

## Albania: Health Care System in the Course of Health Reform. An Overview of Health Insurance System

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**Abstract** This paper introduces and analyses in general the Health Care System (HCS) focusing particularly on the Health Insurance System (HIS) in Albania, as a country in a period of transition. The Government of Albania is in the process of reforming and modernizing its healthcare sector and is moving towards the establishment of a more sustainable health financing insurance system. The aim is to obtain a clear referential structure for the further development of the health insurance system and for the establishment of effective, managing and administrative capacities. This paper is prepared by exploring the published literature and collecting data through secondary sources. Several data sources have been used to describe the health performance in Albania. The review includes several references and, by covering OECD countries. The concepts included here serve us to better know and understand the actual situation of HIS, and what is more to be included in a "general plan" for the preparation of the directives for the organization, implementation, observation and evaluation of the steps that have to be undertaken for the reformation of the health insurance in Albania. Albania should develop an explicit, comprehensive revenue collection strategy that considers all available methods, such as direct taxation, indirect taxation, social security contributions, voluntary health insurance, and user charges, in order to optimize revenue collection.

**Key words:** Health insurance system, health reform, health system financing.

### 1. Introduction

A famous historian of medicine, Hirschfield, close to a century ago wrote "... some see health insurance primarily as a measure of mass education and public health, other argues as an economic instrument to initiate a reorganization of medical practice. Others see it as a tool to save money, while others are confident that it will significantly increase costs".

Health systems financing represents one of the four core functions of the health system. The other three are stewardship (oversight), creating resources (investment and training) and delivering services (provision). The aim of the financing function is to make funding available and to set the right financial incentives so that all individuals have access (financially and geographically) to effective public health and personal health care (WHO, 2000). Health system financing is supposed to contribute to the achievement of the health system goals of improved health, fairness of financial contribution and responsiveness. To do this, it should meet the following targets: (i) generate sufficient and sustainable resources for health (ii) use these resources optimally (by modifying incentives and through appropriate use of these resources) (iii) ensure that everyone has financial accessibility of health services. To achieve these targets and guarantee financially fair, population-wide access to effective, essential health care, three sub-functions are distinguished in health financing schemes: revenue collection, pooling and purchasing. It is assumed that if these sub-functions are strategically designed, the targets can be met. Based on these terms, an analytical framework has been developed to facilitate the design and monitoring of health financing systems (Carrin and James, 2004).

Health Insurance Scheme was considered as a significant mechanism for the reformation of the health system. It had to introduce changes concerning ways of financing and improved the services

quality. This mechanism which based on solidarity principle had to mitigate financial effects resulting from the shifting of the system from a centralized into a market economy, a process during which the Albanian citizens had to cope with the real cost of health services. Health insurances are compulsory and are based on paying of contributions by economically active individuals and by the state budget for the remaining part of the population unable to pay contributions. The steps led to the stabilization of Health Insurance Institute (HII) finances and creation of great possibilities to draft ambitious projects concerning expansion of insurances scheme. According to a project developed by the Albanian Government, which concerns implementation of a deep reform in the financing of health services, HII will become the main agent in financing the public health care sector. The challenges for health insurance scheme are very ambitious, necessary and with social cost. We must consider the fact both main political factors accept that health reform is more difficult and complex, after the property reform.

## 2. Health Care Insurance in Albania

The health care insurance defends people from health risk when they fall ill and consequently from financial risk. In principle, the Health Insurances collect financial contributions from many people, be them ill ones or not. These contributions are gathered together and are used as expenditures to help people who suffer tragic events. Thus, the health insurances are a mechanism for the distribution of the risk over time and among many people. The growing interest in health insurances implies the development of more resources for health care.

