Is it worth to pay health insurance?

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Abstract

This paper addresses the efficiency of health care system in Albania vis-à-vis citizens' social solidarity demonstrated through financial contributions to respond to the dilemma of Health Care reform in Albania, namely "financing the right mix of public-private provision of health care through more public funds, ensured either by the state or by the society-contribution". The evidence-based analysis of budgets allocated to health care system is used to formulate findings regarding "health care system efficiency" and draw conclusions vis-à-vis the relevance of social solidarity.

There is a belief that "social solidarity" should raise awareness about people's right and boost investments into health care services. However, evidence argues that such belief is not justified. The public health care services do not provide equality neither of utilization nor of access in a time when private provision does not offer a solution to the problem. Therefore, the burden is returned on Public Health Care policies which should make the effective use of "social solidarity" and guarantee that it pays off for the best of citizens.
The paper is composed of four sections. Section 1 provides rationale for discussion focused at "Social Solidarity" as the key argument. Section 2 explain methods of research. Section 3 provides an overview of health care system in Albania, addressing some critical concerns that deny the right to health care for certain groups of society. Section 4 advances arguments regarding the way in which "social solidarity" is misused in Albania, leading us to key findings, whilst the last section formulates some conclusions, responding to the addressed questions as well as tackling the role of civic and social education of citizens in addition to law enforcement to guarantee that social solidarity pays off.

***Key words**: Public goods, social solidarity, equality of utilization, equality of access, efficiency, health insurance contributions, health care.*

Social Solidarity and the rationales for discussion

Social solidarity emphasizes the interdependence between individuals in a society, which allows individuals to feel that they can enhance the lives of others. It is a core principle of collective action and is founded on shared values and beliefs among different groups in society. (Douwes et al, 2018).

According to Irina Vladimirovna Naletova et al, upon considering the principal approaches to studying social solidarity it should be noted that this idea is one of the most developed ones in classical sociology. It ranks considerably high in the investigations of the foundations and preconditions of social order. Almost all classics of sociology (A. Comte, H. Spencer, K. Marx, G. Simmel, etc.) have considered the problem of solidarity in their works. The scientists aimed to identify the conditions, the bases, and the components of social solidarity.

However, for countries in transition from a centrally planned to a market economy, like Albania, the concept of Social Solidarity is not new. Communist countries system was supposed to be founded on Social Solidarity. There has been a tendency in Western literature to consider income distribution in communist countries an advantage of that system because it brought about a levelling of the whole society, therefore it influenced a sort of "equal access to social welfare for all citizens on the basis of social solidarity". *As a matter of fact, the society was far from being "solidary", first and foremost due to the lack of freedom, participation and the deny of rights, which resulted not only on the poor economic development, but also on the rationing of social welfare services, including health care.*

It is generally accepted that low level of social development has a considerable impact on the development of social capital, which is used to understand and explain the social rules and relations intertwined into the social structures of the society. It is precisely the models of social relations that allow individuals to coordinate their actions to achieve the desired purposes (Putnam, 1993).

Recently, a young researcher, Dr. Ashiku, has tried to assess "social capital in Albania" by using two measures, namely interpersonal and institutional trust. She concludes that Albanian society is characterized by low levels of interpersonal and institutional trust, including lack of confidence in judiciary, police, political parties, government etc. "If social capital is understood as "an individual sacrifice made to promote cooperation with others", one can easily conclude that Albanians are not willing to forsake personal interests because they understand this 'sacrifice' as in vain as there is a huge suspicion that they will not find reciprocity of this altruistic behaviour in the future" (Ashiku, 2014, p.475). She also confirms that social capital in Albania resides only in the family and is vitalized through family ties.

Hence, the abuse with "social solidarity" and its replacement with superficial morals based on unreal transitory concepts like Party and its connected institutions, brought about a vacuum in social capital because people lost trust. This gradually destroyed the natural collective sense of humanity, eroding civil culture and the historical memory of generations, which had and continues to have a considerable impact on the way in which people still perceive "Social Solidarity".

Professor Tomes, in the late 1990s argued that the process of transformation of communism to capitalism, as a unique social experience couldn't be compared to transformation processes occurring in the countries of Latin America, Asia or Africa exactly because in the latter countries, transformation was related to the restructuring of capitalist economies and did not involve a fundamental change of the whole economic and political system as in CEEC. "Although in Central and Eastern European Countries (CEEC) the tools employed in the reform process may be similar, but the socio-economic environment shall always call for specific treatment, to be acceptable to the people" (Tomes, 1998).

This view does not contradict most analysis concerning political economy of capitalism, which considers 'entrepreneurship, free initiative, net profit and competition' as the engine to promote development, putting aside the concept of 'social development'. It has been generally accepted that economic growth enables increased social welfare expenditure and welfare state expansion.

Scholarship on the welfare state development in the western European countries demonstrates that there are direct linkages between welfare, democracy and capitalism (Esping-Andersen, G. (1990).

But in CEEC, the welfare state came into being under the diametrically opposite conditions of extended one-party rule and a planned economy. In post-Communist CEEC, it is rather democracy and capitalism that have been developing within the framework of an established welfare state.

