Welfare in the Mediterranean Countries

ALBANIA
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The views expressed do not imply the expression of any opinion whatsoever on the part of the United Nations and of Italian Department for Public Administration, Formez and the Campania Region Administration.
“Welfare” in Albania

The core theme of this paper is not the welfare system in itself, the way it is now, but its evolution and how it will probably be in the near future, what its weaknesses are and how to intervene. Since the collapse of the communist era Albania is on a transition path moving from a centrally planned economy to a market oriented one. The transition model implies the gradual introduction of market mechanisms and “New Public Management” principles. Looking at the reforms pattern of the last decade we may find, as the main feature, an effort to decentralize functions and powers in order to obtain more efficiency and to be more effective.

The “welfare” is also changing this way and after ten years of reforms and decentralization efforts we may focus on the assessment of their results and impact.

Before deepening the issues related to the welfare system, meaning by this both social policies (pensions, benefits, labour policies, etc.) and health care policies, a brief picture of the state of things now is needed, just to have an idea of the context within which we will move from now on.

Albania has a population of 3,141,000 with a GDP per-capita of 587,161 leks (around 4,092 US dollars, in 2001). More than 9.5% of the population was older than 60 in 2002 and the dependency ratio was that year around 53%. The fertility rate was 2.3 in 2002 and life expectancy at birth 67.3 years for men and 74.1 for women. According to a World Bank study one-quarter of the Albanian population is poor, meaning that it falls below the “poverty line” of 4,891 Leks (around 35 euro) per capita per month. The latter was calculated as

1 WHO sources
2 WB, “Albania Poverty Assessment”, 2003
the 60% of the median income. The same study shows that “extreme poverty” (persons living with less than 3,047 Leks; around 22 euro) amount to less than 5 percent of the population, who are unable to meet even the basic food requirements. A large number of individuals are clustered around the poverty lines, however. Increasing the poverty line by 10% increases the percentage of poor individuals by 25 to 50%, depending on the poverty line used. This is true for negative shifts in the poverty line as well.

Poverty in Albania has marked spatial and regional dimensions, with rural areas and the Mountain region being consistently poorer than rest of the country (See Table 1).

### Table 1. Poverty in Albania (2002)

<table>
<thead>
<tr>
<th></th>
<th>Poor</th>
<th>Extreme poor</th>
<th>Poor</th>
<th>Extreme poor</th>
<th>Poor</th>
<th>Extreme poor</th>
<th>Poor</th>
<th>Extreme poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headcount (%)</td>
<td>17.8</td>
<td>7.12</td>
<td>20.1</td>
<td>4.8</td>
<td>29.6</td>
<td>5.2</td>
<td>25.4</td>
<td>4.7</td>
</tr>
<tr>
<td>Mean per-capita consumption (leks)</td>
<td>9.043</td>
<td>8.468</td>
<td>7.212</td>
<td>7.801</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: World Bank

Households in the most remote districts in the Mountain region in the north and northeast of the country do not fare well in terms of poverty, and almost half of residents of this area are poor, and more than a fifth live in extreme poverty.

### Table 2. Unemployment

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total registered unemployment</td>
<td>180,513</td>
<td>172,385</td>
</tr>
<tr>
<td>Unemployment rate</td>
<td>16.4</td>
<td>15.8</td>
</tr>
<tr>
<td>Unemployed with primary education (%)</td>
<td>49.475</td>
<td>50.64</td>
</tr>
<tr>
<td>Unemployed with secondary education (%)</td>
<td>48.25</td>
<td>47.73</td>
</tr>
<tr>
<td>Unemployed with university education (%)</td>
<td>2.275</td>
<td>1.63</td>
</tr>
</tbody>
</table>

Source: INSTAT

Low levels of educational attainment and unemployment are perhaps the main demographic factors driving poverty. Primary school enrolment rates are lower among the poor, and lowest among the extreme poor. The

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3 WB, “Albania Poverty Assessment”, 2003
unemployment rate among the poor is about twice as high as that of the non-poor. This is not surprising if we consider that there is a strong correlation between unemployment and the education level (see Table 2).

