

## THE SYSTEM OF CONTRIBUTIONS FOR HEALTH INSURANCE SCHEME IN ALBANIA - PERFORMANCE AND MAIN CHALLENGES

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### **Abstract**

*Albanian health care system is undergoing comprehensive changes. The paper focuses on the system of contributions for health insurance scheme. The paper will argue the need for immediate measures regarding this issue. Based on the primary and secondary data, through an economic analysis is studying the trend of contributor's number for five years. Are identified the economic, social and political factors, that affect this process and whole health insurance scheme (HIS). In Albania, partly scheme function, an informal labor market, lack of incentives for participation in health scheme, weak administration capacity for contributions collecting and poor structure, regulatory and supervisor and all in all its funding challenges, are the main factors that accompanies for years the health care system and as the result the contributions system for health insurance. The main economic factor is a little economic growth and a problem with which Albania has already begun to face. As a result Albania faces a greater inequity in the ability to receive health care. In order to evasion of contributions expected path, immediate measures administrative, managerial, and financial monitoring are needed. Mechanisms for revenue collection should be strengthened. Health care reform has been and will remain one of the major challenges of politics in Albania. Full implementation of its efficiency requires a broad political consensus.*

**Keywords:** health scheme, contribution, health care reform, Albania.

**JEL Classification:** I1, I13, I18, H51.

### **1. Introduction**

The Albanian health insurance system is a Bismarck model of HIS. Health services are provided by a mix of public and private health service providers. Recourses of public financing of the health sector are: State budget, contributions of compulsory health insurance (collected by GTD-SII)<sup>1</sup>, direct payments /co-payment and foreign finances. Public expenditures for health in 2013 are planed 2.56% of GDP. The State remains the major source of health care financing in Albania<sup>2</sup>. Compulsory health insurance scheme covers all the citizens in Republic of Albania (RA) with a permanent residence and also foreigners employed and insured in Albania. HII administers the health care scheme, provides and manages the compulsory health insurances in the RA. HII is the main purchaser of health services and also the main actor of the health care reforms. Participation in the scheme is based on the payment of contributions by; (i) **economically active persons** (employees, employers, self-employed, unpaid family employees, persons who receive revenues from their property on regular basis), (ii) **State**, which pays for economically non-active persons, (children, students, pensioners, unemployed, mothers on maternity leave, disabled people, persons living on assistance and economic aid, based on the consumption per capita of the healthcare during the successive year) and (iii) **voluntary insured persons**. Social health insurance contribution rate in Albania for salaried workers is 3.4%. Contributions for the

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<sup>1</sup>From 1995 up to 2003 the data for the number of contributors and contribution's revenue is taken from the Social Insurance Institute (SII) and from this year onwards from the General Directorate of Taxation (GDT).

<sup>2</sup>Other regional countries have a different composition (social insurance to tax funding), for example Czech Republic 90:10, Poland 84:16, Hungary 90:10 and Slovenia 93:7 (WHO Statistics, 2008).

employees are paid by employer and employee at (50:50). To the self-employed workers and voluntarily insured is 3% up to 7% of statutory minimum wage.

In Albania the contribution rate is at the lowest levels amongst the economies in transition in CEE region (Table 1). Healthcare systems in the regional countries is mostly financed through health insurance contributions, based on the Bismarck model – a mandatory health insurance system in which health insurance payments are deducted from incomes, with pooling of contributions and thus risks. Although in all countries of the region, mandatory payroll-based insurance has been established, the contribution rates differ widely.

