

Autonomy and Financial Sources, Key Factors in the Performance of Health Insurance Scheme: Case of Albania

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Autonomy of public health insurance scheme comprises political, financial, organizational, normative and contractual aspects. The paper analyses the role and position of a health insurance scheme (HIS) within the overall healthcare system in Albania, the relationship to all other institutions, stakeholders and actors. By analysing published literature and collected data through secondary sources, the paper focuses on financial autonomy, which refers first of all to a certain level of budgetary independence regarding source generation and spending on health services. For assuring effective and efficient performance of the single payer for health care services in Albania, need effective changes in the legislation do take into account the various levels of autonomy mentioned above.

Keywords: autonomy, health financing insurance system, single player, health care services, government policy

JEL Classifications: H5, H51, I18

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Introduction

The Albanian health system is in the process of undergoing significant changes. Currently we have a Bismarck solidarity health insurance system based on contractual relationships and quasi-public arrangements. As one of the most important sectors for human development, the health sector is defined as one the priorities of the government of Albania. In 1995, the HII was created in the framework of one of the major reforms planned to be undertaken for transforming the health care system into a split purchaser-provider contract model. As a corresponding national statutory fund and purchasing authority, HII was granted autonomy as a quasi-governmental body. HII is formally accountable only to the Parliament. HII is working to reformulate the regulation framework in order it may become adapted to an enlarging and sophisticated private health sector. Reforms being undertaken within HII intend its transformation into the sole buyer of all health services offered by the public sector. The health insurance scheme in Albania requires a reasonable level of independence from the Government and autonomy regarding all strictly insurance related issues (Lindenlaub Y, Schulte O, 2008). To conciliate autonomy and systemic performance, the health financing and health care provision in Albania are usually facing complex challenges and legal arrangements concerning. It is indispensable to clearly define the role and position of a health insurance scheme within the overall healthcare system and the relationship to all other institutions, stakeholders and actors. An adequate and well-designed regulatory framework provides a country with appropriate means for balancing the various and partly

contradictory interests in place, and assuring both sufficient autonomy and accountability. A series of statutes are required for regulating activities of autonomous health insurance schemes and safeguarding transparency and reliability. Autonomy of public health insurance scheme comprises political, financial, organizational, normative and contractual aspects (Hysi E, Zyba E, 2008). How is the level of autonomy and capacity of HII to organize the health system? These are key factors of social health protection and of the overall system performance. HII as a public institution provided with a certain level of autonomy since 1995. The delivery of financed healthcare benefits started with the reimbursement of a series of drugs considered priority and the main objective was to provide the maximum scope of health insurance benefits. Household surveys show that only about 40-45% of the population is effectively covered by the HII (WB, INSTAT 2005). The major changes introduced in the Albanian health insurance scheme have obviously health financing today depends much more on general taxation than on mandatory obviously changed the source mix of financial resources available for providing HII benefits; contributions. In Albania, general revenues account for over 90% of public sector funding, despite a mandatory contributory health insurance system.

II Source of funding, provider of health care services and goods, functionally defined

In terms of administration health funds, other than the household, the Ministry of Health (MOH) and HII are the main agents handling health funds. MOH resource allocation is skewed mainly toward primary and out-patient care at the health centers and health posts to