Inequality, as estimated according to the level of consumption, is not very evident and is in line with other countries of the region (the Gini co-efficient was 0.28 in 2003). Yet, if considering the non-income dimension of poverty, inequality is much more obvious. Modernization of the country has benefited existing urban areas, particularly Tirana, at a much faster pace than the rural areas. The coverage of basic infrastructure services is nearly universal in existing urban areas, but much less so in rural and recent peri-urban areas, though existing urban areas face serious quality and reliability issues.

There are large income and regional inequalities in health status and in access to health care services. There are large differences between rural and urban areas as regards access to water and sanitation, and while all urban dwellers have access to a sanitation facility inside their house, only half of households living in rural areas have access to sanitation facilities. There are also large income differences in the percentage of people visiting an outpatient care provider, and while the poor and people living outside the Tirana region are more likely to report an illness than the non-poor, they are less likely to seek care when ill. There are large regional differences in inpatient care utilization as well.

Mountain areas are the least likely to receive pre-natal care, and receive the least number of clinical consultations. In contrast, women in Tirana receive two times as many pre-natal consultations than women in other parts of the country.

I could continue with other examples like that but I won’t stress this point further.

1 Social Security System

1.1 Mission, actors, instruments and financing

Social Security finds a juridical legitimacy in the Albanian Constitution where it defines some social rights. For example, art.52 states that “everyone has the right to social security in old age or when he is unable to work” and “everyone, who remains without work for reasons independent of his volition, and has no other mean of support, has the right to assistance”. Moreover, art.54 deserve special protection to the weakest social groups (young, new mothers, etc.), and the chapter V is entirely dedicated to social objectives (employment under suitable conditions, fulfilment of citizens’ housing needs, etc.).
The aim of social policies is, as stated in the National Strategy for Socio-
Economic Development (NSSED), to assist those most vulnerable segments of
the population, guaranteeing a minimal level of income and access to basic
facilities and services for the poor\(^5\).

The Ministry responsible for social policies is the Ministry of Labour and Social
Affairs, which operates at the regional level through the General
Administration on Social Services offices. Growing powers are being assigned
to local administrations.

The instruments built-up by the Administration to reach the above mentioned
objective consist of three major groups of public programmes, plus private
transfers between and within families. The public programmes consist of a
comprehensive social insurance system, social safety net programmes, and
labour market policies\(^6\).

The Social Insurance System provides for comprehensive protection against
income loss due to old age, disability, loss of a primary earner, death,
unemployment, general sickness, occupational injury and work related
illnesses, childbirth and maternity. It is regulated by a new “Law on Social
Insurance”, enacted in 1993, which created a mandatory, publicly managed,
contributory system with universal coverage.

Labour market policies include a National Employment Service (NES)
responsible, among other things, for a national network of labour market
offices (currently limited to urban areas); a National Labour Inspectorate,
which seeks primarily to enforce work safety standards and to require
employers of informal labour to contribute to the Social Insurance Fund; and
professional training. These programmes were developed in part through the
Albanian Labour Market Development Project, which received World Bank
support. A new NES strategy was approved last year through a tripartite
agreement among the Government, employer and employee representatives.
The strategy aims to reform the NES at all levels and it proposes the creation of
an Employment Fund within the framework of the Social Insurance Institute.

The Social Safety Net consists of three cash social assistance programs - a
targeted poverty benefit in cash (called Ndihme Ekonomike or economic aid,
which provides a means-tested cash benefit for eligible families with little or
no earned income); a regular monthly allowance to those disabled since
childhood; and price compensation paid to pensioners and their families - and
a program of social care services for orphaned, disabled, and elderly people. A
few words should be added on the Ndihme Ekonomike, which is the main
cash social assistance programme: it is structured around conditional grants
from the national government that local governments have to administer using

\(^5\) Albanian Council of Ministers, “Progress Report for implementation 2002, objectives and long
term vision of the NSSED, priority action plan 2003”, 2003.

\(^6\) See note 3
nationally specified eligibility and benefit rules. Local governments receive and process applications. The final decision on whether to grant assistance is then made by municipal and communal councils, which also set the benefit amount.

