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TECHNICAL PAPER

PRELIMINARY ANALYSIS ON ALBANIAN HEALTH SYSTEM FINANCING AND CORRUPTION

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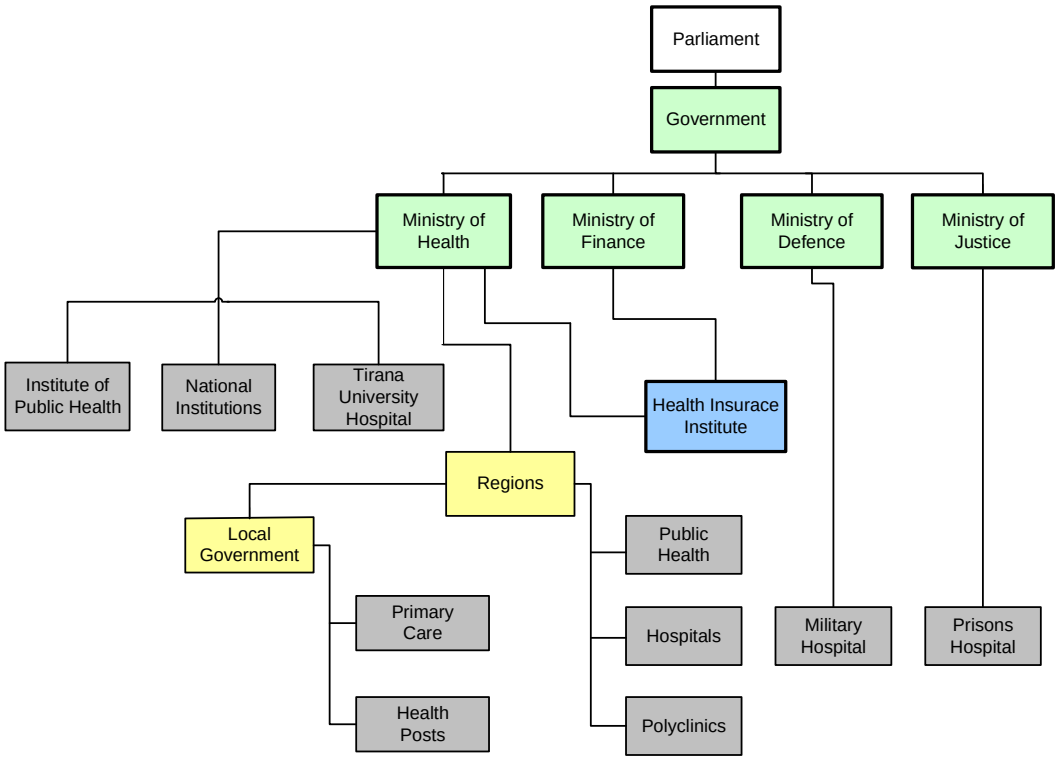
1 EXECUTIVE SUMMARY

After different reforms started in 1995 and speeded up during the last years, Albanian Health Care System, from a typically Semashko model is moving very fast to a Bismarck model. Decentralization of primary care management, privatization of pharmaceutical sector, dentistry and founding of the Health Insurance Institute (HII) were the main milestones of these reforms. Albanian Health system is funded through a mix of general tax revenues, payroll tax revenues for compulsory Health Insurance Institute (HII), voluntary prepayment for Voluntary Health Insurance (offered by HII), out-of-pocket at the time of service use and by different international donors. The main public health system financing entities are the Ministry of Health (MoH) and Health Insurance Institute (HII). Like other public sectors in Albania, the health care sector is also affected from corruption. The way how corruption comes out and which segment of the health care system affect, depends in part on the health financing system. Most of corruption occurring in the health system is a reflection of general problems of governance and public sector accountability. Addressing irregularities as informal payments, improving procurement and distribution of drugs and supplies, increasing the staffs 'wages etc, requires an integrated anti-corruption strategy and a particularly strong political backing.

2 INTRODUCTION TO THE ALBANIAN HEALTH SYSTEM

The Albanian Government is the main provider of health care services in the country. The health care services are structured in three levels: a) primary health care; b) secondary health care; c) tertiary health care.