It was Prince Otto Eduard Leopold von Bismarck, the creator and first chancellor of the German nation–state in 1871, who first decided national compulsory health insurance and then the other states followed it one after another. Lenin after the Bolshevik Revolution(1917) , Britain (1945), Canada(1950-1960), and so on ,until today where almost all developed countries have set up this system. In Albania the first health insurance system was build in 1927, system which has some similarity with Bismarck model, but it was limited only to public administration employees .During the period of the communist regime(1944-1990) many aspects of health care policy in Albania continued to follow the Soviet Shemasko model. In '90 and with the collapse of the communist regime, government services have suffered several problems and the emphasis was switched to hospital care. During the years of transition, the Albanian has made extraordinary efforts to solve these problems helped by aids from international donors. Currently we have Bismarck solidarity health insurance system based on contractual relationships and quasi-public arrangements.

## 3. Administrative Affair

### 3.1. Health Insurance Institute

The Health System in Albania involves a number of structures, organizations and stakeholders. The health services in our country are covered by public and private service suppliers. The health insurances in the Republic of Albania are organized and led by the HII. The HII covers primary health care services, including general practitioner and specialist visits, as well as the reimbursement of a list of outpatient pharmaceuticals ('positive list'). In contrast, hospital care remains under direct state administration. Established in 1995, for the development of a national model in the field of health insurances in Albania, it is an independent body funded by payroll tax contributions as well as contributions from the self-employed and farmers, and governmental budget contributions for the dependent (non-active) population.HII is an independent public institution, a non-profit-making one and which operates in a local level via regional directories of the Health Care Insurances. It offers health care and at the same time it generates and distributes health resources.

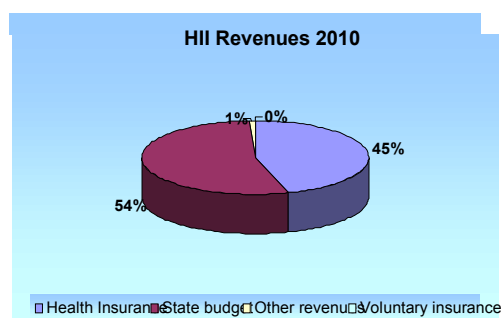
The Administrative Council is the supreme executive body, and it consists of representatives of participant actors in the scheme that HII represents. The health insurances scheme is obligatory, contains solidarity and guarantees the insured free choice of the doctor. It has under its responsibility: i) All the Albanian citizens who are permanently settled in Albania. ii) All the foreign citizens who work here and pay contributions for the health insurance. The health insurances scheme is considered as a very important mechanism for the health system's reformation in general. It has to introduce the changes that are related to the financing ways, to raise the number of health care resources as well as to improve the services' quality and to reduce the financial effects that are a result of passing from a centralized system to a market-based economy, which is a process that obliges the Albanian citizens to afford the health



income. Although by 2005 the increase of the contribution rate has been relatively good, averaging 15%, year 2007 marked a significant improvement in improvement in revenue growth of HII, about 24% compared to 2006. Continued upward pace in years.

In 2010-n, revenues from health insurance were four times higher than in 2000 and two times higher than 2005. The percentage of the health insurances contributions changes according to the population categories. The funds of HII in 2010 are mainly collected from the health insurances contributions, paid from the active population (54%), as well as from the state's budget transfers, as a contribution to the inactive population (45%).

**Figure 2.** Health Insurance Institutes revenues, 2010

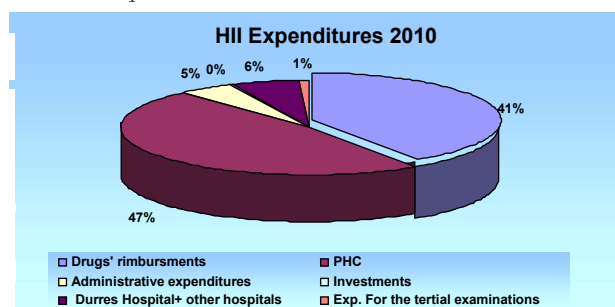


Source: HII, 2010.

The contribution's percentage from the public and private sector workers is 3.4% of the monthly salary. 50% of it is paid from the employer and 50% from the employee. The contribution's percentage for the self-employed ones in town and village is calculated according to the minimal monthly salary, annually approved by the Council of Ministers. The contributions vary from 7% in town, to 3% in mountainous regions and 5% in lowland ones.