Between January and September 2003 the Albanian Government spent 42,266 million leks in social insurance outlay. In 2002 public transfers represented 21.3% of household income. Private transfers represented a further 14.4%. Together, therefore, they provided more than one lek out of every three making them a more important source for household income, on average, than either earnings from employment (31.5%) or agriculture (25%). The major contributions came from urban, rural, and other pensions and Ndihme Ekonomike (in that order). The other public transfer programmes made modest additional contributions. Among all Albanian households, the overall poverty rate of 25.4% in 2002 would have been 11.8 percentage points higher if there had been no public transfer programme. The public safety net reduced the number of poor households by almost one-third.

Social security programmes could also benefit from various multilateral financial assistance, such as that of the European Commission, through the Country Strategy Paper. It supports activities for the local community development in Albania, including one aimed at increasing the level of local basic infrastructure, to improve living conditions of the rural population and therefore preventing people leaving for Tirana or other major cities. Then, there is an interesting project financed by the WB: the “poverty reduction support credit III”, aimed at supporting the objectives of the national poverty reduction strategy. This project, still in the preparation stage, will support activities aimed at improving service delivery and social safety-net effectiveness and will strengthen the policy formulation process.

Finally, several bilateral assistance agreements are in place. The most active countries in this field are Great Britain, the Netherlands and Greece. The latter reached an agreement with Albania on a “five-year development cooperation programme (2002-2006)” by which the Hellenic Republic committed itself to contributing to the economic development and European orientation of Albania. Within this cooperation plan the two governments agreed on some goals of the aid, such as supporting the welfare state and addressing economic inequalities.

8 WB, “Albania Poverty Assessment”, 2003
9 See note 8
1.2 The reform pattern

In a broad sense, the current safety net has replaced an inherited social protection strategy in which people were assured of guaranteed employment at low wages on collective farms and in government enterprises, while a system of administered pricing within a closed economy kept consumer prices low.

Since the beginning of the last decade the Albanian Government undertook several measures to reform the social security system, even though the “Country Strategy Paper”, which provides a strategic framework for the EU assistance in the period 2000-2006, underlines the need to improve existing social assistance schemes for a better orientation of benefits towards the most vulnerable groups, decentralising and promoting community based schemes, and reorganising residential care services.

The Social Insurance scheme was the object of significant interventions in 2002, such as the lowering of contributions, the raising of the pension age, the reduction of social insurance evasion, institutional strengthening, the adoption of incentives for spreading the insurance system, etc. Further reforms should aim to strengthen financial stability, narrowing the difference between expenditures and income by 3-4% every year. This goal could be accomplished through the enlargement of the contributor base and requires the institutional empowerment of the structures and the reduction of the informal sector.

Another medium-term objective should be the reduction of the disparities between urban and rural pensions, being aware that the majority of poor people live in rural areas and pensions schemes could be an important means of income redistribution\(^\text{10}\).

Moreover, since 1995, the administration of the assistance programs was decentralized at the local community level, with the central and regional General Administration on Social Services offices performing general monitoring and supervision function. A World Bank study\(^\text{11}\), carried out in 1998, tried to address the question on whether the Ndihme Ekonomika Programme was well targeted and the effect was on households' welfare since the decentralization of the NE programme in 1995. Concerning the first point, it concluded that social assistance in Albania is well-targeted to the poor in comparison with other developing countries. It observed that half of social assistance is going to the poorest quintile, and 76% of it is going to the poor, demonstrating that it is more targeted to the poor than virtually any significant program of price subsidies or food-related transfers elsewhere in the developing world. However, there still are poor that do not benefit from the assistance.

\(^{10}\) WB, “Albania Poverty Assessment”, 2003

Concerning the second question, the ultimate conclusion of this paper is that there have been small gains from the decentralization. It is important to understand that even if decentralizing responsibility presents a great advantage, due mainly to the fact that local governments are usually better able to assess the needs and preferences of the local community, nevertheless there are some potential disadvantages. For example, there is the potential for powerful local elites to monopolize the benefits of the program. Moreover, decentralization can make it more difficult for the central government to monitor the implementation of the program.