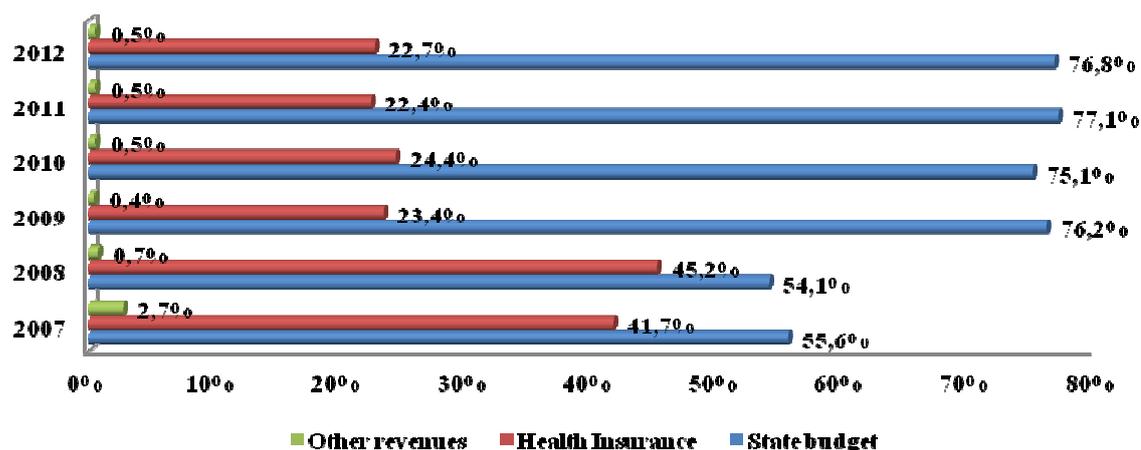
**Table 1** Social health insurance contribution rate in regional countries

Country	Contribution Rate for Salaried Workers (percent of payroll)	Employer: Employee shares
Albania	3.4	50:50
Czech Republic	13	66:33
Hungary	<b>14</b>	79:21
Romania	14	50:50
Macedonia	9.2	100:0
Montenegro	15	50:50
Serbia	15.9	50:50
Bulgaria	6	75:25
Slovakia	13 <sup>1/4</sup>	50:50
Slovenia	13 <sup>1/4</sup>	53:47
Bosnia - Herzegovina	17	24:76

Sources: Bredenkamp and Gagnolati (2007); Dixon et al. (2004); Preker et al. (2002).

The basic contribution rates for mandatory health insurance vary widely, from around 3-6% in Albania and Bulgaria, to 17% in Bosnia - Herzegovina.

Health services covered by HIS are; health services of the primary health care, hospital health care services and pharmaceuticals of the opened pharmaceutical network. The health services of HIS are funded through a mix of taxation and contributions of health insurances. HII manages a total budget of approximately 200 million Euros. This budget in 2013 is planned approximately 2% of GDP, while for three years, 2010-2012 the rate of 2.1% has not change. The scheme revenues in 2011 and 2012 came approximately 23% from health contributions and approximately 77% from State budget/tax funding (Figure 1). The State budget revenues remain the main sources not only for all health sectors, but also for the HIS. This misbalanced situation continuous since the HIS establishment in 1995.



**Figure 1** HIS Revenues, 2007 – 2011  
Source: HII data, author's calculations

The review above makes Albania one of the few countries in region, together with Bulgaria, where health insurance contributions are not the main source of health care financing (WHO, 2006).

## 2. Health insurance contributions in Albania – An economic analysis of the trend of contributor's number from 2007 – 2011.

The key problems, clearly evident, of HIS in Albania, are the small contributor's number for health insurance and some difficulties in collecting payroll taxes. The revenues are collected based of six contributors' categories: budget workers, non-budget workers, private firms, self - employed, agricultural private sector and voluntary contributors.

In order to analyze the problematic situation in the system of contributions for health insurance, I made an economic analysis of the number of contributors in 5 years, from 2007 to 2011, based on the average number of contributors, declared by SII to HII (Appendix, Table 2).

First I compared the number of contributors, according to six categories by finding the difference with the previous year in percentage (Table 3).

Second I calculated the indexes of change of contributors by category (Table 4).

Third I calculated the coefficient of the average annual growth in the number of contributors by categories.

### 2.1 The comparisons' results by health contributor's category

The comparisons show that despite of frequent fluctuations in the number of participants in the scheme, their level remains almost the same from year to year.