Organisation of Health System in Albania



a) Primary Health Care Service (PHC) is provided in health centres/posts and polyclinics. PHC services at the community are the first level of access to health care (INSTAT et al, 2010).

b) Secondary Health Care is provided in regional and/or district hospitals.

c) Tertiary Health Care is provided at the single University Hospital Centre in the country, in the capital Tirana.

In each district functions a directory of Public Health, which coordinates all health services of the district. The exception is Tirana, where through a pilot project is created the Regional Health Authority. Ministry of Health aims to create in the future such regional authorities also in other Albanian regions, which will be coordinating the functioning of health services at regional level.

3 FINANCING OF THE ALBANIAN HEALTH SYSTEM

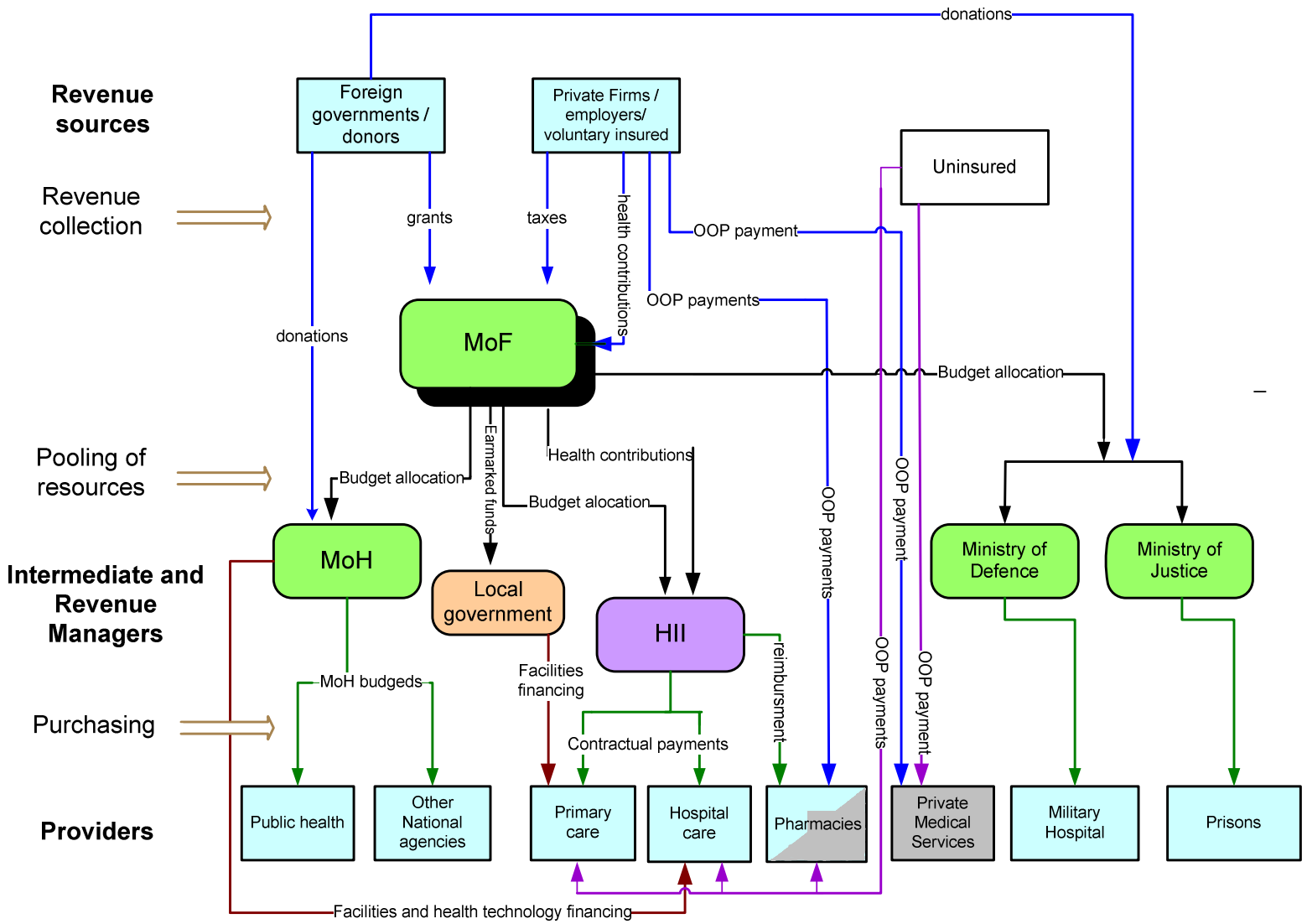
After different reforms started in 1995 and speeded up during the last years, Albanian Health Care System, from a typically Semashko model is moving very fast to a Bismarck model. Decentralization of primary care management, complete privatization of pharmaceutical sector, dentistry and founding of the Health Insurance Institute (HII) were the main milestones of these reforms. The Health system is funded through a mix of general tax revenues, payroll tax revenues for compulsory Health Insurance Institute (HII), voluntary prepayment for Voluntary Health Insurance (offered by HII), out-of-pocket at the time of service use and by different international donors (see Table 1 and Health financing flowchart).