These observations convince me that a better targeting of the programs (in general, of all the assistance programs) is needed, including a reform of the way in which the central government allocates funds among local authorities, taking into consideration the “poverty map” in Albania and therefore the poverty distribution (among regions, among social classes, etc.). This could be done with further decentralization of authority to local communities (and the Albanian Government intends to move this way starting with pilot projects in some municipalities and communes). However, this makes no sense without a more comprehensive reform process that involves the establishment of a system of incentives to encourage local governments to use their limited funds in a more cost-effective way. An interesting project of the Cremona provincial administration in Italy could be taken as a good example to be implemented in Albanian districts. I am referring to the establishment of an Observatory for Social Policies, the aim of which is to support the Provincial Administrations by providing complete information and correcting the inconsistencies in the supply of services so as to better use the available resources. The observatory represents a basic resource for the territorial programming of social services. Its complete implementation will allow the districts to have specific information about the needs and services with the aim of realizing joint analyses of the social demand and interventions offer.

Moreover, according to various studies, a social assistance program that is perfectly target-efficient (benefiting those under the poverty line) would also imply the elimination of incentives to work. Thus, it seems to me important to consider a more complex reform, such as that carried out in Bulgaria\(^\text{12}\), which imposed work requirements on some recipients as a condition for receiving the benefit. In addition, to avoid the “poverty traps” around the poverty line (it refers to the situation in which there is no incentive to increase one’s income above the poverty threshold), benefits should vary more slowly than incomes so that increases in income lead to benefit reductions smaller than the income changes that caused them.

\(^{12}\) For more information, see A. Kuddo (2003). “Public Works in Europe and Central Asia”. Spectrum 2003
Finally, it is important to analyse the non-monetary dimension of poverty and to use proxy indicators to supplement measured income in the definition of beneficiaries. This is even more relevant in countries such as Albania, with limited administrative capacities and a big informal sector, where it is difficult to measure or estimate family income. To this extent, a poverty benefit model such as that used in Armenia could be a good example. An Armenian scheme constructs a ‘family need score’ by multiplying together factors representing (i) family information on each member’s social risk category and ability to work, (ii) the household’s place of residence and (iii) the household’s income. A family is eligible if the family need score exceeds a threshold level.

The action plan set up in the Albanian National Strategy for Socio-Economic Development (NSSED) for the year 2003-2004 seems to go in the right direction when it targets as immediate goals: the improvement of the method for the allocation of the Economic Assistance funds based on higher social and economic indicators; the preparation and periodical updating of a poverty map; the inclusion of poor into employment promotion programs; the institutionalization of “Community Care Planning Committees” for planning community services at regional level; the elaboration of social service standards; etc. 13

In the medium-term, the programme of economic help for poverty will continue through financial support for poor families. Meanwhile, the number of families is foreseen to decrease in 2006 by 12% from the actual number and the average degree of support will reach double the actual level. According to the NSSED, the increase of social support for the poor and social categories in danger should mainly come through the increase of the efficiency and efficacy of social assistance programs. Institutional empowerment, improvement of the data base, accomplishment of the verifications, cooperation with the local government and further decentralization will serve to the 100% coverage of all the poor families14.

Other areas of reform that came out of the previous analysis as priorities in for reducing poverty are employment, education, and infrastructure development (specially in rural areas), but I won’t stress these points too much here.

2 Health care system

Among social policies, one that deserves particular attention in Albania is health care. This is essentially due to a couple of reasons. The first one is an

14 Albanian Department of Information web-site
historical reason: During the Communist era the health sector was not considered a priority, because it is a non-productive sector, and thus few investments were made on it. The infrastructures were outdated, the quality of service was poor and hospitals were kept overstaffed by keeping salaries low. In addition, the system was strongly centralized, there was no management training, no procedural guidelines, no performance indicators or incentives. To this picture we should add the problems caused by the civil war after the collapse of the communist regime: almost a quarter of the city health centres and two thirds of the village health posts were destroyed during the period 1991-1992. It's obvious, then, that the restructuring of the health care system is still now, a decade later, a primary need. The second reason refers to a problem of democracy. The right to health care is a fundamental principle in each democratic State and Albanian Constitution guarantee it with Article 55 when it says that “everyone has the right to health insurance”.