In general, all EU countries suffer the problem of saving the membership of rural areas. The other challenges are, demographic changes, as well as the fall of work-force, whose results are noticed in the reduction of the income basis. There are over 600 thousand contributors to the health insurances in Albania. For 16 years the revenues collected from the health insurances contributions are about 340 million \$ and from state budget about 340 million \$, too. The contributions to health insurance are collected from Tax Office. Today, Albania has the lowest amount of contribution in Europe. (Vasili, P., MoH, 2011).

**Figure 3.** Health Insurance Institute Expenditures, 2010.



Source: HII, 2010.

In expenditures – the important part is occupied by Primary Health Care (PHC) with 5.899 million Lek (45%), reimbursement with 5.927 million Lek (45.2%), while the expenditures of the Durres Hospital are about 5% and the administrative expenditures about 4%.

The total health expenditures for health in Albania increased from 52 to 65 billion LEK in the period 2007 – 2009<sup>3</sup>. As compared to earlier estimates the privately financed share is significantly lower.

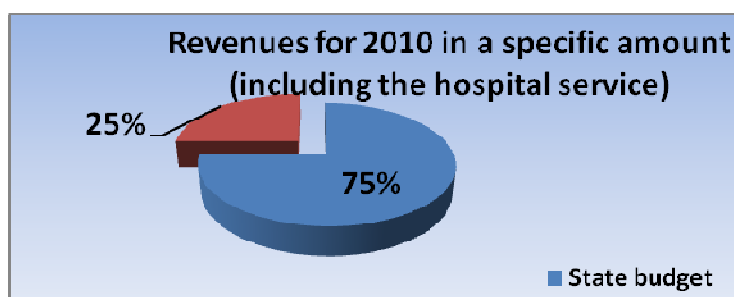
<sup>3</sup> Look at Appendix 1, Figure 1. Financing of health expenditures, 2007-2009

In total, 5.7% of the GDP is devoted to health in 2009, 50% public funded, 47% privately funded, and 3% financed by Foreign Programs. The Albanian share of GDP devoted to public health care expenditures is the lowest share in Europe together with Cyprus. (Development and Institutionalization of National Health Accounts (NHA), 2010, *Albania*).

#### 4.2 Source of Funding, Provider of Health Care Services and Goods, Functionally Defined.

Source generation for health insurance scheme in Albania is based on various sources such as the contribution of the active population, the State<sup>4</sup> co-payments and voluntary health insurance contributions. This amount of contribution varies between different social groups, based on their work relations and their geographical factor. One of the core tasks of the HII is to collect and channel funds earmarked for health benefits covered by the national single payer health insurance scheme. The economic and financial situation for the last year, was: In Revenues – the state contribution for the inactive population excluding the hospital service, is of 7.235 million LEK, so 53% of the total amount, while the contribution of active population is of 46% or 6.304 million LEK. If we are going to include the state contribution for the hospital service, the figures shall be 75% comes from state budget and 25% of health insurance contributions comes from the active population. (HII data, 2010)

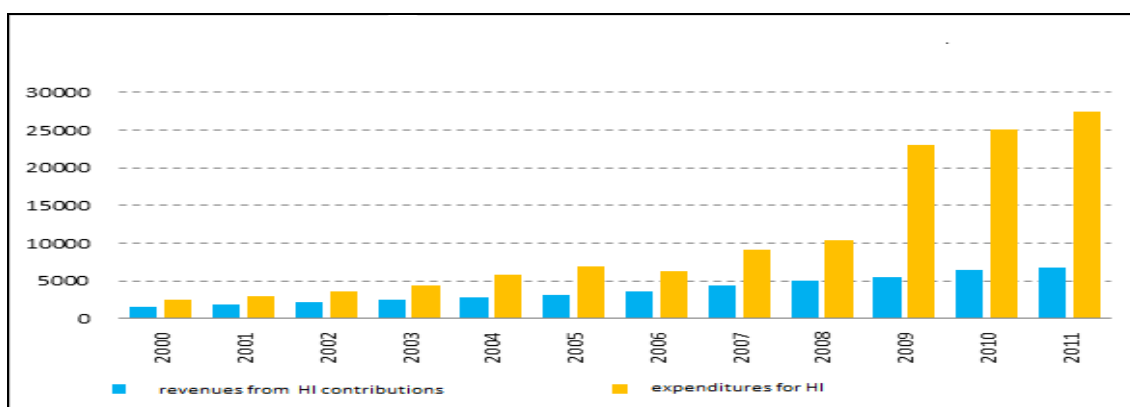
Figure 4. Revenues of Health Insurance Scheme, 2010