The right to health care is enshrined in international law and in the basic law of the Albanian state. The new Constitution of the Republic of Albania recognizes the right to health care for all its citizens, sanctioning the principles of universal coverage. More specifically, in Article 55 thereof it states: "Citizens enjoy in an equal manner the right to health care from the state. Everyone has the right to health insurance in accordance with the procedure provided by law" (OSCE, https://www.osce.org).

However, the issue of health care's right fulfillment is not only a matter of legislation or institutional practices. It is a question of public policies, grounded on a solid base of social, civic, and institutional responsibilities.

"Healthcare are the services provided to persons or communities by health service providers aiming at promoting, maintaining, monitoring or restoring health." (WHO, 2004). As such, Health care comprises a set of services that are

provided to the citizens because they are required by him. If we imagine health care as a commodity, then there is a market, where this commodity is traded at a certain price that depends on the ratio of demand to supply. But on the other hand, health care is not an ordinary commodity. Health care is a "public good" (Barr, p. 182) because it is non - rivalrous and non - excludable.

If "health care "would be provided in the free market, than the issue of "quantity" and "price "would deem necessary to raise in this discussion. But, as long as "health care "is a public good, then it is the government, as the primary duty bearer, to ensure the realization of the "citizens 'right to access and utilize health care services based on their needs, guaranteeing "efficiency" and "equality", alike.

Yet, citizens themselves, as right holders play a crucial role. They exercise social responsibilities, relying on social solidarity, demonstrated through the payment of taxes and contributions, which makes them the most and foremost guarantees of the functioning of health care. Hence, the society has to respond to their needs, not because of generosity, but because of the responsibility to return the share of investment through equitable delivery of quality health care services.

Hitherto what was explained is neither new nor non-elaborated. What concerns us relates to the problems of health care system in Albania during transition, to discover the relevance of social solidarity as a social and financial instrument alike, to respond to the dilemma of financing the right mix of public-private provision of health care through more public funds, ensured either by the state or by the society-contribution.

Although the post-communist governments in Albania struggled to "allocate efficiently resources to boost growth and equitable delivery of public services, the vacuum in social capital intertwined with weak law enforcement, dissolves the role of "Social Solidarity", whilst people continue to lose the confidence on the institutions.

This paper argues that without ignoring the role of financial resources allocated to health care sector, health care efficiency plays the most significant role, while laying the foundation for equitable delivery of health care services, which in the end contributes that citizens enjoy the right to health care.

Methodology

Based on the literature, Efficiency is doing things in the most economical way (Drucker PF, 1966, p.25). Although health care is defined as a "Public good ", still it is possible to measure "efficiency "comparing outputs delivered by the system with financial inputs. Theoretically, although the core idea of efficiency is easy to understand in principle, in practice it can be challenging to measure and interpret

metrics, especially how can we understand and evaluate efficiency in health systems? (Cylus, Papanicolas&Smith, 2017, p.7)

Based on the model suggested by Cylus, Papanicolas & Smith in their Policy Brief 27 on "Health systems and policy analysis ", a similar analytic framework that seeks to facilitate the interpretation of health system efficiency measures, is suggested. To assess efficiency, the following aspects are considered:

- the entity to be assessed: Public Health Care Services.
- the outputs (or outcomes) under consideration: Equality in access (% of uncovered people either by insurance or by services); Equality in utilization (health contributions per capita versus health expenditure per capita) and some other key health indicators.
- the inputs under consideration: Health care resources such as staff and health care premises, Health expenditure by revenues and by financing schemes.
- the external influences on attainment: Informality of labour market.
- the links with the rest of the health system: Dual health insurance contribution in compulsory and private schemes.

Equality per se means whether individuals enjoy the same opportunities, though equality in health care is strongly connected to accessibility and utilization of appropriate and qualitative services, alike. Hence, relevant data are used to illustrate financial inputs of health care system and outputs of its management, which shed lights on the misuse of "Social solidarity ", demonstrated through payment of taxes and health insurance contributions.

To reach the purpose, a careful desk review analysis of legislation and budgets allocated to health sector is conducted. Using available data from secondary sources on public and private health care services, the analysis focuses on health expenditures from the viewpoint of "contributors". The elaborated data help to formulate an evidence-based response regarding health care efficiency and its impact on "Equality ", assessed through indicators of "Access "and "Utilization ".

Overview of health care system in Albania and its functioning

Republic of Albania, a small country in the Balkan peninsula, with an area of 28.748 square kilometers and a population of 2.845million (INSTAT, 2020), has been witness to almost three decades of rapid change and deep transformation since the collapse of the Berlin wall. These changes first, have influenced economic, social and political landscapes, and second, have unearthed a range of issues, which were previously hidden or suppressed by political regime. The transition period has

also been marked by a series of upheavals and crises, from economic shocks and civil unrest to emigratory waves (the most significant in 1990,1991,1997-1998) due to which the country lost almost 20 percent of its population (INSTAT, 2013).

Albania characterized by the historically heterogeneous governance marked by striking disregard of the stages, spent 45 years, from 1945 until 1990, under the most oppressive, authoritarian political system in Europe, from which it has been slowly emerging for the past 30 years. Since the fall of the communist regime in 1991, the country has embarked on a new path aimed at establishing democratic regimes through the protection of human rights and at raising the standard of living.