Table 1: Health System financing, Albania

Health Systems data		Country level data		Average value of regional comparator		Average value for income group comparator	
	Source of Data	Albania	Year of Data	Europe & Central Asia	Year of Data	Lower middle income	Year of Data
Health Financing Module							
Total expenditure on health as % of GDP	WHO	6.2	2006	6.2	2006	6.08	2006
Per capita total expenditure on health at average exchange rate (US$)	WHO	174	2006	258.21	2006	106.91	2006
Government expenditure on health as % of total government expenditure	WHO	11.3	2006	11.35	2006	9.57	2006
Public (government) spending on health as % of total health expenditure	WHO	35.5	2006	57.95	2006	57.13	2006
Donor spending on health as % of total health spending	WHO	3.7	2006	2.26	2006	11.13	2006
Out-of-pocket expenditure as % of private expenditure on health	WHO	94.7	2006	91.67	2006	85.6	2006
Out-of-pocket expenditure as % of total expenditure on health	WHO	61.08	2006	38.73	2006	37.51	2006
Private expenditure on health as % of total expenditure on health	WHO	64.5	2006	42.05	2006	42.87	2006

Source: http://healthsystems2020.healthsystemsdatabase.org/datasets/countryreports.aspx

Health financing flowchart



The main public health system financing entities are the Ministry of Health (MoH) and Health Insurance Institute (HII).

3.1 Ministry of Health

The Ministry of Health has been rapidly changing its traditional role as "Health directorate" toward the function of leadership in health policy development and health strategy implementation. However, it still remains the major financing body of healthcare with two-thirds of the total healthcare budget. MoH is at the same time policy maker, decision maker and manager, controlling also the human resources and trainings. "Public Health services are provided within the framework of primary health care and are coordinated and supervised by the Institute of Public Health. Other national health institutions that report to the MoH and that provide specific services are: National Centre for Blood Transfusion, the Centre for Child Development and Growth, the National Centre for the Quality, Safety and Accreditation of Health Institutions, the National Centre for Drug Control, the Centre for Continuing Education and the National Centre of Biomedical Engineering." (INSTAT et al, 2010)

In the district level all non-hospital health services are coordinated by Directorate of Public Health which directly reports to Ministry of Health. Local authorities are also involved in the health care financing. From MoF they receive earmarked funds for covering facilities' maintenance costs.

Ministry of Health is also financing all mental health services, three psychiatric hospitals (Vlora, Elbasan and Shkodra psychiatric hospitals), all capital investments and medical technology of all public hospital services in Albania as well as the Center of Helicopter Transports. The MoH receives the government budget funds allocated for health from the Ministry of Finance and financing from different donors.

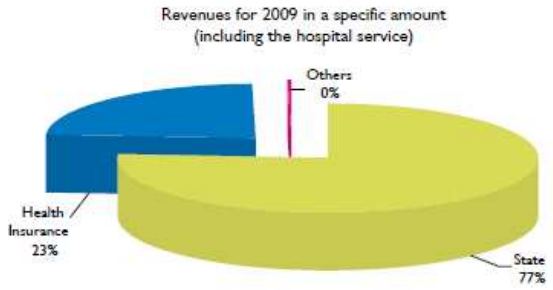
Presently budget allocation is done in a historical principle, based on previews expenses and capacity of institutions. Ministry of Health is trying to draw budget proposals according to development strategy and priorities, but this also seems not easy, because of separate structures of service and budget planning.
Ministry of Health for the year 2010 has a total budget by general state budget of 2.25% of the GDP.