Source: HII, 2010.

The functional classification highlights the dominance of medical goods in the allocation of financial resources within the Albanian health sector.

Figure 5. Revenues from contributions and expenditures for Health Insurance 2000-2011 (in million LEK)



Source: MoF, 2011.

In European countries, 70% - 90% of health expenditure is financed from tax revenue or public contributions (OECD, 2009). The public health care funding is very low in Albania and accounts only for

<sup>4</sup> According to the law waged persons (economically active), paying compulsory insurance contribution at a fix wage rate, are considered as main financers of HII as it is also the State.

41.6% of total expenditure on health (Table 1), whereas the share is 70.8 % in Poland and even 85.2 % in the Czech Republic.

**Table 1.** *Healthcare expenditure in Albania and OECD countries*

State	Total expenditure in % of GDP	Per capita in US-\$ (purchasing parity)	Share of public expenditures in %
Albania (2004)**	6,6	433	41,6
Australia*	8,7	3137	67,7
Austria	10,1	3763	76,4
Canada	10,1	3895	70,0
Czech Republic	6,8	1616	85,2
Denmark	9,8	3512	84,5
Finland	8,2	2840	74,6
France	11,0	3601	79,0
Germany	10,4	3588	76,9
Greece	9,6	2727	60,3
Hungary	7,4	1388	70,6
Ireland	7,6	3424	80,7
Italy	8,7	2686	76,5
Japan*	8,1	2581	81,3
Netherlands	9,9	3837	n. a.
Poland	6,4	1035	70,8
Portugal*	9,9	2150	71,5
Slovak Republic	9,1	1555	81,7
Spain	8,5	2671	71,8
Sweden	9,1	3323	81,7
UK	9,4	2992	81,7
USA	16,0	7290	45,4

Source: *HC expenditures in OECD Country, 2009.*

This data reveals an obviously crucial point of Albania's health policy: Public funding is far below the level, which is generally required for achieving universal access to health care.

## 5. The Structure of the Health Services that are Financed by HII

In Albania, the health packet, that is covered by health insurances, covers only a small part of the health expenditures, or only one part of health services, in other words basic services. It is sure that even this aspect is related to the income level, collected by the health insurances, which comes as a result of two main factors: (i). *the low level of contributions* and (ii). *the illegality level in economy.*

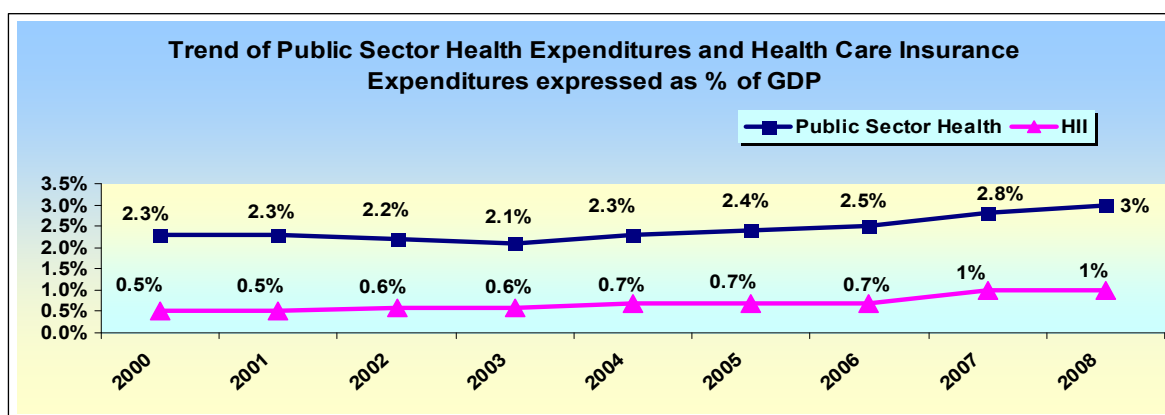
The insured people benefit:



- 50-100% of the cost of drugs included in the Reimbursement Drug List (RDL) (420 generic drugs in RDL, 2010). A considerable amount of the general expenditures on the Albanian health are used for the drugs' reimbursement. This amount is about 39% of the expenditures and about 40% of the HII annual expenditures.
- Family doctor's services
- Free visit to general practitioner
- Pharmaceutical service
- 90-100% of the cost of 12 tertiary unique examinations.
- The primary health care services, as well as hospital services in the city of Durres. This is a pilot project which has started since the year 2001.
- HII makes contracts with the services' suppliers, such as doctors, chemists etc, for the health services financing.

The major part of health care schemes in European countries, suffer from sub financing. A basic principle of public finances for the health financing system is to raise enough revenues to provide individuals with basic packages of essential services and financial protection.

Figure 6. Trends of public sector health and HII expenditures



Source: MoH, 2009

The average of the health spending in European countries is around 10-11% of the GDP. The total health spending (public and out-of-pocket) is about 5-6 % of the GDP in Albania. In order to improve the health services for population, it is necessary to raise this percentage to at least 7% of the GDP (Financial situation of HII, 2010). This assumes an improvement of the system to collect the taxes and the payrolls and also be informed of the percentage that Albania is ready to pay for the health of its population.

Albania is lined up the last among all the regional countries, as referring to the health sector financing. The governmental expenditures in Albania, during the years 2000 - 2008, occupy 3% of the GDP (World Bank, Albania Health Sector Note, No. 32612 – AL, 2006).

As a percentage of the total expenditures, public expenditures remain in low figures (~40%) when compared to the private ones, which are higher (~60%)<sup>5</sup>. The public health financing is realized through general taxation, income tax (health contributions), and some donations. The health system has macroeconomic impact, due to the way that the health care expenditures are related to the GDP and the public expenditures, therefore they are often facing similar challenges, such as the financial stability. So, we have had and will be having debates on the health system's future.

According to the World Bank (2006), the public health financing system is fragmented and fails to give providers the incentives for efficiency and quality improvements, nor does it establish clear lines of accountability. The finance system is fragmented with the MoH paying for hospital care, non-physician salaries and at times other operating costs for primary health care, as well as capital costs, while the HII pays for salaries of PHC physicians, prescription drugs and high-end diagnostics. Financing responsibilities have changed repeatedly over the past several years. Together, this situation has led to a

<sup>5</sup> Household or out-of-pocket: Spending by people on health services provided by health providers for them.

lack of accountability for sectorial performance. The introduction of user fees for outpatient care for those not covered by health insurance or those who circumvent primary care created uncertainty and left space for abuse.

## 6. Aspects of the Reform Undertaken Until Now

The health sector reform launched in 1992 found varying degrees of support from different stakeholders, such as the government, parliamentarians, health providers and the population. This made it possible to implement successfully some key elements of reform as follows: the privatization of pharmacies and dentistry services; the introduction of private medical practice; an autonomous health insurance fund managed by the Health Insurance Institute; the transformation of most rural hospitals to outpatient clinics; the reorganization of national health care service in a unified university hospital; more managerial autonomy for district health administrations; subsidies for the national essential drugs list; the creation of mechanisms for drug registration and licensing etc. During the year 2006, HII undertook a range of precautions to reduce the reimbursement cost, such as reduction in the list of reimbursable drugs, reconsideration of the profit margin of the chemists and wholesaler, settlement of fixed tariffs for each prescription, as well as the settlement of some limits on the drugs' use. All these undertaken precautions led to the stabilization of the HII finances as well as to great possibilities to initiate ambitious projects which have to do with the expansion of the insurances scheme. In conformity with the project of the Albanian Government, which has implemented deep reforms in the health insurances financing, HII became the only one from the public sector to finance in the health care.