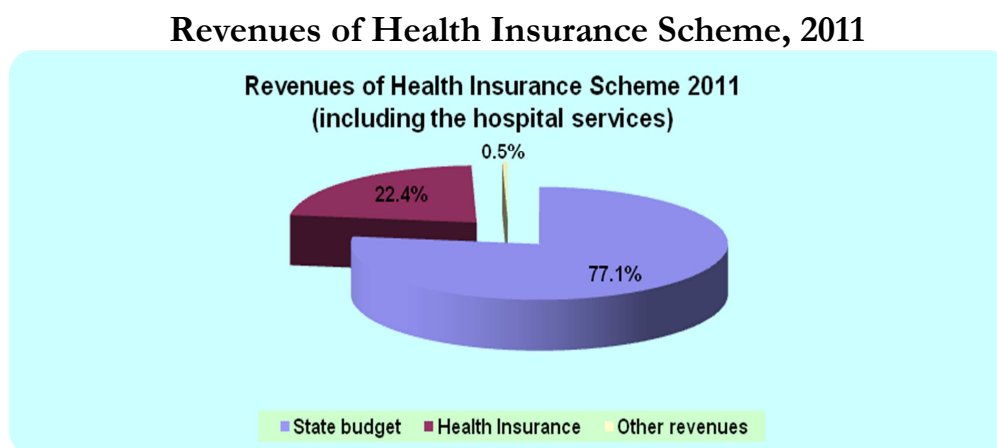
cover the entire country. It is financed through budget derived from general revenues (taxes) and donations from donors. Contributions of the insured people are collected by the Ministry of Finance (MF) through taxes on HII account.

Albanian health services are funded through a mix of taxation and statutory insurance. The majority of funding still comes from the state budget. Sources of funds are the MF; Employer funds, Household funds and Donors Funds. Contributions for health insurances administered by HII amount to a total of 3.4 % of the salary, out of which 1.7% is paid by the employer and 1.7 by the employee. The self-employed pay 7% of the minimal salary. Another source of contributions is the voluntary insurance that stands at 3.4% of the minimal wage. To all the individuals paying health insurance contributions, such services as reimbursed drugs, free of charge visits by general practitioners (GP) and specialist doctors, various medical analyses are offered at public health institutions.

In 2011, the total incomes of HII amounted to 26.877 million ALL / € 192 million, while expenditures amounted to 26.970 million ALL / € 193 million. The structure of revenues performance fragmented according to contributions is presented as such: 6.030 million ALL / € 43 million are health insurances contributions, 7.812 million ALL / € 55.8 million are State contributions 12.912 million ALL / € 92.2 million are State budget for hospital services and 124 million ALL / € 0.9 million are other revenues. Currency in Albania; 1 € exchange with 140 ALL.

In 2011, health insurance contributions of the active population account for 22.4 % and the contribution of state budget for 77.1 % of the total budget of health insurance scheme (HIS).

Figure 1



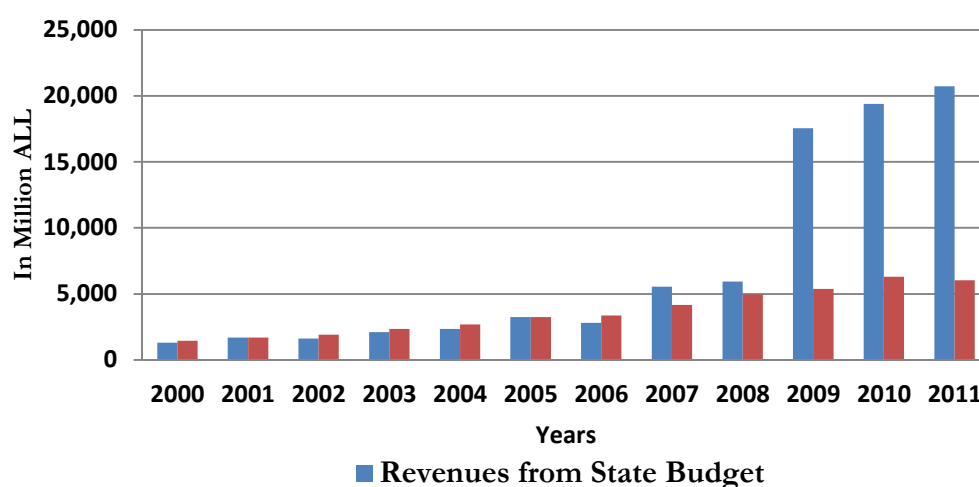
Source: HII data, my calculations

Almost the same indicator are for 2012. The state remains the major source of health care financing: The MOF allocates money to the Health Insurance Institute, mainly to cover unwaged groups and to the Ministry of Health. Source generation for health insurance scheme in Albania is based on various sources such as the contribution of the active population, the State² 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.