3.2 Health Insurance Institute (HII)

According to the Decision of the Council of Ministers in 1994 "For the Health Care Insurance" it was created the HII, as a state institution, independent, non budgetary and non profitable, with the mission to cover the expenses of the health services of the general practitioners and the reimbursable drugs by the contribution of the health insurances.

Since then, different changes, improvements and modernizations had been made in the legislation of the health system and health insurance. Health insurance is obligatory for all citizens of the Republic of Albania and also for all foreigners who live and work in Albania. It is a scheme of the Bismarck model.

The HII is financed by state budget and obligatory social insurance contributions. Different donors, mainly international, also contribute to the total budget of HII. In 2009 revenues of HII were: Government contribution for inactive population (excluding hospital service) 54% of the total amount and contribution of the active population 45%. If the contribution of the government for hospital service is included in the revenues of HII the figures shall be 77% government contribution and 23% contributions of active population.



Focus, April 2010

The State budget contributes for all inactive and endangered groups of citizens: children, pupils and students, pensioners, disabled people (mental, physical), orphans, unemployed and those who benefit state social assistance and economic support, etc

All employed citizens pay for health insurance 3.4% of the monthly salary (employee 1.7% and employer 1.7%) and self-employed citizens depending on geographical location (rural areas, hilly and mountain areas) pay 3 - 5% of minimal fixed month salary. For persons whose income falls under the defined living minimum, the state pays the insurance contribution. However, entitlement to such payments is subject to assessment of family income, which may lead to situations where an individual has no *de facto* income yet their health insurance payments is not reimbursed by the state.

Health insurance in Albania is personal and it's not covering other family members of the insured person. Contributions by employed and self-employed citizens living in urban areas are collected by tax administration, while contributions of the self-employed living in rural zones are collected by social insurance entities and they are transferred to HII. According to the law, in cases when economically active citizens delay or fail to pay contributions for social insurance (health insurance included) they are fined. Citizens should pay in such cases the contributions and the fine, otherwise coverage by HII is stopped.

3.3 Entitlements for insured persons

Insured persons are entitled to the following: medical visits free of charge at the family doctor and if the insured is using the referral system, free of charge visits to the specialist doctor, treatment at health centre and in hospital and also base medical examinations; Reimbursement 50% to 100% of the price of generic drugs from the positive list (reimbursement drug list). After following strictly guidelines of the referral system the insured can use relatively expensive examinations at tertiary hospitals, paying only 10% of their price.

The uninsured must pay for the visits to GP/FD and to specialist doctor, medical examinations and full price of medicaments. Hospital services are covered by HII.

The insurance scheme is today present in three levels of health care services, in primary and secondary health services, as well as in the tertiary health services.

"The idea that HII will be the only purchaser of the service is becoming real, but it is still a challenge, the key to a better financing for the health system, which will led[!] to a better quality of service for the patient." (FOCUS, 2010)

HII has contracts with health centres and other primary health care institutions (polyclinics) with almost 420 Health Centres all over the country, involving 1625 General/Family Practitioners and 6636 nurses who provide general services of health care. Health centres are autonomous juridical, public and not for profit entities with a bank account and a special statute. They function as professional contracted staff with HII in order to provide with the well- defined package of health services (See: FOCUS, 2010).

3.4 Payments to healthcare providers

Health centres services are paid based on three components:

- Fix monthly payment – payment per inhabitant (per capita), but until at the end of 2010 will be based on historical expenses. This fixed payment will be calculated as 85% of historical expenses of the Health centre.

- Monthly Payment on the activity of the centre – payment for number of medical visits for insured citizens, calculated as 10 % of the total contracted fund at regional level. This sum is divided to each health centre according to the number of medical visits of insured citizens.

- Quarterly payments. This payment will be based on performance and quality service indicators and will be calculated as 5 % of the total contracted fund at regional level. This sum is divided to each health centre according to registered number of inhabitants.

3.5 Payments to medical doctors (General practitioners/Family doctors)

General practitioners and Family Doctors (GPs/FDs, hereinafter GPs) are paid based on different components:

- GPs get a basic monthly remuneration (base salary) for providing general prophylaxis and hygiene-sanitarian duties and health preventive services.