Since then, Albania has made considerable progress, led by long-standing dream of European Integration. As such, on 24 June 2014, the European Commission granted EU-candidate status to Albania due to its demonstrated progress in legislative reform and political dialogue, and the latest decision guarantees the opening of negotiations for "Membership Status" soon.

The end of 45 years of communist rule and establishment of a multiparty democracy in the early 1990s have proven challenging. Despite reforms and its wealth of natural resources, Albania was and remains one of the poorest countries in Europe with high absolute and relative poverty rates. The number of people living in poverty increased from 12.4 percent in 2008 to 14.3percent in 2012, and extreme poverty rose from 1.2 percent in 2008 to 2 percent (INSTAT, 2013) for both urban and rural areas. Because of revisions in PPP exchange rates, poverty headcount ratio measured as the percentage of the population living on less than $5.50 a day at 2011 international prices, cannot compare with the previous evidence. Data showed that poverty rate for 2017 was 33.80%, a 3.2% decline from 2014(World Bank, 2020).

Albania also remains one of the most corrupted countries of the world and the most corrupted in the Balkans, together with Kosovo, ranked 99 out of 180 countries (http://www.transparency.org, 2019). In general, the fragile growth rates as well as structural economic reform are not sufficient to ensure country's strategic objectives. The failure to address chronic and extensive unemployment, disparities and social exclusion, poor levels of government investments in social and human development as well as informality of the economy, are considered critical weaknesses vis-à-vis the sustainable development of the country.

A look at key health care performance data shows that health indicators in Albania are among the lowest within CEE countries. Although life expectancy in Albania has increased steadily in the past twenty years in both sexes (in males: from 67 years in 1990 to 76.3 years in 2019; in females: from 71 years in 1990 to 79.9 years in 2019 (WHO, 2019), child mortality, infant mortality and maternal mortality rates are high in comparison with average rates for EU countries (CCA, 2020).

In Albania, Primary Health Care (PHC) is organized through a public network of providers of health services. Each of the 61 municipalities has PHC centres with affiliated health post–ambulatories. On average, one PHC centre offers services to 8.000–20.000 inhabitants, varying for urban and rural areas, registering a doctor: patient ratio of 1:2500 and nurse: patient ratio of 1:400 (WHO, 2018).

The Albanian health care system, as most of former communist countries inherited the Soviet "Semashko" model, which would no longer respond to the needs of citizens due to the changes first and foremost, of economic relations, from centrally planned to a market economy.

There has been a tendency in Western literature to consider income distribution in communist countries an advantage of that system because it brought about a levelling of the whole society, therefore it influenced a sort of "equal access to social welfare for all citizens". These countries, even the smaller ones like Albania, are included among modern societies when only physical and human capital are considered: the spread of literacy, urban population, modern communication and information, access to health care services, social protection of people in need, provision of contributory and non-contributory benefits, protection of cultural heritage and art as well as encouragement of research and development (Ymeraj, 2003, p.20).

It appeared there was no need for intervention in the health services, because it was considered by no means as the biggest advantageous of the socialist state. However, the critical point related to the quality the health care services were produced. Perhaps in terms of quantity "equal access" was achieved. Data on number of institutions and respective staff bring in sufficient evidence on the "supply side", whilst equality vis-à-vis demand (beneficiaries), was not considered at all, especially in rural and remote areas.

The basic concept was rationing in the delivery of health care, while selectivity was the result. Imposed "egalitarism" for the masses was achieved in conditions through uniform rewards (rations) with preferences for the "new class" based on political principles other than regular achievement in economic activities (Tomes, p.15). Therefore, the transformation of health care system was of utmost importance not only to respond to the citizens 'needs but to guarantee the realization of health care rights, as well.

The reformation of health care system was challenged by critical decision making of the modes to finance health care services and guarantee a universal coverage, regardless the insufficiency of state revenues. Hence, the first public policy response was the delivery of services, funded by the state budget through general taxation, pushing the health care system towards the Beveridge model.

However, alongside the Beveridge model, experts suggested the building of pillars of Bismark system, based on the direct contributions of citizens, which

proved to be difficult due to lack of structures to collect contributions. Despite impediments, the Institute of Health Care Insurance (since 2014, it was transformed into Compulsory Health Care Insurance Fund, CHCIF) was established in 1994, whilst the first law on Health Insurance was adopted on 13 October of the same year (Beci, Belishova, Kola, 2015, p.22).

As self-governing body, the fund has regulatory functions with respect to outpatient health services. The health insurance system is based on statutory insurance that is thus compulsory and regulated by law. CHCIF covers primary health care and some of the cost drugs in the reimbursement list and some of the costs of hospital care. Copayments on both were introduced in 2008. It is funded by a 3.4% charge on gross salaries.

The Law 10383 dated 24 February 2011, that took effect in 2013, specifies that membership in the CHCIF is mandatory for employees and other economically active persons, who must pay contributions to the tax authority to obtain benefits. The Government transfers funds to the CHCIF to cover economically inactive people, such as children aged under 18 years, students under 25 years, pensioners (the retirement age is 65 years for men and 60 years for women), people registered to receive social assistance or disability benefits, registered unemployed people, asylum seekers and a few other categories set out in special laws. CHCIF membership is voluntary for self-employed people, small family businesses and farmers. Uninsured people are entitled to free emergency care (since 2013), a free annual basic health check-up (since 2015), and free visits to GPs (since 2017) (CHIF 2013; 2016; 20017; 2018).