² 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.

Figure 2

Trend of HIS Revenues from 2000 - 2011



Source: HII data, my calculations

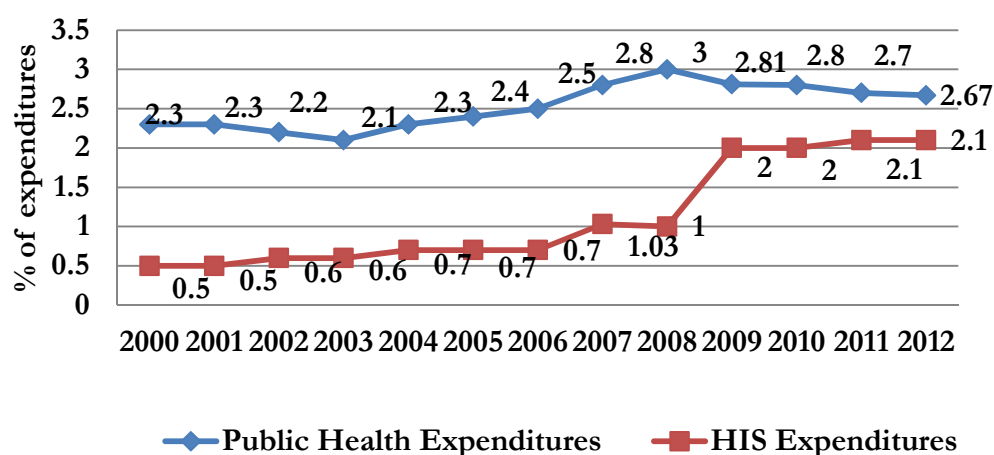
Although the state maintains the brunt of the costs of the health insurance scheme (HIS), its funding still is not sufficient. Subfinancing is an important problem for the autonomy of health insurance schemes in Albania. Figure no. 3 shows a trend of HIS expenditures and total public expenditures on health (THE), as percentage of GDP in Albania.

The expansion of HIS and reforms that have begun in primary health care (2007) and hospital services (2009) are not accompanied by adequate financial support from the state. This situation didn't

strengthen HII autonomy and leads to the violation of its role as the single payer of health system in Albania.

Figure 3

**Trend of HIS Expenditures and THE over 2000-2012 in Albania
(in % of GDP)**



Source: HII, Ministry of Finance Draft Budget Raport 2012

Allowance for the Ministry of Health according to draft the 2012 budget amounts to 29.114 billion ALL / approximately € 208 billion (MOF, 2011). The budget of MOH in the total for 2012 compared to the revised 2011 budget is increased only 1%. This budget represents 2.09% of GDP³, come down compared to 2011 where the MOH

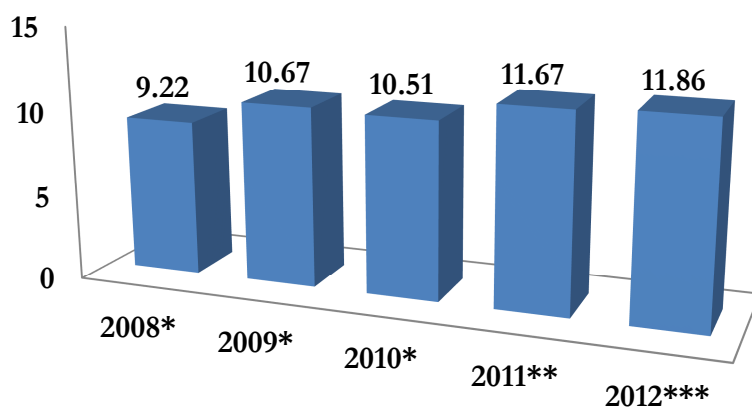
³The Draft Budget Report of 2012,
http://www.minfin.gov.al/minfin/Projekt_Buxheti_2012_2771_1.php

budget accounted for 2.2% of GDP according to the MPB 2011-2013 forecasts (Open Albania Fondation 2011).