Starting from January 2007, the Health Care Insurance Institute is the only financing source on the primary health service. It is the first time that there is a clear determination of the roles of the main actors. From this period, Health Centers (HC) will be independent; will have their own bank account and the Institute will have a bigger role in the process of collecting and delivering the funds. HII is trying to make contracts with these centers for the packet of services that they will offer. It is the first time that there will be applied this mixed formula on the centers' payments, 85% of which will be a fixed one, 10% will be based on the center's activity and 5% bonus depending on its performance. These have brought about many changes in financing and a kind of the system's decentralization. This is a very ambitious project which aims at raising the health center's productivity through introducing the market elements, such as the flexible budget, competition among the centers and the secondary income.

This is just the first step towards the final draft of the contracts which are related to the services' performance and which will be further developed. In a second phase, after the Health Ministry will have fixed the tariffs for the medical staff, will have set new standards for the services, will have calculated the services' cost and will have accredited the primary health care centers, HII will buy more services according to the performance.

In 2009, the financing reforms was expanded in the secondary and tertiary health services where HII has been major hospital financier. This had at the same time the support of the private initiative in offering the services.

### 6.1 Management of the Health Insurance Reform

The arrangements concerning health financing and health care provision in Albania and elsewhere are usually facing complex challenges, as they have to conciliate autonomy and systemic performance. Needs a series of statutes are required for regulating activities of autonomous health insurance schemes and safeguarding transparency and reliability, contracting new types of providers and, thus, for developing adequate contractual frameworks. Needs the legal attributions to contract providers at the primary, secondary and tertiary health care level. While the role of the MOH is continuously shifting from healthcare provision to legislation and regulation, the relevance of the HII as single public contractor and payer has been rising considerably. Against this background, and as a part of the national debate on a new health financing law in Albania, the question of HII's level of autonomy and its capacity to organize the health system are key factors of social health protection and of the overall system performance. Autonomy of public health insurance schemes comprises political, financial, organizational, normative and contractual aspects.



### 6.2 The Trends of Health Financing Reform

The Albanian healthcare system requires additional reform steps both in primary health care and hospital service delivery. In the context of improving and strengthening the health insurance scheme, HII is always looking to further develop its capacities. This effort has to be accompanied by a number of changes in the existing legislation in order to strengthen the scheme. For further improving health care, strong political will seems to be indispensable. Furthermore, improved legislation concerned, enhanced institutional capacities, radically improved service management, intensified vocational training of service providers and international expertise will be required. Will be needed a series of other concrete interventions and measures, in order to improving the Albanian public health insurance scheme. This will include the strengthening of the role of HII as the sole purchaser of publicly financed health services; therefore the insurance scheme has to be provided with the right to select the best service providers available. A series of legal amendments for increasing the institutional autonomy of the HII will be necessary for improving performance. An important step is undoubtedly the approval of the new health insurance law, which is expected to strengthen the role of the HII as the purchaser of health care services from public and potentially also from private providers. Contracting opportunities with private providers for increasing access to qualitative services might be another option. Contribution collection has to become more effective and a transparent and reliable co-payment system will be indispensable. Expanding population coverage is another key element for transforming the HII into a relevant public entity that allows all citizens to benefit from the health service package and to enjoy social health protection. Therefore broader financial, managerial and structural autonomy of public providers will be required for guaranteeing access of all Albanians to HII services. This is promising to allow for achieving sufficient flexibility and increasing access of the population to necessary healthcare services.