In 2008, private health insurance was also established by private insurance companies. Although the majority of health care services is provided by public sector (42 hospitals, 413 health care centers), (Health Care Strategy, 2016-2020), private sector is gaining space rapidly (10 private hospitals, 111 diagnostic medical centers and 229 diagnostic laboratories), (Uruçi&Scalera, 2014).

The Ministry of Health and Social Welfare is responsible for health policy and legislation. It plays a supervisory and facilitating role among the numerous actors involved in health care, with several functions being shared with, or delegated to, the 12 Regions, although the degree of decentralization is deeper only in Tirana, the capitol. In 2018, reform on organizing the service provision established the institution of the Operator of the Health Services under the authority of the Ministry of Health and Social Protection as an intermediate level of governance between the central level and 36 directorates of public health in 61 municipalities.

CHCIF is the single buyer in the Albanian healthcare system. The money, pooled there from different resources: general government budget, social contributions, etc.., are used to buy services from all public primary, secondary and tertiary health services and some private institutions that are contracted by the CHCIF.

In general, main characteristics of the Albanian health care system are:

- Mostly centralized, with tendencies to decentralize, although very few competencies are delegated to regional authorities and local government.
- Aims to provide universal coverage, though around 70% of population is covered, respectively 67% from general taxation and 33% through statutory insurance. (Table 2).
- Health expenditure is funded through public funds, collected from compulsory health insurance contributions and taxation, although out-of-pocket payments comprise almost 50%. Despite the establishment and development of Health Private Insurance, it is not complementary to Compulsory Health Insurance system. In the contrary, it duplicates the Compulsory Insurance system.
- Mixed service provision – public and private

During almost three decades of reforms, despite improvements, the legacy of the Semashko system still remain visible especially in the state ownership of public healthcare institutions, public provision of the services, as well as the funding from the general tax base. (Tomini, S. et al, 2015, p.1).

WHO data show that since 2013, the total health care expenditure for the country stacked at 5.3 to 5.4 of its GDP (WHO, Global Health Expenditure Database, 2018), much lower than the average 8.5% for the EU15 countries (Ibid). However, only about 48.4% of the total health care spending in Albania comes from the general state budget (Ibid), while the share of private expenditures and out-of-pocket expenditures is considerably high, 45% in 2018, although it was 60% in 2000 (Ibid). Reasonably, the utilization of health insurance and of taxation, namely of Social Solidarity, attracts the attention on the effects on efficiency of the health care services, and beyond that, on the realization of the right to health care. Although a full analysis of the economic pattern is not possible, the general framework of relations and interactions in which transition develops has to be borne in mind. Undoubtedly, this influences the controversial opinions about the production of public services and the way they have to be provided to the citizens. And more importantly, what are the main policy implications for equitable delivery of health care services?

Key findings

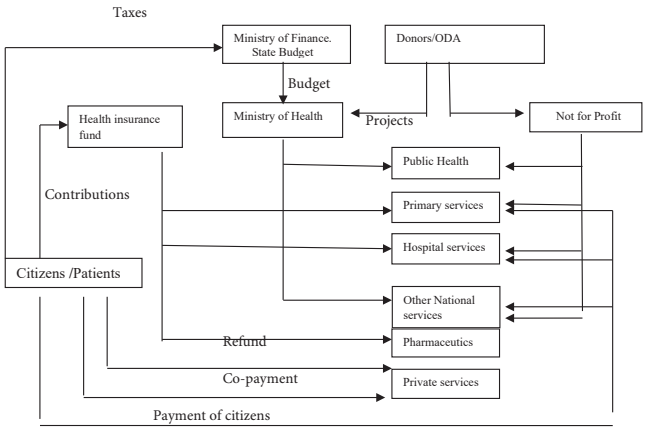
Organization, management and finance of health care in Albania is guided by objectives of the National Strategy for Development and Integration, 2014-2020 in which financial resources are translated into certain social objectives, notably:

"Our Policies in the health sector seek to ensure equitable access to health services, better service delivery quality and improved financial efficiency of the health system" (NSDI, p.31).

To finance a health care system, money has to be transferred from the population or patient – the first party, to the service provider - the second party. Fund for Compulsory Health Care Insurance is the link between the first and the second, which has to pay or to ensure health expenses for beneficiaries for the times when they are patients. The aim is to share the costs for medical care between the sick and the -healthy and to adjust for different levels of ability to pay. This mechanism of solidarity reflects consensus in Albania that health care is a social responsibility.

The structure of financing the health sector is presented in the following scheme.

FIGURE 1: Resource flow scheme



Source: Ministry of Finance, Budget Department.