The 2012 draft budget to the health sector has a very small increase compared to the reviewed budget of 2011. While the difference between the draft budget of 2011 and reviewed budget of 2011 is considerable, about 843 million ALL / € 6 million⁴. Regardless redundancies, expenditures in this sector have been increased and the weight of the Ministry of Health against of the total public expenditure, given in the figure no. 4.

Figure 4

MOH Budget against Total Expenditures, 2008-2012 (in %)



* Approved Budget 2008 -2010; ** Reviewed Budget 2011; ***Draft Budget 2012

Source: Ministry of Finance, Bank of Albania.

⁴ Chards of the Reviewed Budget 2011

[http://www.minfin.gov.al/minfin/3_tabelat_e_buxhetit_te_rishikuar_2011_\(korrik\).xls](http://www.minfin.gov.al/minfin/3_tabelat_e_buxhetit_te_rishikuar_2011_(korrik).xls)

Ministry of Health budget is distributed mainly between the two main programs are services and Primary Care Secondary Care Services which use respectively 34% and 56% of the budget for 2012. 70% of these costs go to secondary care and about 28% for primary care.

For the year 2012 expenditures in secondary care program amount to 16,416 million ALL /€ 117 million, which decreased by 3.2% compared to the revised budget year 2011. Primary care has been a priority in relation to fund expenditures for this sector, which is 11.8% higher than for 2011.

The Albanian share of GDP devoted to public health care expenditures is the lowest share in Europe together with Cyprus (NHA, 2010).

In European countries, 70-90 % of health expenditure is financed from tax revenue or public contributions (OECD, 2009). The public health care funding was very low in Albania and accounts only for 39% of total expenditure on health in 2010. Public health expenditure in Albania was 2.81% of GDP in 2009. Total expenditure on health in as percent of GDP was 6.55% in 2010 and only 6.3% in 2011 (WHO, 2012).

Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and non governmental organizations), and social (or compulsory) health insurance funds. Total health expenditure is the sum of public and private health expenditure. According to World Bank, public health expenditure, as percent of total health expenditure from 2007 to 2010, are as below.

Table 1

Public health care expenditure in Albania and in some Regional Countries, as percent of total health expenditure

State/Years	2007	2008	2009	2010
Albania	38.2	39.6	41.2	39.0
Croatia	87.0	84.9	84.9	84.9
Greece	60.3	59.9	61.7	59.4
Italy	76.6	77.5	77.9	77.6
Macedonia, FYR	64.3	68.2	66.5	63.8
Slovenia	72.3	73.4	73.4	73.7
Montenegro	69.2	70.4	71.3	67.2

Source: The World Bank 2011

2.1 Challenges and 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.

2.2 What autonomy requirements?

Political autonomy does certainly not imply complete independence from government and other public bodies, but it refers to the options of social health insurance schemes to develop and design their own institutional setting and to be provided with a reasonable level of protection against the attempt of other institutions to both interfere in the core tasks and to access funds earmarked to health. A prerequisite of financial autonomy, first it will refer to the level of budgetary independence regarding resource generation and spending on health services. Organizational autonomy implies defining the institutional setting, the relationship to other public and private bodies and formal independence from government institutions. Health insurance schemes also require normative autonomy in order to set internal and external rules with regard to the core functions. A contractual autonomy has become a priority challenge for HII.

For organizing and managing outpatient and inpatient care, the HII is required to develop contractual frameworks and to directly contract with providers all over the country; this should be mainly linked to expected outcome indicators and the potential to ensure fair access to adequate healthcare for all citizens and not to inter institutional rivalries or unclear health system conditions. For defining the tasks,

the role and the level of autonomy of the HII, an adequate legal framework is indispensable. The set of regulations and laws referring to health insurance in Albania is currently highly fragmented and partly not fully compatible to each other. According to hospital reform, autonomy is the extent of decision rights hospitals have over various aspects of production, including inputs, outputs and management processes (Maxwell 1997, Parker 2003).