### 6.3 Achievements of Reforms in Health Insurance System

As a part of the ongoing health sector reforms in Albania, the HII started in 2007 the reform in Primary Health Care (PHC) to measure and evaluate performance indicators and in 2008 six quality indicators were introduced and assessed. These indicators comprise the percentage of persons that visited a Health Center (HC) for the first time in a year, the average prescription cost per diagnosis, follow-up of chronic patients, reproductive health care, immunization and continuous medical education. While some of reasons, such as the low quantitative and qualitative levels of service delivery, the centralized financing mechanism, the lack of autonomy and management capacities of Albanian hospitals and severe gaps and weaknesses in the supply and administration of drugs, equipments and other medical materials at hospital level, had created an increasing need for reforming of the hospital sector. The main achievement of reforms in health insurance system until now can be divided in two direction. **(i) in primary health care, (ii) in hospital reform.**

#### **(i) Achievements of the Primary Health Care Reform.**

During the years 2008 and 2009 one of the main challenges was the introduction of new concepts for improving service quality and their implementation in the field. Other improvements in recent years that have had impact on the PHC service delivery were the formulation and implementation of a basic benefit package since January 2009, the set up of the health information system, a new supervision system and the screening process for population enrolment. During the year 2008, about 250,000 additional HII beneficiaries visited for the first time the General Practitioners (GP) at their HC compared to 2006. Financial benefits of the performance in 2009 by the HC have increased by 25% compared to 2008 and by approximately 200% versus 2007. Despite the difficulties in the set up, the implementation of quality indicators in the Albanian health insurance scheme worked out well and all the providers, which had been contracted by the HII, contributed to the successful implementation.

**(ii). Achievements of the Hospital Reform.** . As main achievements of the hospital reform so far, it has to be pointed out that the HII has drafted and entered into contractual arrangements with four university hospitals, 12 regional hospitals and 23 municipal hospitals for delivering and financing inpatient and specialized outpatient services. Hospital authorities have in turn started to individually contract their employees. The HII is financing the salaries and other expenditures regarding personnel wages, health and social contributions of the staff, and other goods and services. There is a new method in place for reporting the hospital activities that will allow the HII to have a more comprehensive view of the level of services offered by the hospital. Hospital providers are now enabled to fully use secondary revenues for hospital needs and purposes. In the light of strengthening the autonomy of hospital management, it will

be very important to ensure the establishment and functioning of regional managerial health authorities in order to assure financial and managerial self governance, a certain level of independence regarding the delivery of services and a more flexible system of payment based on the performance of each provider.

## 7. The Strategies for Implementation the Reform

An ideal health system would be the system that is able to provide basic health services, easily accessible and acceptable quality in the population and high efficiency. The main aim of the following strategies is reform of the current health system based on models of successful experiences enabling the realization of final objective: “security and continual improvement of healthcare for the population”

- Preparing/ changing the regulatory procedures:
- Elaboration of a new model of “autonomous hospital”
- The hospitals is given the status of the non-profit public institutions;
- The hospitals keep the incomes from the co-payments;
- The health system is based on a foundation of primary health care;
- The (standard) costing of the major activities of the hospital;
- Financing the hospitals with a global budget (lessons taught by the experience of the hospital of Durres);
- The development of the model of the contractual relationship between HII and the hospitals;
- The computerization of the medical and economic activity of the hospitals;
- The expansion and improvement of the managing knowledge and capacities of the hospitals as a response to the new financing system;
- Human resource rationalization and development
- More managerial autonomy is given to districts and to create health regions.

### 7.1 Strategic Priorities in

#### i) growing the managing capacities

- ✓ Elaboration of a “new model of hospital management” adapted to the conditions of hospitals in Albania
- ✓ Setting up the standards, norms and clinical protocols in management of health services.
- ✓ Restructuring the MoH in order to improve the capacities of policy making and creating and completing the necessary structures in the field of health insurance policies.
- ✓ Expanding of partnership public-private.
- ✓ Encouragement of special service privatization at all the levels of health care.
- ✓ Empowerment of control and monitoring capabilities of the private health activities in order to protect the health of the population from abuse and harmful practice.
- ✓ Reposition of manager role at public health institutions.
- ✓ Consolidation of quality approach system and security of health system.
- ✓ Empowerment of the monitoring/evaluation unit, which will observe the developments in healthcare system and will contribute to the orientation of the strategies and activities.