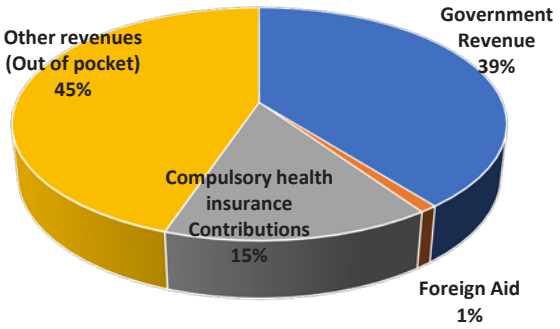
Health care is funded by (see figure 2, year 2018):

- Transfers from government revenue.
- Social Insurance Contribution (portion from Health Insurance).
- Other revenue not classified (Out of pocket payments).
- Transfers distributed by government from foreign origin.
- Foreign aid

As figure 2 shows, "Other revenues, out-of-pocket payments" constitute for almost half of revenues of health expenditures, while transfers from government and health insurance contributions counts for 55% of total revenue. This evidence

clearly challenges the issue of accessibility to health care, which seems to be conditioned by the availability of income.

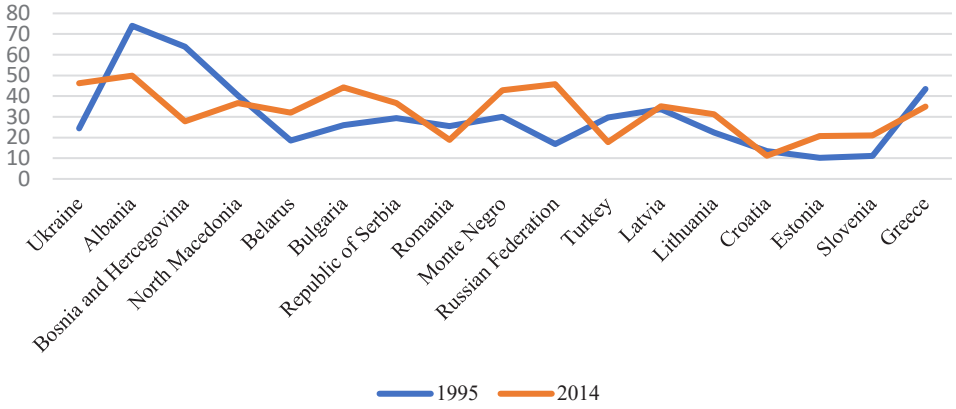
FIGURE 2: Health expenditures by revenues, year 2018



Source: Global Health Expenditure Data base, WHO.

The above-described concern is confirmed by another data, that regard the weight of out-of-pocket money as a percentage of Health Expenditure in Albania from 1995 to 2014, compared to Balkan and East European countries (figure 3). As it is observed, although the proportion of out-of-pocket versus health expenditure in Albania has decreased from 70% to 50%, it still remains the highest.

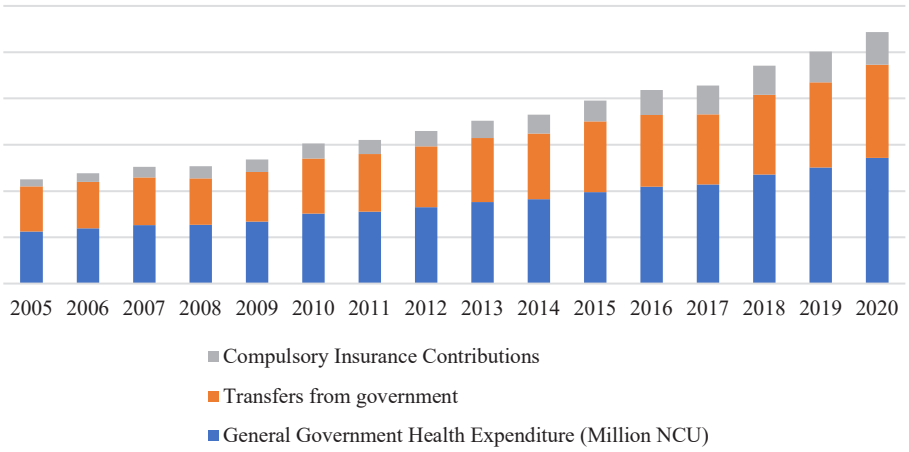
FIGURE 3: Out of pocket as % of Total Health expenditure in Balkan and East European countries, 1995-2014



Source: Tomini, S et al, 2015

Since the establishment of Health Insurance scheme, the contributions have significantly increased, even compared to "Transfers from government" as figure 4 shows. However, they still compose only 27% of the total health expenditure.

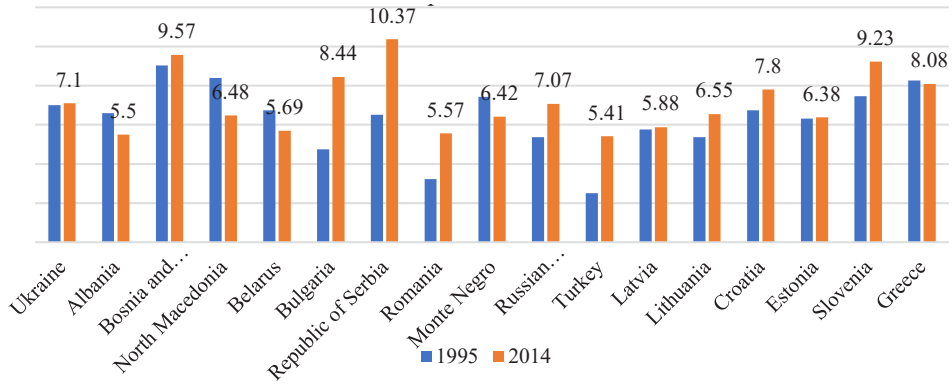
FIGURE 4: General government health expenditure by years and by financing sources, 2005-2020



Source: Global Health Expenditure Data base, WHO; Ministry of Finance, https://www.financa.gov.al/ligji-i-buxhetit; and Beci, Belishova &Kola, 2015.