Autonomy is important because; it provides the critical instrument that enable organizations to respond to incentives, the ability to tackle a problem locally is likely in most cases to lead to faster and better decisions, local circumstances vary sufficiently to call for local flexibility and if central government control is to be made less rigid, then local accountability should be strengthened.

III The trends of health financing reforms

The Albanian healthcare system requires additional reform steps both in primary health care and hospital service delivery. 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. 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. 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. It is of interest to accurately determine the contribution of the state for the non-active population in order to generate sources for adequate health care of these population groups. 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.

3.1 Achievements of two main 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 year 2009 marked the start of reform in the hospital services, where 38 hospitals began funding the health insurance budget. Relations between HII and hospitals are built on the basis of annual bilateral contracts. Total budget approved by Parliament hospitals. The budget for each hospital and divided into three main voices of expenditure (600, 601, 602) and wages of employees. Hospitals fully using other income to realize their activity is reportedly determined by CA and HII (30% investment, 40% goods and services and wages 30% of remuneration). Investments hospitals are part of the MoH budget. Hospitals are autonomous drug procurement carried out by regional hospitals. End of year 2010 and following the implementation of HII instructions that compute and report to hospitals HII: actual expenditures (HII funds only) in total and detailed costs for each service. The average cost per case in the services with beds costs per day/patient in the services with beds the full costs for services without beds (laboratory, imaging, etc.) day average attitudes of patients to hospitals by services level of utilization of bed.

3.1.1 The situation of the provides and the problems found and of the hospital reform

Autonomy and accountability should be closely linked. If management autonomy is increased at hospital level, managers should be publicly accountable (to central and local levels) for how they exercise that autonomy; financial probity and accountability are in use of funds. Well-designed provider payment mechanisms have proven to be not sufficient conditions for restructuring hospital systems. There is a lack of alignment between reform of provider payment mechanisms and organizational reforms. More decentralization of decision rights is not going with appropriate accountability mechanisms and incentives.

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.

But what are the effects of the new mix of hospital autonomy and accountability on the hospital and its performance and how has the mix of funding sources changed, and have funding levels increased? What have been the effects of the new mix of hospital autonomy and accountability on the allocate efficiency and equity of resource allocation patterns in the health sector? Are the services provided by the hospital more closely aligned to its intended role and function in the health system? Or has the autonomy policy caused a divergence, suggesting a negative impact on efficiency of the health sector?

There is an inappropriate financing method and old arrears. Has a lack of incentive methods to incite providers in improving service delivery. Autonomy as one of the significant indicators for the well-operation of the hospital remains a sharp issue. Management level is still a sharp issue, centralized nominations and lack of flexibility in service organization and delivery. It's insufficient delivery of service package with respect to diagnosis equipments and drugs, insufficient number of Medical Staff (regional hospitals), improper professional level of both specialist physicians and other medical staff with middle education. There is a very low level of hospital services indicators, a poor quality of service and under the table payments by the patients.

IV Problems and limitations of the health insurance scheme

- Public sector expenditures on health as a share of GDP remain substantially below European and middle income country averages.

- Financing responsibilities have changed often. The main source of public sector funding is the state budget, but has limits on the amount that governments can spend on health imply the need for explicit or implicit rationing that, in turn, means trade offs between the attainment of the health financing policy objectives and the need for fiscal balance.
- Hospital expenditures dominate public sector spending on health. Albania allocates a higher share of total public sector spending to hospital care than do OECD or EU-8 countries. Hospital expenditures account for about half of all public sectors spending on healthcare in Albania compared to an OECD average of about 38%.
- Out of pocket health care expenditures are wide spread phenomena as well as in the Central and Eastern European countries and Former Soviet Union countries after the fall of the communism (Ensor 2004, Falkingham, 2004, Delcheva et al. 1997, Vian et al. 2006, Liapopoulos et al. 2008, Gaal et al. 2005). As result of: the scarcities of the financial sources allocated to health care, the lack of efficient policies for both health care financing and for human sources management, as well as high informality present in all sectors of economy.
- The budget mainly is planned based on the historical trends.
- In the framework of reforming the sector of health, the decentralization is important within the sector, as well as for sharing responsibilities, competences and functions with the organs of the local power. The actual experience is not very positive.
- At the health sector there is still centralization of tasks and budgetary competences from the MOH and central institutions, which has badly influenced in the composition and administration of the public funds. It is worthy to underline that after 2006 the local government units do not have any role and

responsibility in the health sector and as a consequence do not play a specific role in the composition and implementation of the budget in this sector.