- GPs get, in addition, 2 percent of the basic monthly initial payment for every working year served.

- GPs get additional payment according to geographical position/location (rural, hilly or mountain area) of the primary health centre they are working. This payment is higher for GPs working in mountain areas, offering more incentives for GPs working in such areas.

- GPs get additional payment per number of inhabitants covered/registered. Allowed number of inhabitants covered by a GP is falling in between 1700 – 2600. Exceptions must be agreed and allowed by HII.

- Family doctors, pediatricians and other specialist doctors who have a degree in a post-university Specialization certified by Tirana University Hospital receive an additional payment.

- If a GP is the Director of the Health centre, he/she receives an additional payment.

3.6 Payments to nurses

Nurses are also paid based on several components:

- A basic monthly remuneration which for nurses is changing according to their professional education: 1 - 2 years professional training / Professional middle school / University degree.

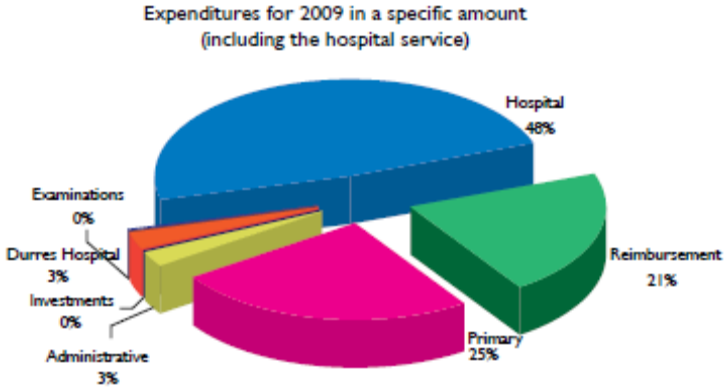
- In addition, 2 percent of the basic monthly initial payment for every working year served.

- Additional payment according to management position.

3.7 Hospitals (Secondary and tertiary care)

Since the beginning of 2009, HII has contracts with 39 hospitals in Albania: 1 tertiary Hospital (in Tirana), 3 University Hospitals (in Tirana), 11 regional hospitals and 24 District Hospitals. Hospitals are financed according to historical budget.

During 2010 there are introduced in the contract between HII and Hospital also elements related to quality and performance indicators, but monitoring these indicators it seems to be very difficult, if not impossible, because clinical protocols and medical hospital standards are not yet prepared. Hospitals in Albania are not yet accredited.



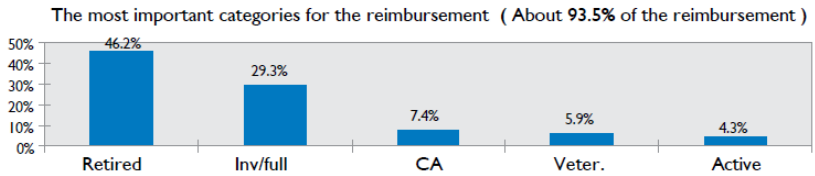
3.8 Pharmacies

HII has contracts with 590 pharmacies and 160 pharmaceutical agencies (in rural areas). Pharmacy sector is the only private sector which, until now, is contracted by HII.

Patients treated at Health centres/polyclinics, who need a pharmaceutical product receive a prescription and can get it from a private pharmacy. (Gjeci, n.d.)

A positive list of reimbursement medicaments is updated by a committee established by the order of Minister of Health and announced by HII every year. Insured persons can profit the reimbursement of medicaments price from 50% to 100% depending if they are economically active or inactive or from endangered groups of citizens.

The percentage of reimbursement is calculated using a reference price which represents the lowest retail price of a generic drug (lowest CIF price [cost, insurance and freight price] + wholesale margin + retail margin). (Gjeci, n.d.)



Focus, April 2010

4 CORRUPTION IN THE HEALTHCARE SYSTEM

There is a widespread perception that informal payments are the main type of corruption within the Albanian Health Care System. However, other types of corruption also exist. The SIDA Albania Anti Corruption Study (2008) distinguishes three different types of corruption:

> "In the Albanian health sector, there seems to be three main manifestations of corruption: i) informal payments to doctors and nurses; ii) doctors' and nurses' misuse of power and iii) corruption in the procurement of drugs and equipment."