Total Health Expenditure (including out-of-pocket as a crucial source to finance health care) as percentage of GDP in Albania have remained the lowest among the Balkan and East European Countries (figure 5)

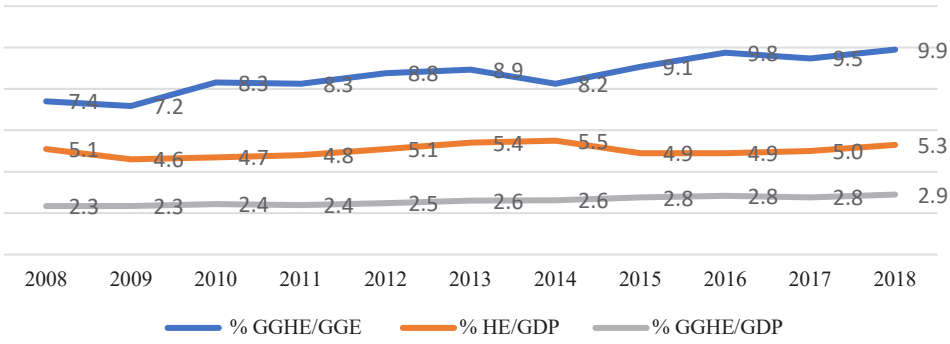
FIGURE 5: Total Health Expenditure as % of GDP in Balkan and East European Countries



Source: Tomini, S et al, 2015

On the other hand, despite the priority given to health sector during the last decade, the proportion of General Government Health Expenditure (GGHE) to Gross Domestic Product (GDP) and General Government Expenditure (GGE) has slightly increased, while the percentage of Health Expenditure to GDP has almost remain the same, around 5 percent.

FIGURE 5: Comparative data on Health Expenditures, 2008-2018



Source: Global Health Expenditure Data base, WHO.

Not surprisingly, a careful look at the data of health expenditures demonstrates that more than 40% of employees are uncovered by health insurance, although since 2014 that proportion has declined by 10% (table 1).

TABLE 1: Uncovered employees by Compulsory Health Insurance Scheme

	2014	2015	2016	2017	2018	2019	2020
1.Employees	925,000	973,000	1,043,000	1,096,000	1,138,000	1,147,000	1,133,000
2.Average monthly gross salary NCU	45,539	47,900	47,522	48,967	50,589	52,380	52,815
3.Annual contribution per person into CHI (3	18,580	19,543	19,389	19,979	20,640	21,371	21,549
4.Compulsory Health Contribution Fund (Mil	8,199	8,988	10,820	12,544	12,592	13,290	14,216
5.Insured people (4/3)	441,283	459,904	558,049	627,874	610,068	621,870	659,720
6. Uncovered people (1-5)	483,717	513,096	484,951	468,126	527,932	525,130	473,280
7.In percentage	52	53	46	43	46	46	42
8.In percentage to population	17	18	17	16	18	18	16

Source: Global Health Expenditure Data base, WHO; Albanian Ministry of Finance; INSTAT; Civici, A. (2017).

Using in depth analysis of health expenditures per capita, it is acknowledged that in addition to those who work informally, it results that proportion of uncovered people is higher, comprising almost 1/5 of population in 2018 (table 2).

TABLE 2: Uncovered people by Social Contributions (SS means Social Solidarity)

Population Inhabitants Thousands	2,896,305	2,890,513	2,886,438	2,884,169	2,882,740
Emplyees thousands	925,000	973,000	1,043,000	1,096,000	1,138,000
Insured people by Health Insurance	441,283	459,904	558,049	627,874	610,068
Health Expenditures per capita in NCU	**26,513**	**24,296**	**25,078**	**26,950**	**29,688**
From General Government Health Expenditure (GGHE-D)	12,495	13,553	14,303	14,382	16,030
From Private Health Expenditure (PVT-D) (equals Out of pc	13,827	10,517	10,475	12,013	13,258
From External Health Expenditure (EXT)	191	226	300	555	400
Health contributions per capita (only contributors)	**82,756**	**85,935**	**74,992**	**68,206**	**77,221**
Tax on salary	64,176	66,392	55,603	48,228	56,581
Compulsory Insurance Contributions	18,580	19,543	19,389	19,979	20,640
Calculations					
Coeficient of social solidarity	3.5	3.4	2.9	2.4	2.7
Number of people that can be covered by SS	1,524,208	1,562,399	1,600,351	1,515,646	1,672,397
Total number of covered people	1,965,491	2,022,303	2,158,400	2,143,520	2,282,465
Uncovered people	930,814	868,210	728,038	740,649	600,275
In Percentage	32	30	25	26	21

Source: Global Health Expenditure Data base, WHO;

Hence, it is hard to believe in the achievement of equality in access. Information from ADHS, 2017-18 confirms that poor people "find difficult to access certain types of health care services such as antenatal care, in which the prevalence of at least four visits was substantially higher in urban areas (82%) than in rural areas (57%). Similarly, it was considerably higher among higher-income individuals (91%) than those in the lower-income category (49%). Concerning under-five stunting, the prevalence was higher in among the worse-off individuals compared with their better-off counterparts (27% vs. 13%, respectively), while under-five mortality rate was considerably higher in rural areas (28 vs. 13)." (ADHS, 2017-18&Albania Health Report, 2014, p.130).