- The differences between the contributors and beneficiaries have caused premises for a considerable fiscal evasion, which influence in the raise of contributes from the general taxation. In this case, this should be considered the reason for stimulating in an indirect way the bribes and other corruptive elements in this sector.
- A lack of responsibility from the institutions which draft the budget and accomplish budgetary policies.

V Results

- The financial autonomy, which refers first of all to a certain level of budgetary independence regarding source generation and spending on health services, is a prerequisite.
- The Government of Albania is in the process of reforming and modernizing its health sector and is moving towards the establishment of a more sustainable health financing insurance system.
- Is working on an up-dated legal framework for health financing.
- The above mentioned law states that HII has to provide the financing of health care as a single payer public institution, but recognize the right of private health insurance operators as well to offer voluntary supplementary health insurance after their legal registration and licensing. There are no clear rules however regulating licensing and supervision of these operators, leaving little room for interpretation and tries to prevent abuse to the detriment of the beneficiaries of such services.

- Constituting an efficient cooperation and legitimacy between HII and MOH ensures independence for HII, as an autonomous public institution.
- As health insurance is meant to alleviate the financial burden of payments for health care, this finding suggests an extremely relevant conclusion: When health expenditures are similar for insured and uninsured people, health insurance does not effectively prevent enrollees from paying a relevant share of costs out of pocket.
- Amendments to the legal framework on HII with the objective of: drafting legal and sub legal acts to ensure independence of the HII; avoiding discrepancies between the law and statute about the authority of managing bodies and other issues regarding the operation of this institution; increasing the number of representatives through greater inclusion of different groups of interests.
- It is facilitating the establishment and proper functioning, of revision of reimbursed drugs list for beneficiaries by health insurance scheme, within HII authority.
- HII must have its own budget, independently from the state budget, which should also apply to its reserve funds and the collection of fines.
- HII is exploring possibilities that exist, for increasing the number of services offered as part of the basic compulsory health insurance package.
- 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.

VI Conclusions

Health insurance scheme require normative autonomy in order to set internal and external rules with regard to the core functions. Due to the recent changes occurred in the HII and in the whole Albanian healthcare sector, contractual autonomy has become a priority challenge for the institute. For assuring effective and efficient performance of the single payer for health care services, need effective changes in the legislation do take into account the various levels of autonomy mentioned above. Even such a crucial measure as the extension of health insurance benefits to hospital care, which implied completely new contractual relations and reimbursement rules and almost doubled the HII budget, is based only on a specific by law.

Significant changes are focused in the following main directions; change of the base for the contributions calculation, health service packages drawing up and possible change of the payment methods for service providers. The current draft law starts with setting some basic definitions of terms and continues with an in depth set up of all aspects of a health insurance including the definition of affiliates and beneficiaries, contributions and other revenues, benefits, administration and organization of the HII, cost sharing arrangements, contracting, statistics, and information system. In view of the ongoing legislation process the HII is required to actively contribute to further elaborating the statutory framework that will regulate the scheme's future tasks, duties and obligation.

The HII should make sure that the forthcoming changes in the legislation do take into account the various levels of autonomy mentioned above for assuring effective and efficient performance of

the single payer for healthcare services in Albania. In the circumstances of a wide spread informal economy the best way to increase the number of contributors is to try to convince the non contributors to join the scheme. This implies the increase of the share of voluntary contributors. The faster way to reach this target is through intensive advertising of HII services and benefits of being covered since, as earlier suggestions imply, good proportions of respondents are not aware of the benefits of being insured, combined with efforts to recalculate premiums and to differentiate them according to population strata and amount willing to be paid.

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