- Budget workers –compared to 2007, 2008 has the largest decreases, with about 9.4%. And compared to 2009, 2010 has the largest increase, with about 5.8%. For the entire period studied, from 2011 compared to 2007, this category is 1.7% decreased.
- Non-budget workers - the largest decrease is in 2008, compared to 2007, with about 37.1%. A small increase of 0.6% was only in 2011, compared to 2010. For the entire period from 2011 compared to 2007, this category has the greatest reduction (54%), of all categories.
- Private firms - is a category mainly resulting increased in 2011, compared to 2010 (9.3%). There is an increase of 19.3% in 2011 compared to 2007.
- Self-employed –The only reduction of the contributors' number in this category was in 2008 (8.5%), compared to 2007. The largest increase was in 2011, compared to

2010, with about 25%. For the entire period of five years, from 2011 compared to 2007, this category has an increase of 24.2%.

- Agricultural private sector – It is characterized by a non-stable situation. Only in these two years, 2009 and 2011, the contributors' number is increased. And for the period of five years this category has a decrease.
- Voluntary contributors - have the highest growth of all categories, with about 131.9% in five years. The only decrease is in 2011 compared to 2010.
- In total, for all categories, the number of contributors for five years, from 2007 to 2011 has a little increase of 2.6%. Only in 2008 result in a decrease of 10.5%, compared to 2007.

**Table 3** Compare numbers of contributors, according to six categories

Categories of Contributions	I 2008/2007	I 2009/2008	I 2010/2009	I 2011/2010	I 2011/2007
Budget workers	-9.4%	-1.5%	5.8%	4.1%	-1.7%
Non-budget workers	-37.1%	-13.5%	-15.9%	0.6%	-54.0%
Private firms	-4.2%	7.3%	6.3%	9.3%	19.3%
Self employed	-8.5%	6.2%	2.3%	25.0%	24.2%
Agricultural private sector	-10.6%	9.1%	-17.2%	13.7%	-8.2%
Voluntary contributors	14.1%	66.7%	30.0%	-6.2%	131.9%
<b>TOTAL Categories</b>	<b>-10.5%</b>	<b>3.2%</b>	<b>1.0%</b>	<b>10.0%</b>	<b>2.6%</b>

## 2.2 The average annual growth of contributors of HIS

From calculations of the contribution index categories, taking time basis in 2007, result:

**Table 4** The indexes of change of contributors by category

Categories of Contributions	I 2008/2007	I 2009/2008	I 2010/2009	I 2011/2010	I 2011/2007
Budget workers	0.91	0.98	1.06	1.04	0.98
Non-budget workers	0.63	0.86	0.84	1.01	0.46
Private firms	0.96	1.07	1.06	1.09	1.19
Self-employed	0.91	1.06	1.02	1.25	1.24
Agricultural private sector	0.89	1.09	0.83	1.14	0.92
Voluntary contributors	1.14	1.67	1.30	0.94	2.32
TOTAL	0.89	1.03	1.01	1.10	1.03

The average annual growth rate coefficient of the number of contributions by category, is calculated with two formulas:

$$\bar{K} = \sqrt[n]{I_1 \times I_2 \times I_3 \times \dots \times I_n} - 1 \quad (1)$$

For example,  $\bar{K}$  in "Budget Workers", where:

$$I_1 = I_{2008/2007} \quad I_2 = I_{2009/2008} \quad I_3 = I_{2010/2009} \quad I_{5-1} = I_{2011/2010}$$

$$\bar{K}_{\text{Budget workers}} = \sqrt[5]{0.91 \times 0.98 \times 1.06 \times 1.04} - 1 = \sqrt[5]{0.98} - 1 = 0.994 \text{ or } 99.49\%$$

$$\bar{K} = \sqrt[n-1]{\frac{q_n}{q_0}} \quad (2)$$

$\bar{K}$ - Average annual growth rate coefficient

$n = 5$ , number of years to study

$q_n$  = the number of contributors in 2011

$q_0$  = the number of contributors in 2007

For example,  $\bar{K}$  in “Budget Workers” results:

$$K = \sqrt[n-1]{\frac{q_n}{q_0}} = \sqrt[5-1]{\frac{138,645}{140,994}} = \sqrt[4]{0.98} = 0.994 \text{ or } 99.49\%$$

Both methods led to the similar results, reflected in **Table 5**.