Finally, looking at other system inputs, such as human and physical capacities (table 3), it is sadly observed the very modest increase of the number of physicians during 15 years, while the number of nurses and midwives has slightly decreased.

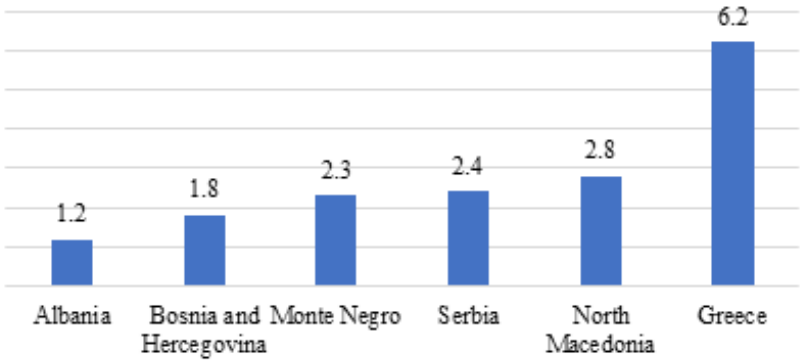
TABLE 3: Health workforce per 100 thousand inhabitants

Years	2006-2013	2014-2020
Physicians	115	120
Nurses and midwives	399	375

Source: National Health report, 2014; Primary Health Care in Albania: Rapid assessment, 2018; Global Health Expenditure Data base, WHO.

Figure 6 confirms that number of GP per 1,000 inhabitants is the lowest in the region.

FIGURE 6: Number of GP per 1,000 inhabitants



Source: Global Health Observatory, 2019

To complement the consideration on "equality in access", according to the data of Ministry of Health and Social Welfare, the hospitals' mean bed occupancy rate is as low as 50%, far below standard benchmark of 80–85%. The mean average length of stay is as high as 5.5 days and observed mean bed turnover was 21.27 patients/bed/year, portraying also high level of inefficiency in hospitals, which in turn impact on "inequality in access".

Regarding equality in utilization, health expenditures per capita by financing schemes, including those occurred privately and in the form of "private prepaid insurance plan" are analyzed from another point of view, namely from the weight they have on household revenues and in comparison, with average consumption per capita on health (Table 4).

TABLE 4: Monthly consumption expenditure on health per capita vs GHE

Indicators	2019	2020
General Health Expenditures (GHE) (Millions NCU), by financing schemes	91,147	98,849
Government schemes (GT+CHC)	50,131	54,367
General Taxation (GT)	36,841	40,151
Compulsory Health Contributions (CHC)	13,290	14,216
Household Out -of - pocket payment (OOP)	41,016	44,482
Population Inhabitants	2,874,873	2,869,350
GHE per capita per month (calculated based on HE finances schemes) NCU	2,642	2,871
From GT per capita per month	1,068	1,579
From CC per capita per month	385	413

From Out - of- pocket per capita per month	1,189	1,292
Household Budget		
Monthly consumption expenditure (Price Index 2019=5.7%) NCU	82,235.0	86,922.4
Monthly consumption expenditure on health (4.3%, LSMS 2019) (CE)	3,536	3,738
Monthly consumption expenditure on health per capita (Av.Hous. 3.8)	931	984
GHE per capita per month (calculated based on HE financing schemes)	2,642	2,871
In percentage, CE per capita per month on GHE per capita per month	35	34

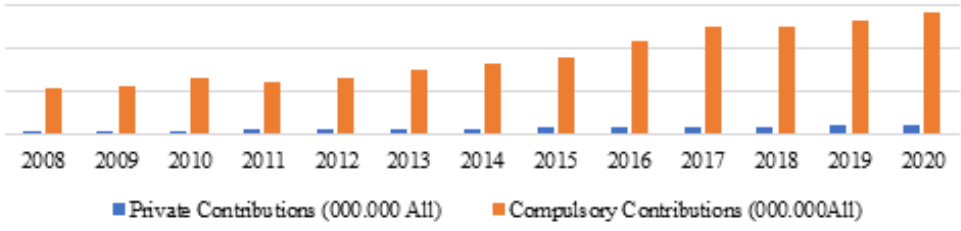
Source: INSTAT, Household Budget Survey, 2019; Global Health Expenditure Data base, WHO;

Data elaborated in table 4, brings into the attention another concerned issue: utilization of contributions. As far as the evidence is concerned, only 35% of contributions per capita is incurred to cover households' health care needs, whilst the rest of contributions likely is used to invest in the health care system. However, considering that Out-of-pocket payments comprise 45% of General health expenditures, it clearly challenges the issue of Health system inefficiency.

In addition, there are almost 65,000 people (10% of employees) who are enrolled in "Private prepaid health insurance plans", either on a voluntary basis or by their employers. While they are entitled to almost the same publicly provided health care systems, the burden on the household budget is critical.