#### ii) growing the health services' access

- ✓ Management of primary health care system through expansion and strengthening of the autonomy of the primary service aiming the scheme “public financing and autonomous services (private)”
- ✓ Define of basic package of health services and its monitoring
- ✓ Establishment of a mechanism for coordination of all information system, which serve to the health system in Albania.
- ✓ Empowerment of family doctor institution and improvement of its image.
- ✓ Re construction of health service providers network, due to geographical, demographic and privatization policies conditions
- ✓ Improvement of refer system
- ✓ Maintaining and developing of programs for public health
- ✓ Decentralization of health system with the final goal his autonomy, as an optimal solution for good management and the system integrity.

#### iii) financing the health system

- ✓ Reinforcement of HII role as strategic purchaser of health services in public and private system
- ✓ Improvement of the financing health system legislation.
- ✓ Direct contracting of service providers as health working in groups or individuals (general physicians/family)
- ✓ Improvement of collecting contribution system
- ✓ Efficiency at collecting contribution from salaries
- ✓ Adoption of a combined model of payment per capita in payment for services (fee for services), in order to avoid negative effects of a single payment form.
- ✓ Consolidation of contributions from obligatory insurance for inactive population, from state budget
- ✓ Reconsideration of the contribution rate
- ✓ Establishment of mechanisms to measure the cost-effectiveness of health services, particularly those secondary and tertiary, which are more expensive (management of information system)
- ✓ Decreasing of informality
- ✓ Presentation of co-payment
- ✓ Identifying the insured population through health card

## 8. Conclusions

The Health Insurance Institute is committed to consolidating efforts to strengthen the management of the health insurance system. It is necessary for the HII to raise its capacities, to set the progress standards as well as the reporting systems and at the same time, to create a suitable transparency and monitoring process as regards performance.

Remaining challenges include strengthening control in the market; increasing transparency in the various commissions that make decisions, setting a profits packet for the public financing, revision of the level of pharmaceutical distribution margins implementing co-payments and developing an informing and monitoring system of the progress by the services suppliers. The success of these efforts will depend greatly on the future organizational model adopted as well as on the improvements in the rules and management capacities of the health system. The existing data of the HII must be improved by the use of tools to analyse expenditures in order to pool health risks and the use of routinely available data to provide information for risk management. There are available standardised management models and tools that can be easily adapted.

There is evidence that the introduction of standardised organisation and management structures in hospitals can result more efficient in the use of resources and also improve the service quality. This requires qualified and motivated managers using modern management tools and suitable training courses.

There is evidence that encouraging providers to measure their performance and compare it with other peer groups can help to improve standards. There are examples of systems of performance management, which introduce the "benchmark" system to improve the quality and efficiency of their services, against similar types of providers, which support the introduction of national standards.

Albania, as a country that accede to be part of EU, also in order to achieve all these objectives, need assistance and collaborative relationships with the European Partners as well as with the homologous institutions which implement advanced schemes on the health insurances sector.

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## Appendix 1

Variable	2007	2008	2009
Total health expenditures	52.004.977	59.618.766	65.166.360
International functions	as % of THE		
HC.1 Curative Care	35.7	39.6	37.8
HC.2 Rehabilitative Care	5.8	5.9	7
HC.3 Long-term nursing care	0.1	0.1	0.1
HC.4 Ancillary services	2.6	2.5	3.6
HC.5 Medical goods	42.5	41.5	40.6
HC.6 Public health *	6.2	3.5	3.2
HC.7 Administration	1.3	1.4	1
HC.R Investments	5.7	5.3	6.7
Total health expenditures	100	100	100
Albanian functions	as % of THE		
SC.1 Primary care	61	59.4	59.6
SC.2 Secondary care	29.4	32.3	31.3
SC.3 Public health *	6.9	4	3.7
SC.4 Administration **	2.7	4.2	5.4
Total health expenditures	100	100	100