Categories of Contributions	$\bar{K}$	$\bar{K}$ (%)
Budget workers	0.994	99.49%
Non-budget workers	0.823	82.35%
Private firms	1.044	104.44%
Self employed	1.055	105.52%
Agricultural private sector	0.979	97.93%
Voluntary contributors	1.240	123.41%

Even with a simple comparison, even of calculation of average annual growth rate coefficient for each contributor’s categories, I came to the same conclusions:

The contributor’s number in “Private firms” increased on average 4.44% each year during the period 2007-2011.

The contributor’s number in “Self-employed” increased on average 5.52% each year during the period 2007-2011.

The contributor’s number in “Voluntary contributors” increased on average 23.41% each year during the period 2007-2011.

There isn’t the average annual growth in the other three categories (“Budget workers”, “Non-budget workers” and “Agricultural private sector”).

The lack of growth in the contributor’s number in these categories, corresponding macroeconomic indicators, for the same period 2007-2011 (Bank of Albania, 2013). For examples, the employment rate of public sector in total employment for 2011 was 17.8%, against 18.1% in 2010 and 18.5% in 2009. Also the employment rate of agricultural private sector in total employment for 2011 was 54.6%, against 55.3% in 2010 and 55.2% in 2009.

The limited contributor’s number in the health insurance scheme, reflected in the low level of contributions for health care in Albania and its performance.

### **3 The lack of political decision-making - Performance and main HIS challenges**

HIS financing should respond its continuous expansion pace. Implementation of effective reforms in the three levels of health services: primary, secondary and tertiary, must be accompanied by increased contributions funding sources as well as from the State budget. But in fact, it turns out that there are not taken the necessary measures to increase the number of contributors in the scheme and as a result to increase the revenues from them. There were ongoing discussions on the change of contributions’ rate in Albania, from the World Bank in

2006 as well as from the HII's own proposals<sup>3</sup>. Even in the new law for health insurance in Albania, was left again the contribution rate of 3.4%, with some minor changes in the basis of calculating the contribution<sup>4</sup>. The changes aim to able the increasing of financing sources for the health scheme, as well as respect for its principles.

### 3.1 Problems in the collection of health contributions

The process of collecting contributions for health insurance by the tax authorities, not only hadn't reached the expectations (increase of the number of contributions and better administration of the process), but it has led to various anomalies, such as delays in data reporting and inaccuracies of the data. It was anticipated that these authorities (SII and GDT), would identify the on-line contributors and the incomes from health insurance contributions. In the first year of implementation of the Law (2003), contributions poured directly to the HII. With the intervention of the Ministry of Finance, the contributions are now collected by the tax authorities, together with social insurance contributions, and then they are transferred to a treasury account in the SII, which transfers in HII parts of the contributions collected, after the calculations based on different contributions categories. Delays in the pour of contributions for health insurance, by authorities that administrate them, errors in calculations, reporting of inaccurate data in the bank, and also the barriers to the treasury structures delivery, have limited the possibility to use even those few contributions that are collected.

### 3.2 The scheme lacked efficiency - Impact in the contributors' level in the HIS

Health insurance Schemes, on the Basis of Contributions, have about 18 years, that is applied in Albania. BUT the problem is that this scheme has never functioned with a full efficiency. Before the fall of the Communist regime, the health system in Albania was modelled on the Soviet Semashko system of universal health care coverage, with a virtually exclusive role for the state in financing and delivery. Albania introduced social health insurance in 1995, but the pace of reform of health financing has been slow (Nuri, 2002). From 1995 to 2007 HIS covered mostly the expenditures of the pharmaceuticals drugs' list and salaries of general practitioners in primary services. Only in 2007, when has become the full involvement of the primary health care (PHC), it can be said that HIS began to function fully, at least at this level of services (based on current indicators until now, can say that the scheme is successful in PHC). Despite the problems that accompany the pharmaceutical sector HII contractual relations as service buyers with pharmaceutical service providers, are consolidated. Even though in 2009 the public hospital service legally passed under the administration of HIS, reform in this sector is failed. This mainly due to lack of political will, due to the strong social impact, that will accompany the full implementation of this reform. Malfunction with full efficiency of the financial reform in the health system and the lack of incentive mechanisms to increase the number of participants in the scheme, leads to an unfair treatment of insured persons, to those uninsured.<sup>5</sup> The same benefits for both categories, insured and not insured ones, do not stimulate the category of not insured to insure themselves. This is a pointed problem of the public hospital service, where even the costs of treatment are higher. For example an uninsured patient pay a minimal tariff, of € 21 in the hospital (less for a visit to GP), and this persons can profit even the operation for free. This situation adds costs for self-insurance persons and for the State budget.