Before entering the core of the reform process, it would be useful to look at the statistics in Table 3 and the organizational structure in the next paragraph.

### Table 3: Some Health indicators, 2001

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>per-capita GDP in dollars</td>
<td>4,092</td>
</tr>
<tr>
<td>Total expenditure on health as % of GDP</td>
<td>3,7</td>
</tr>
<tr>
<td>Public Health expenditure as % of total health expenditure</td>
<td>64,6</td>
</tr>
<tr>
<td>Public Health expenditure as % of total public expenditure</td>
<td>7,3</td>
</tr>
<tr>
<td>Private Health expenditure as % of total health expenditure</td>
<td>35,4</td>
</tr>
<tr>
<td>Out-of-pocket payments as % of total private expenditure on health</td>
<td>65,3</td>
</tr>
</tbody>
</table>

Source: WHO

The NSSED\(^{15}\), setting out some medium-term objectives (for the period 2003-2006) of the health system reform states an increase in public expenditure for the health care sector from 2.7% of GDP in 2002 to 3.2% of GDP in 2006.

#### 2.1 Organizational structure\(^{16}\)

The basic structure of the Health Care System in Albania has continued almost unchanged in the last decade. The system remains highly centralized, both in the management and in the funding functions. The Ministry of Health remains the major funder and provider of health care services. Many health care institutions are under the direct administrative control of the Ministry, with


\(^{16}\) Nuri B. “Health care systems in transition: Albania”. The European Observatory on Health Care System, 2002
the partial exception of primary care. Through its directorate of human resources and district health teams, the MoH is also responsible for controlling human resource development and some training. The MoF allocates money to the other ministries, including the Ministry of Health, and provides local governments with earmarked funds. It also transfers to the Health Insurance Institute (HII) the basic service and essential drug subsidies available to some of the more unprotected and vulnerable segments of the society, including retired people, children and students.

However, the last decade has seen important changes. Two public administration reforms have affected health services. First, after the 12 regional prefectures were created in 1993, some administrative authority has shifted from them to the centre. Each prefecture comprises an average of three districts and each district is responsible for administering district hospitals and polyclinics, specialist hospitals and Primary Health Care (PHC) centres. Second, the 1993 law On Local Government, aimed at strengthening the role of local authorities that now own their PHC facilities and are thus partly responsible for PHC. The MoF gives them grants earmarked for equipping, maintaining, operating and upgrading PHC centers and posts, as well as for paying some staff salaries.

Moreover, following a government decree of July 2000, a new model was introduced in the Tirana Prefecture (which includes two districts) with the assistance of the United Kingdom Department for International Development and the World Bank. Primary care services and public health programmes have been integrated under the Tirana Regional Health Authority (TRHA), a single organization that is responsible for their planning and management. A regional health board has been set up and is responsible for endorsing proposed regional policies, plans and budgets. It is hoped this model will pave the way for the Ministry of Health to delegate more authority and power to regional bodies.

Furthermore, two important bodies were recently established: In 1995 the Health Insurance Institute (HII), which represented an important step in moving from a “State budget” financing model toward a “Bismark model”, and in 2000 a new “Policy and Planning Department” with a twofold objective: To develop the Ministry capacity for making and planning health policies and to strengthen its capacity for coordination among different donor interventions in accordance with the short and medium term strategies.

Finally, most of the privatization has been carried out with dental practices and pharmacies, whilst hospitals, polyclinics, health centres and health posts remain publicly owned. Special attention should be paid to law no. 7718 (1993) that abolished the concept of universal free health care and paved the way for the introduction of private medical practice. Since then the private health sector has been continually expanding. Though the decentralization initiatives noted here are now being implemented, no decision has been made about the
extent or form of future decentralization. The Ministry of Health apparently intends to test different models before proceeding with a larger decentralization programme at national level. The pilot initiative in Tirana has demonstrated the challenges and difficulties of the decentralization process. On the one hand, the Tirana Regional Health Authority prefers to keep all health resources of the Tirana region under its direct management and control. The preferred model here is that of delegation of authority and responsibilities from a central body to a regional one. The alternative model is that offered by the Health Insurance Institute, as a direct purchaser of primary and secondary outpatient services from the public and private providers, in the region of Tirana. It is not clear which model will prevail.

