pharmacy vigilance etc.'

3.6 Secondary and Tertiary Hospitals

3.6.1 Dürres Hospital

Detailed expenditure by department add up to a slightly different total than HII consolidated data for Dürres, with differences on the salary bill and non-salary recurrent expenses (see tables 23 and 24).

TABLE 23: DÜRRES HOSPITAL EXPENDITURE (Lek million)

	BUDGET CHAPTERS				TOTAL	TOTAL
	600	601	600 & 601	602	EXPEND	STAFF
2002 EXPENDITURE	96,8	31,0	127,8	87,1	215,0	684
2003 EXPENDITURE	123,8	34,9	158,7	142,3	301,0	736
2004 BUDGET	172,0	50,4	222,4	132,6	355,0	736

TABLE 24: DÜRRES HOSPITAL EXPENDITURE BY DEPARTMENT - 2003 (Lek Thousand)

	BUDGET CHAPTERS				TOTAL
ANNUAL EXPENSES	600	601	600 & 601	602	EXPEND
Primary Health Care	19 288	5 954	25 241	8 916	34 157
General Surgical Department	30 312	9 096	39 408	44 940	84 348
Delivery Department	30 180	9 264	39 444	20 580	60 024
Pediatric Department	19 284	5 916	25 200	10 872	36 072
Orthopedic Department	4 776	1 464	6 240	3 936	10 176
Shijak's Department	8 316	2 500	10 816	5 412	16 228
Polyclinics of Specialties	17 352	5 328	22 680	2 016	24 696
Emergency	10 114	3 104	13 218	14 352	27 570
Sterilization	0	0	0	104	104
Blood Post(Station)	953	293	1 246	384	1 630
Examination Center	4 057	1 244	5 302	2 052	7 354
Physiotherapy	565	173	738	84	822
Pharmacy	1 062	325	1 387	216	1 603
Pathologic Anatomy	726	223	949	324	1 273
Others(laundry, File-holders etc)	6 936	2 105	9 041	3 078	12 119
TOTAL	153 920	46 989	200 909	117 266	318 176

3.6.2 Other Hospitals

The staff and recurrent expenditure of the 36 secondary and 3 tertiary hospitals are recorded in Tables 25 and 26. As for primary health care institutions, salaries and contributions have increased in relation with salary raises, with a limited decline of staff in secondary hospitals. On the other hand, non-salary recurrent expenditures increase by respectively 15% and 22% in secondary and tertiary hospitals. The impact of salary raises is such, however that the share of salaries and contributions in total recurrent expenses does not change.

TABLE 25: SECONDARY HOSPITALS RECURRENT EXPENDITURE AND STAFF (Lek million)					
	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	8557	1624,1	516,4	1613,3	3753,8
YEAR 2003	8520	2003,3	590,3	1869,9	4463,5
YEAR 2004	8217	2080,8	614,7	1854,2	4549,6

TABLE 26: TERTIARY HOSPITALS RECURRENT EXPENDITURE AND STAFF (Lek million)					
	STAFF	600 SALARIES	601 CONTRIB.	602 O&M	TOTAL
YEAR 2002	3610	706,0	231,0	1090,0	2030,6
YEAR 2003	3590	818,4	243,2	1000,0	2065,2
YEAR 2004	3659	916,0	269,1	1329,3	2518,0

Over half of patients are admitted into urgencies. The average ratio of inpatients per bed and the strong variance across services suggests short inpatient stays in hospitals and under-utilization of facilities in some services (see Table 27). Since data are not available by hospital and service, it is not possible to assess more precisely the utilization of facilities, but it is most probable that there is a strong variance of utilization of facilities across hospitals and services.

TABLE 27: HOSPITAL BEDS AND INPATIENTS BY SERVICE (2003)				
	N° SERVICES	N° BEDS	INPATIENTS	INPATIENTS/BED
Pathology	44	1325	30312	22,9
Pediatrics	50	1139	45996	40,4
Surgery	38	1310	45958	35,1
Infections	27	552	13065	23,7
Infective Pediatrics	19	342	11455	33,5
Ophthalmology	14	136	5814	42,8
ORL	14	145	7451	**51,4**
Neurology	15	230	5035	21,9
Psychiatrics	7	795	2767	**3,5**
Pneumology	4	389	6175	15,9
Cardiology	4	161	5083	31,6
Endocrinology	2	43	1205	28,0
Gastro-Enterology	2	75	1846	24,6
Dermatology	6	81	1552	19,2
Hematology	2	39	1364	35,0
Rheumatology	2	30	745	24,8
Orthopedics-Traumatology	6	229	4669	20,4
Oncology	1	120	5114	42,6
Urgencies	42	216	341886	**1582,8**
Obstetrics	43	1232	46879	38,1
Gynecology	29	528	21103	40,0
Neonatology	27	702	33265	47,4
Others	17	148	4937	33,4
TOTAL	**415**	**9967**	**643676**	**30,9**

CONCLUSION

Data on health financing and expenditure are scattered in MOH, HII, TRHA and health care providers' files and are not easily accessible; there is an urgent need to design a comprehensive health management information system based on present and future needs of users. Analytical capacity should also be strengthened, not only in the MOH policy and planning department but also in HII, TRHA and hospitals.

Financing and resource allocation mechanisms of the health sector must urgently be reformed, since they have obviously reached clear limits:

- Over the past years, MOF has progressively transferred part of the burden of health expenditure from taxpayers (the central government) to users by controlling and limiting its contribution to HII for dependent people. There is an urgent need to review the policy in this area, based on long-term projections of health expenses, including for dependent people, and a discussion of principles, criteria and priorities for funding health expenses and sharing the burden between taxpayers, insured people and users. The issue of support to dependent people health expenditure should be examined in depth. In this regard, it is worth noting that the new law on health sector financing does not mention the State contribution to HII;
- Ensuring long-term funding of the health sector based on criteria of quality of service and equity is only part of the task for the health sector. Improving efficiency is also crucial and must be based on a series of measures including: (a) autonomy of health care providers, with full ability to reallocate internally resources with approval of the board (see new law on health financing); (b) accountability of health care providers to their board and HII district/regional directorates, in the areas of service rendered, expenses and utilization of resources; (c) improved management of health care providers based on continuous capacity building; (d) changes in the budgeting process which should be based on contractual arrangements between health care providers and HII; (e) establishment of a long-term human resource development policy aiming at progressively reducing over-staffing, improving staff capacity and reaching a better balance between the distribution of staff by category and the needs of the sector; (f) raising staff salaries and considering changes in salary scales allowing staff to be promoted to higher positions based on merit; (g) enforcing a stricter control over under the table payments to health care staff by patients; (h) increasing resources for health care providers non-salary recurrent expenses.