4.1 Informal payments

Informal payments to doctors and nurses are arguably the single type of corruption that most Albanians are familiar with and have engaged in. News stories and word of mouth in Albania report numerous horror stories of poor patients being admitted to hospital but largely ignored by the medical staff because of their inability to pay informally – writes SIDA on the report of 2008. Informal payments are widespread yet go largely unreported (Sinoimeri). Information on the level and nature of informal payments can only be obtained from observation, or, more commonly, reports from household surveys and/or reports from friends, neighbors, colleagues, relatives, etc.

Informal payments have to be considered under different aspects, firstly as payments for additional health care services which are not included in the basic package covered by the government (MoH/MoF)/HII, secondly as payments to contribute covering the cost of different health care services, due to the lack of budget/funds and thirdly as payments which occur as a consequence of power misuse. The consequences of informal payments made for expressing appreciation are less serious than informal payments made to guarantee an adequate health care, or because patients are asked or forced to make such payments. These last payments are the most serious types from the point of view of corruption. There is also the social-cultural dimension to be considered, namely the Albanian *'bakshish*' behaviour. Last but not least, the economic treatment of medical staff by state budget/HII make patients feel obliged to pay 'under-the-table', as indicated by the following quotation:

> "The government should increase the doctors' salaries. After that, it will be the people's turn to say 'no' to these payments. The salary doctors get is not enough." (Vian et al. 2004)

In a general viewpoint there is a common agreement that informal payments is a problem which has to be addressed, but at the same time they are also some single motivations to accept and make continue this type of payment, as the citation in: Vian et al., 2005 illustrates through a suggestion of researchers in Poland: "In a

system where both physicians and patients have come to understand the advantages of informal payments, any change therein may require many attitudinal adjustments" (Chawla et al.,1998).

4.2 Other forms of corruption

In addition to informal payments for medical treatment, other types of corruption in the healthcare system in Albania include the following.

- There are cases of medical staff directly misusing their position in order to increase informal payments, for example where doctors suggesting overly complex operations or other unnecessary treatment in order to attract higher payments from patients.

- There are good opportunities for corruption in the process of procurement of drugs and equipments in Albania. This includes bribing of the evaluation committee/tender board in case of pharmaceutical contracts or by undue influence on the drafting of the call for proposals in a certain bidder's favor. Another corrupt practice is the use of bribes to politicians or public officials to get a drug approved or, in particular, get in on the national list of essential drugs, which are eligible for substantial subsidies, thereby boosting sales. (SIDA, 2008)

- It is a frequent practice for doctors to intentionally avoid using facilities and equipment available within the public provider (e.g. hospital) for patient examinations, instead referring patients to private providers of the same services, with which the doctor has links (or is even the same person).

- Patients in hospitals are often obliged to buy medicines which are supposed to be free. In addition, doctors overprescribe and suggest to patients the pharmacy where they can buy the prescribed medicament/s, in return receiving payments from the pharmacy. Some interlocutors allege that doctors and nurses in hospitals embezzle medicines and divert them to pharmacies that then sell them the the patients that should receive them for free. Private purchases of medicines is encouraged by the fact that the quality of medications reimbursed by HII is not high. The percentage of reimbursement by HII is calculated using a reference price which represents the price of the cheapest available generic drug. Doctors themselves often complain about the results of the therapy with such medicaments. For their part patients decide (or are effctively forced) to buy higher quality medicines, which are only partly covered or not covered by HII, thereby increasing out-of-pocket payments.

- Patients also often have to pay for non-medical services such as linen and bedding, cleaning and food.

5 CURRENT REFORMS

Corruption in the health sector is not an isolated phenomenon, but occurs in other public structures causing a general service failure. Addressing irregularities such as informal payments, improving procurement and distribution of drugs and supplies, increasing staff salaries/wages and so on requires an integrated anti-corruption strategy and strong political backing.

Any health reform to be undertaken has to take into consideration the existing informal payments, as gifts or as unofficial payments, made by own willingness or not. Recently the rules for formal payments from the uninsured persons are being enforced, this is supposed to decrease the informal payments, but at the same time this carries the risk of excluding the poorest from health care service. Reforms should provide protection to the most vulnerable social groups, as poor, elderly, Roma and Egyptian minority, etc.