2.2 Health care financing

Albanian health services are funded through a mix of taxation and statutory insurance. The bulk of funding still comes from the state budget, but the tax base is problematic due to low incomes, unemployment, a large informal economy and tax collection problems. As a consequence, financing levels remain very low. The Ministry of Finance allocates money to the Ministry of Health, to the Health Insurance Fund, mainly to cover unwaged groups, and to local governments, for paying staff costs (excluding general practitioners, who are paid by the HII), operational costs of health centres and health posts, and maintenance costs.

A major transformation in Albanian health system is represented by the introduction of an health insurance scheme offered by the Health Insurance Institute (HII). Yet, it is still a very limited scheme, not only in terms of the population covered, but also in terms of the number of services it covers. According to the Law in Health Insurance (Law No. 7870, 1994), all economically active individuals in Albania, whether they are employees, employers, self-employed, or unpaid family workers are obliged to contribute to the scheme and obtain a 'license'.

HII enrolment varies among different population groups. Most of the unwaged are automatically covered by the state budget. Of the active workforce (70% of the population), about 40% was covered in 1999. Contribution rates are set according to income rather than health risks. They amount to 3.5% of wages, split equally between employers and employees. The self-employed contribute between 3% and 7% of their incomes depending on whether they live in rural or urban areas. Lower rates are set for private farmers. The State is responsible for the insurance contributions of the economically inactive, and pays the insurance contributions of children, full

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17 See note 14
18 These data are dated 2002.
time students, retirees, the disabled, the unemployed, pregnant women, and citizens under compulsory military service. Eligibility for health care is now based on both citizenship and payment of insurance contributions. Access to free primary care and pharmaceuticals is restricted, in theory, to patients who have paid their insurance contributions. However, the state is considered responsible for low-income groups, and in practice, therefore, people are not refused medical services.

State budget and health insurance are not the only sources of financing, though they are the main ones. Two additional sources are consumer “out-of-pocket” payments (most dental care services, drug costs, etc.) and external aid, coming from foreign governments and NGOs. Unfortunately, another important source is represented by illegal, under-the-table, payments to doctors. More than three-quarters of the population have admitted paying illegal fees to doctors and the situation is made worse by the fact that people in rural areas and those who are less educated and poor cannot afford these payments\(^9\). Private health insurance has also been legal since 1992, but private firms have not yet entered the health insurance market with the exception of the Insurance Institute (INSIG) which provides health insurance for limited periods to Albanians travelling abroad.

### 2.3 Health care reform

Since the collapse of the communist regime the health care sector reform is on its way, moving toward the introduction of some market mechanism in the financing system and toward a decentralized and efficient model. The Ministry of Health, in close collaboration with the WHO, published a paper in 1999 on the “Albanian health system reform: a position paper on policy and strategies for Albanian health system reform”, based on the lessons learned in implementing previous policies. The paper identified three essential areas of reform and challenges: Reforming regulation. The main aims are to transform the MoH from an organization that manages and operates facilities into a policy-making and planning organisation, as well as a national regulatory body; Reforming health financing and resource allocation. It is intended to increase and protect the health budget, allocate resources more transparently and efficiently, and fight corruption; to advance a “Bismarck” model, combining solidarity and responsibility in health financing, where the state budget must coexist with health insurance and out-of-pocket payments; Reforming health services production. It refers to the improvement of services quality\(^20\).

\(^9\) Albanian Ministry of Health. “Towards a healthy country with healthy people: public health and health promotion strategy”

\(^20\) Nuri B. “Health care systems in transition: Albania”. The European Observatory on Health Care System, 2002
The document formed a sound basis for further discussion on reforms, but it was not a plan of action. A more comprehensive strategy (a 10-year strategy) was later formulated by Ministry of Health and WHO technical experts, but the government has not yet approved it.

We can say that the reform is moving along two axes: the first is that of the decentralization of powers and the second is that of modernizing the financing model. Then, there is a horizontal objective to reach, and it refers to the enhancement of health care quality. Thus, efficiency gains should be intended as achieved without any loss in the quality of health services. There is a lot to do in this field, considering that health care regulation so far doesn't involve standards, quality accreditation, etc.