<sup>3</sup>The proposal to increase the rate contribution from 3.4% to 7% was not taken into account.

<sup>4</sup>Basis for calculating contributions for economically inactive persons is: consumption per capita of the health care, indexed with the inflation rate, consumption per capita for health services.

<sup>5</sup>As health expenditures are similar to those insured and not insured persons, health insurance does not protect participant in the scheme by paying a personal significantly percentage of costs.

Incomplete reforms in the financing of the health system in Albania (mainly the reform of public hospitals), are a more reason for the not fully functioning of HIS. Only after several years of operation with full efficiency of the health scheme<sup>6</sup>, we can say, if it is appropriate one for Albania, to continue or to change this scheme, based on the general taxation (Beveridge scheme is arguing today, as required by the Albanian opposition, even for pre-election effects)<sup>7</sup>.

### **3.3 The economic factors tend to contribute negatively to a disable environment for the contribution of HIS in Albania.**

- Informal sector employment causes: 1. difficult to administering mandate payroll tax on employers and /or employees, 2. difficult to locating employers and collecting premiums. Based to the official data of Bank of Albania, there is an increase of informal sector employees, because of the economic crises of these years. This situation influenced the reduction of contributors. In 2011 from a total labour force of approximately 1.1 million, just 478 thousand of them contribute to the health scheme (Appendix, Table 2 and Table 6).
- Following the widespread informal sector, the contribution evasion in private sector appears in two forms: less people declared themselves employed and lower wages are declared. Informal sector workers are facing two different elections: their contributions to of social and health insurance to be payee by employer, which will reduce furthermore the incomes, or not to pay insurance social and health contributions and thus they receive more cash. It is understandable that most of workers in the informal sector will choose the second option.
- Low wages and salaries: 1. increase economic burden of payroll tax and lack to finance broader benefit entitlements<sup>8</sup> and 2. decrease the opportunity to finance broader benefit entitlements.
- High poverty rate increase need subsidize membership of poor households.
- Inefficiently functioning provider networks: 1. aggravate access by members to providers, 2. reduce choice of providers and also the possibility of quality-based competition among providers.
- Little human resource capacities bring the disability to manage SHI and monitor and evaluate quality.
- Weak administrative support is less available for banking, accounting and legal support.
- The lack of government capacity to regulate is reflected to the capacity for regulating the quality and manages grievance procedures.

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<sup>6</sup>Many of countries have established the principle of universal coverage via SHI. This process took 127 years to achieve in Germany, 118 in Belgium, 79 in Austria, 72 in Luxembourg, 48 in Costa Rica and 36 in Japan.

<sup>7</sup>Beveridge-system: state financed system – example: Great Britain, Bismarck-system: the system is financed by contributions to a social security or insurance system – example Germany, Semashko-system: completely state-controlled system and Market-oriented systems: example USA.

<sup>8</sup>The major of the contributors of HIS for 2011 are budget workers (29%) and workers in private firms (38%).

### 3.3.1 The macroeconomic indicators and Economic Challenges

According to the official data for 5 years<sup>9</sup>, Albania has an annual real growth of GDP in 2011, but compared to 2007 there is a decrease of 2.8%. In 2011, per capita income was € 2,959; the official unemployment rate is 12.7% (almost the same level in these five years) and 18.5% of the population lives below poverty line. There is no increase of employment rate in the period of five years. The labor force report of employment: unemployment was (86:14). Just 15.4% of labor force works in public sector, or 17.8% of total employed. The employment of budget workers has a little reduction in 2011, compared to the other years. The employers in the agriculture private sector take the major part of the total employment in Albania, 54.6% in 2011 (INSTAT, 2011, 2013).

The financing of HII still remains a major challenge. A country's level of economic development and its economic structure influence how many people can be covered and how rapidly HIS can expand toward universal coverage.