Some of the current reforms undertaken or envisaged by the government are: the patient referral system; introduction of official fees; calculation of service costs; and digitalization and 'informatization' of the health care system.

5.1 The patient referral system

The patient referral system had been introduced as a tool for regulating patient's access to healthcare services and as a way of controlling patient's consumption levels.

> "Regulating access through institutional arrangements is commonly known as gatekeeping or family doctors systems. These arrangements are expected to have positive effects both on efficiency and quality of care due to the informational superiority of the physician compared to the patient. (…) It is assumed that by preventing unnecessary procedures utilization of services and, consequently, costs can be reduced. (…) Additionally, gatekeeping GPs coordinate treatments for different illnesses and thus help to prevent unintended interaction affects of different treatments." (Riebling, Wendt 2008)

Practically, access to specialists is regulated through a very restrictive option: since 2002 patients have been required to have with them a referral from their GP/FD in order to access secondary care services. Same referral is needed from the specialist doctor of regional hospital to access tertiary care services. People can also skip the referral system by accepting the payment of official fees (OOP) introduced by "patient referral system" – in other words patients may go directly to a specialist without a referral from their GP/FD if they pay official fees.

The newly introduced patient referring system, is a positive step against corruption, but still in some chains of the system there are many bureaucratic procedures, which

are focused on controlling instruments and not in the aim of 'the patient in the center of the system'.

For the so-called expensive examinations, according to the reimbursement from HII, in the hospitals patients have to pay only 10% of their price, but the complicated and bureaucratic procedures established by HII, very long waiting lists and the fact that the necessary equipments are often out of use, make this service often inaccessible for patients and they find the solution by making use of the private providers service. HII should reimburse also the examination made by private providers, which at least are licensed by the MoH. This can be done after an accreditation process.

5.2 Introduction of official fees

The introduction of the official users' fees is intended to eliminate informal payments and to generate incomes. In a pilot project the Durrës Regional Hospital introduced user fees in order to decrease informal payments and has succeeded in increasing medical doctors wages five-fold while increasing utilization. After this project it was introduced in all other hospitals in Albania. While good examples in generating incomes through the introduction of users fees exist, the effect of such fees in reducing or eliminating informal payments is still unclear, especially when the informal payments are made to reduce waiting times, receive qualitative drugs at hospital, or to ensure better attention and improved quality of services. In addition, any reform to introduce official fees should particularly demonstrate how it is intended to maintain access for the poor and vulnerable and to ensure equity in health care.

5.3 Calculation/definition of service costs

The calculation of the service/diagnosis costs as part of hospital reform will improve the financing and the management mechanisms of hospitals and clarify the financing/reimbursement of healthcare costs by the HII. This will also contribute to reducing informal payments. Unfortunately, it seems the process is being delayed by the lack of standards and medical treatment protocols, and should be pushed forward without delay as a key condition for other reform measures to have an impact.

5.4 Information systems

Digitalization and the introduction of a modern information system in the healthcare system is expected to increase efficiency and improve healthcare quality in general, inter alia by increasing the transparency of the health system and reducing corruption. This has begun with the creation of a database of medical prescriptions registered by pharmacies so that the HII can exercise oversight, and should continue with the creation of a database of patient files.

6 OTHER SUGGESTED MEASURES: A MORE CONSOLIDATED APPROACH

Corruption in the health system, in one way or another, is a concern in all countries, but this is an important problem particularly in developing countries like Albania, where the economy is in transition and the public financings for health are limited. The way how corruption comes out and which segment of the health care system affect, depends in part on the health financing system. Most of corruption occurring in the health system is a reflection of general problems of governance and public sector accountability. More specifically, corruption in the healthcare system is rooted in a number of key factors that are not sufficiently addressed by current reforms. For example, while the introduction of the compulsory health insurance system is undoubtedly a positive step, it will not yield its potential benefits without reforms of other aspects of healthcare financing.

In addition to the measures described in Section 5, the expert wishes to stress the following reforms as desirable.

6.1 Level of financing

In general, an increase in the personal contribution for health insurance and the level of official payments by the uninsured should improve the finances of the healthcare system and reduce informal payments. Among other things, an increase in the salaries of doctors and other medical staff is necessary if they are to be expected to resist temptations to engage in corruption, or at least taking informal payments. Reforms should be designed in order to generate the collaboration of medical staff in implementing reforms – not least so that interventions to punish corrupt behaviour will carry more legitimacy.