Concerning the first axis, the health system in Albania is on the path of decentralization, delegation of authorities and privatization, according to the principles of the New Public Management theory, as almost all the other transition countries. The main objective of the government is to transform the MoH from an organization that manages and operates facilities into a policy-making and planning organisation, as well as a national regulatory body. An important step was the creation of the “Policy and Planning Department” in 2000, but it still lacks experience, capacities and trained professionals. So far, decentralization is limited to only managerial functions or to primary care in some pilot projects (as in the Tirana Regional Health Authority). The presence of private firms in the health sector is limited to drug distribution, dentistry services and outpatient specialized care. Even if decentralization is a government priority, this process is facing a lot of difficulties, obstacles, lack of managerial capacities, etc.

Furthermore, decentralization is a controversial subject in economic theory. Though in principle it has been argued that decentralization improves governance and public service delivery by increasing allocational efficiency through better matching of public services to local preferences and technical efficiency through fewer levels of bureaucracy and better knowledge of local costs, it nevertheless often fragments the functions of collecting money and pooling funds, duplicating administrative costs and exacerbating geographical inequity. Analysts are split sharply over the best way to restructure health care systems. Some contend that policy should focus on decentralization, democratization and improved management (Segall M, 2000)\(^\text{21}\). Other researchers believe that containment of expenditures requires centralized planning and administration of health services and greater centralization within the health sector (Bjorkman J, 1985)\(^\text{22}\). Recent experience with the health

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\(^{21}\) Segall M. “From cooperation to competition in national health systems - and back? Impact on professional ethics and quality of care”. 2000

\(^{22}\) Bjorkman JW. “Who governs the health sector? Comparative European and American experiences with representation, participation, and decentralization”. Comparative politics, 1985
sector suggests that decentralization and re-centralization are not necessarily opposite processes but can develop in a parallel manner, with certain functions being regulated at the central level while other functions or units remain decentralized. For example, Czech Republic and Slovakia have recently proposed a re-centralization of their multiple health insurers into a single national health insurance company. Another example can be found in Hungary, where the 19 county regional health insurance branches have been merged into the single national fund with the most administrative functions centralized.

With regard to the second axis, the current Albanian funding system is a mix of four sources: general taxation, health insurance contribution, private insurance and out-of-pocket payments, but with a much greater importance of the state budget and an insignificant role of the private insurance. The model is moving toward a “Bismarck Model”, predominantly financed by payroll taxes. As a matter of fact the role of the Health Insurance Institute is becoming more central day-after-day. Payroll taxes may present great advantages and a lot of transition countries are moving into this direction. First, they represent a non-arbitrary revenue source for the health sector which is not subject to the political bargaining process at the time of tabling the annual government budget. Secondly, it is a common understanding that people more readily accept a raise in payroll taxes, where they know what they are going to finance, than a raise in general taxes. Finally, but probably most importantly, payroll taxes should guarantee more transparency.

Unfortunately, before proceeding with further steps in this direction some problems, also connected with a system based on social insurance, should be taken into account and some corrections are, to my opinion, needed. Health insurance revenues are subject to some socio-economic factors outside the control of the policy-makers. Rising unemployment, wage levels, ageing of the population, growth of the informal sector and increased liberalization of employment arrangements in the formal sector all contribute to a shrinking revenue base. To make this system work efficiently and effectively, coordination with labour policies or broader economic reforms and the fight against the informal sector is fundamental. Then, in order to reduce the burden on the State budget, Albania should pass from a model in which the state pays for unwaged groups (as it is now) to a model in which contributions by the active population should cover all the expenses, but this is not possible until the unemployment rate and the percentage of workers in the informal economy diminishes.

Finally, a different balance among financial revenues and thus different collecting, pooling and allocating systems have a different impact on efficiency, equity and financial sustainability. For example, we can consider the impact on equity: Health insurance revenues are usually more regressive than general taxation. In Albania the contribution rate is a fixed percentage of the income and thus proportional and not progressive. A solution could be the introduction of different layers of contribution.