Public expenditures for health in 2013 are planned only 2.56% of GDP, the lower figures, from 2008. In terms of an economic recession<sup>10</sup>, the health sector will face difficulties in realization with efficiency in the health reforms undertaken. My country also faces the problem with high levels of unemployment, low wages and large informal sectors; the formal employment base for generating resources is extremely small in relation to need and provides considerable scope for the avoidance of payment. The health care contributions increase the cost of labor regardless of who pays them (this encourages employers to hire workers on temporary contracts, without registering them). If health insurance costs for employers were partly reduced and shifted to the government budget, labor costs would be proportionately reduced without reducing net wages, which would most likely encourage employers to create new jobs. Health insurance reform is thus closely related to the issues of labor market flexibility and opportunities for increased employment (Mihaljek, 2008). On the other hand, the contribution incentives mechanisms for the active labor force are overall weak, and the health scheme provides limited benefits (Avdi, 2011).

In Albanian economy the high level of the informal payments can create several negative effects on health system performance. Informal payment can have implications in governance of a health system and negatively affect access, equity, efficiency and utilization of health care services. World Bank<sup>11</sup> and INSTAT<sup>12</sup> have accounted the situation of informal payments in Albania.

Based on the results of official data there is the same situation even today. The most patients have to pay under the table for health care and that unofficial payments represent the most relevant share of individual health expenditure (approximately 60% of the health expenditures). Regardless of the reasons behind, the fact is that household expenditures on health does not differ between insured and uninsured. This is a fact that the insurance status does not have measurable effect on out-of-pocket spendings. If people notice that contributing

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<sup>9</sup> Appendix, Table 6

<sup>10</sup> Appendix, Table 6

<sup>11</sup> The effective coverage by HII is limited and only about one-third of the active work force makes contributions.

<sup>12</sup> Data in the Living Standards Measurement Survey (LSMS) conducted in Albania, by comparing 2005 - 2008 were analyzed the informal payment and the access to health care services, in order to find out how the situation had changed over this three-year period. At the macro level, analysis identified that in 2005 and 2008 the prevalence of patients making informal payments in various health settings varied between about 18% and 53%, the highest prevalence being in the hospital care setting. Household survey data show that about only 40% of the population is effectively covered by HII, mainly concentrated in urban areas and the upper income quintiles, with significant regional variations.

to health insurance does not prevent them from relevant health expenditures and that they have to pay practically the same amounts of money out of pocket as those citizens which are not affiliated to the HII, they will probably become more reluctant to affiliate to health insurance and insurance coverage might further decrease. Given the level of poverty in the country, one of the reasons for non-payment of contributions, is the lack of ability to pay out a portion of the population.

### **3.3.2 Political challenges**

Health care reform has been and will remain one of the major challenges of politics in Albania. Given the strong social impact, which accompanies its full implementation, so far no government has “dared” to undertake it fully. Full implementation of its efficiency requires a broad political consensus. Each political party will come to governing after June elections, should start comprehensive reform of the HIS, in the first year of its mandate.

There are no plans to allocate general revenue to supplement health insurance, and the current 3.4% of wage contributions (half from employer and half from employee) from contributors is insufficient to cover costs. More than half of total health care costs are said to be out of pocket payments by patients.

The focus of the government isn't on increasing enrollment to close the financing gap, but there is no analysis which suggests this will be feasible or adequate to generate needed revenues.

Should increase accountability and collaboration of the institutions responsible for the process of administration and management of contributions for HIS in Albania. In this electoral year, in Albania is turned the debate about the funding model of the health insurance scheme, at the first view with a lot of problems, defects and malfunctions. Apparently, the continuing and the possible changes of the HIS are depended to the June elections.

However dictated by the situation, I think that by policy makers should be considered a potential increase in health contributions rate, accompanied by the relevant legal changes (even is delayed). In terms of extending the health scheme and full implementation of the reform of hospital services, better functioning system will stimulate contributions to the health system decentralization, internal competition, the creation of the concept of hospital-enterprise as a fundamental element for the development of hospital. In this way will stimulate not only public but also private sector, considering that part of the health system and creating the necessary space for competition and for the creation of advanced models of the health system. The reform of public hospital sector should be implemented as soon as possible. Although this reform has in fact begun in 2009, until now, the HII has done just the transfer of funds for salaries and hospital equipment.