6.2 Rules for budget allocation

Hospitals are still financed on the basis of historical budgeting, a payment system based only on provider characteristics and in particular capacity norms such as the number of beds. From year to year the historical budget given to a hospital is adjusted by an inflation factor and sometimes by reallocation across spending categories. Modern payment mechanisms for hospitals based on characteristics of provided services, number and type of patients, and performance indicators adopted in other European countries have not yet been applied in Albania except on an experimental pilot basis.. This fact combined with the lack of incentives provided to medical staff by the salary system leads to indifference of staff to efforts improve performance and to many of the practices described in this paper such as abuse of the referral system, with predictable results such as unequal access to healthcare, lack of drugs - undermining the credibility and effectiveness of public healthcare services in general.

6.3 The role of private provision

Increasing the role of non-state healthcare providers in the provision of public healthcare can be an important tool for reducing corruption under certain conditions. The financing system of HII for health care services does not include the private providers, except the pharmacies. If different medical laboratories, private medical centres, hospitals, etc would also be contracted by HII to provide healthcare services within the publicly-provided sytem, this could help create competition between healthcare providers, allowing patients to choose among competing providers. In particular, the referral of patients to private providers could become the result of an informed choice of the best provider, under at least certain of the following conditions:

- Patients can choose to which private provider they are referrred.
- There are sufficient restrictions on doctors operating in both public and private providers.
- The definition of costs of given units of medical care is completed (see previous section)
- There is a clear system of benchmarks by which to judge the quality of provision by different providers.
- The HII exercises real oversight vis-a-vis the providers it reimburses for medical services provided
- The system of financing healthcare institutions is changed in the manner indicated paragraphs below

6.4 Transparency and awareness raising

The transparency of the healthcare system and its financing should be increased. In order to encourage resistance of patients to informal payments, awareness campaigns should make clear to patients the services to which they are entitled for free and/or which tariffs for paricular services. Detailed information on budget flows from the government to the HII should be made public. Healthcare institutions should be more active on raising the awareness campaigns on patient's rights and transparency within their institutions. A good practice on transparency within health care institutions was the pilot project of the Regional Hospital of Shkodra supported by OSCE; providing leaflets and posters with informations on the patients' rights and services offered by hospital. Unfortunately this was not continued. Another measure recently introduceD was the publication of the medicaments list available in hospitals, but these lists have to be up-dated to prevent misunderstandings between patients and doctors.

6.5 Complaints mechanisms

Complaint mechanisms should be established in order to provide possibilities to report abuses and malpractice by medical staff. Such mechanisms should offer clear procedures by which patients can make such reports, with adequate protection of their identity as appropriate.

6.6 Enforcement

Last but not least, reforms and policies themselves are important and necessary, but not sufficient; enforcement is as well important. While there have been a number of recent cases of doctors and nurses arrested and accused of/prosecuted for corruption, these efforts were not followed through properly. If the measures and policies outlined in this paper are pursued, the importance of enforcement to punish instances of corruption will increase as the factors that effectively justify corrupt behaviour of medical staff disappear.

7 POSSIBLE SOURCES FOR RESEARCH

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7.2 List of relevant persons for interview

Ministry of Health:

Vice Minister – Mr. Bardh Spahija

Director, Financial Planning Department & Implementation of World Bank Project – Mr. Saimir Kadiu

Health Insurance Institute:

General Director – Mrs. Elvana Hana

Prime Minister Cabinet:

Counselor for Health issues and Social affairs – Mrs. Mirela Tabaku

Parliament:

Commissioner for Labor, Social affairs and Health - Mr. Tritan Shehu

Other:

Former Vice Minister of Health – Mrs. Zamira Sinoimeri

Director, Regional Directorate of Public Health, Shkodër – Mrs. Irena Shala (Shestani)

Former Director of Shkodra Regional Hospital – Mrs. Alma Kurti

8 CONCLUSION

Further reforms in the financing of health system generally and specifically in hospital care, as well as further privatization of health services could reduce corruption. At the same time this will encourage concurrence, improve quality and performance of the services. Addressing different corruption concerns requires a strong political commitment.

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