Abnormalities are mainly related to the payment system and the provision of services for uninsured persons. Uninsured patients versus only a negligible fee, profit high-cost health services, such as all types of surgeries and hospital examinations. But this way of benefit, don't force them to pay.

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. This should be considered the reason for stimulating in an indirect way the bribes and other corruptive elements in this sector. There is a lack of responsibility from the institutions which draft the budget and accomplish budgetary policies and the lack of political consensus (Avdi, 2012).

Over all, it is important that health and finance specialists, not politicians to assess realistically how much funding for health services can be raised through HIS contributions. This must take into account incomes, levels of other deductions and taxes, the labour market structure, the acceptability of paying contributions.

#### 4 Conclusions and Recommendations

In Albania, partly scheme function, an informal labor market, lack of incentives for participation in health scheme, weak administration capacity for contributions collecting and poor structure, regulatory and supervisor and all in all its funding challenges, are the main factors that accompanies for years the health care system and as the result the contributions system for health insurance. The main economic factor is a little economic growth and a problem with which Albania has already begun to face. As a result Albania faces a greater inequity in the ability to receive health care.

Health insurance reform is thus closely related to the issues of labor market flexibility and opportunities for increased employment.

The successful introduction and extension of HIS is dependent on my country's institutional and organizational capacity. This relates to the three subfunctions of collection, pooling and purchasing, which are undertaken by different organizations and actors.

In order to evasion of contributions expected path, immediate measures administrative, managerial, and financial monitoring are needed. Mechanisms for revenue collection should be strengthened. Contributions for health and social insurance (27.9%), should be deposited separately, due to the different period of benefit of each scheme, or the inability to pay part of the social insurance contribution (the social contribution's rate is higher, 24.5%), or for lack of wish, to pay. This becomes an obstacle for the payment of contributions for health insurance. Revenue collection should be done by HII because of the management effect. Staff should be equipped to manage the collection of contributions and support the process of identifying entitlements.

Informal payments are partly a reaction to the health care system, particularly of the managers of health care, the lack of financial resources and patients' response to a system that is unable to provide adequate access to basic services. In this situation is necessary to: apply copayment differentiated according to the social categories with different incomes. To stimulate participation in the health scheme by strengthening protection mechanisms for groups with low income. In the circumstances of a wide spread informal economy another 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. HII should play a key role to inform the population the benefits of the scheme about.

Governments should ensure that limited resources are more efficiently targeted to ensure access to basic services. Needed to strengthen administrative and technical capacity by HII as main buyers of the health services, both through the development of information systems that can distribute accurate time information from providers, and through the training of personnel. Many problems related to the HIS require a long-term strategy in the health sector reforms.

#### 5 Appendix

**Table 2** Contributor's number for study, in HIS in Albania 2007-2011

<b>Categories of Contributions</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
Budget workers	140,994	127,783	125,856	133,211	138,645
Non-budget workers	47,101	29,611	25,612	21,546	21,677
Private firms	152,580	146,139	156,743	166,612	182,057
Self employed	63,502	58,101	61,690	63,082	78,839
Agricultural private sector	61,495	55,000	60,000	49,664	56,453
Voluntary contributors	263	300	500	650	610
<b>TOTAL Categories</b>	<b>465,935</b>	<b>416,934</b>	<b>430,401</b>	<b>434,765</b>	<b>478,281</b>

Sources: HII, SII

**Table 6** Macroeconomic indicators, 2007 - 2011

Years	Annual real growth of GDP at constant prices (%)	Per capita income EURO	Labor market	
			Employment rate (%)	Unemployment rate (%)
2007	5.9	2,470.5	44.7	13.2
2008	7.5	2,800.8	45.8	12.7
2009	3.3	2,746.5	41.9	13.8
2010	3.8	2,782.8	42.3	13.3
2011	3.1	2,959.7	42.1	12.7

Sources: INSTAT, Ministry of Finance, Bank of Albania

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