Since the establishment in 2008, Private Health care sector has increased, although Private Health Insurance contributions still comprise around 8% of Compulsory Health Insurance Contributions (figure 6). Based on the estimations of the Private Insurance Companies, the number of insured people is less than 65,000, while the minimum annual insurance price peaked at All 18,300 in 2020. Nevertheless, neither the number of insured people nor the price of insurance concerns us the most. Rather than being a complementary system, private health insurance is a parallel system to the public one.

FIGURE 7: Private Contributions vis-à-vis Compulsory Contributions, 2008-2020



Source: SIGAL, 2020

Hitherto, there are no public policy initiatives to address the issue of double contributions, which fuels inefficiencies. Insured patients do not have any incentive to look for public health care services, unless rare emergency situations. Low quality of services, long waiting times and bribery, demotivate people, despite coverage by insurance. By contrast, responsiveness, and quality of services, are the driving forces versus private health care services.

However, there should be a coordination of benefits, to share costs among public and private sectors and lays the foundation for more investments into public sector (Table 5).

TABLE 5: People covered by dual Health Insurance Plans

People with dual Health Insurance Plan	63,000	65,000
Average gross salary	**52,380**	**52,815**
Monthly Compulsory Health Insurance Fund (Million NCU)	**112.2**	**116.7**
Annual Compulsory Health Insurance Fund (Million NCU) (CHIC)	**1,346**	**1,401**
Annual Privat Health Insurance Fund (Million NCU) (PHIC)	**1,153**	**1,190**
CHIC vs PHIC in %	**16.8**	**17.8**

Source: Estimations SIGAL, AlbSig, 2020

As it is acknowledged by table 5, Annual Compulsory Health Insurance Fund is slightly higher (18%) than Annual Privat Health Insurance Fund. Should the systems be complementary to each other, ¾ of the current insured people by dual Health Insurance or 47,250 people more would get insured.

Besides the impact on system efficiency, double health insurance adds burden on household budget and on the labour costs. Social Solidarity tax (share of income tax that finances health expenditures) and Compulsory Health Insurance comprise 19% of Average Monthly Gross salary. Including Private Health Insurance, the burden on Monthly Average Gross Salary achieves at 22%.

Looking at Health Outcome, based on ADHS, 2011, it is confirmed that under-five mortality rate was significantly more concentrated among the worse-off (40.1 per 1,000 live births) than the better-off (12.9 per 1,000 live births) (concentration index: -0.19, $P<0.01$). Similarly, stunting showed a negative value (concentration index: -0.12) indicating that it was more concentrated among the poor ($P<0.01$). Underweight was also significantly more concentrated among the poor ($P<0.05$). Conversely, antenatal care was significantly more concentrated among the better-off individuals (concentration index: 0.14, $P<0.01$). Skilled birth attendance was also more concentrated among the better-off individuals, albeit less so (concentration index: 0.003, $P<0.01$). In addition, contraceptive prevalence

was more concentrated among the higher income group (concentration index: 0.11, P<0.01). (Albania Health report, 2014, p.135).

Reasonably, a reader would be surprised by knowing the significant share of employer health contributions in the form of Tax on Social Solidarity, Individual Compulsory Health Contribution, Out-of-pocket payment or even Private Health Insurance, which unfortunately do not pay off neither the contributor nor the others.

This finding is backed by the relatively low level of monthly consumption expenditure on health per capita vis-à-vis General Health Expenditure per capita per month, high proportion of uncovered people by health services, extremely high proportion of out-of-pocket payments as well as the high rate of informality in the labour market.

The modest data elaborated here provides evidence to argue that Health Care system fails to provide efficiently health care services, which fuels inequality in access and utilization, alike. Rather than raising people's awareness on their rights and boosting investments into health care services, "Social Solidarity" does not seem relevant.

Conclusions

Efficiency is doing things in the most economical way, unfortunately this is not the case of the Albanian Health care system. The shared analysis proves that while equality in access and in utilization are impeded, the Albanians' right to health care is far from being achieved.

Equality in access for low-income groups and rural people is denied since:

- 45% of Health expenditures by revenues is composed of Out-of-pocket payments;
- More than 40% of employees or 20% of population are uncovered by any health insurance;

Equality in utilization for middle and low-income groups, is also denied since:

- Consumption of Health Expenditures per capita per month comprise only 35% of General Health expenditures per capita per month.
- 10% of employees are covered by double contributions, while 1/5 of population is totally uncovered.
- Double contributions, if used properly may serve to extend health care coverage by 75%.

Albanian employees (those who work in formal labour market) contribute significantly to health care performance since Social Solidarity tax (share of income tax that finances health expenditures) and Compulsory Health Insurance comprise 19% of Average Monthly Gross salary, while together with Private Health Insurance, the burden on Monthly Average Gross Salary achieves at 22%. Nevertheless, while what they pay does not help the equitable delivery of health services, they themselves are not paid off either, because the services they get back are poor.

Perhaps shifting some services from public to private sector may sound logical. However, despite the lack of evidence here to support such conclusion, private provision of health care services does not seem a pertinent recommendation for Albania. The solution lies on the well management of the current resources as well as on the investment towards sustainable development.

There are two fundamental theorems in economy, which argue that "it is impossible to redistribute resources and make somebody better off without causing that another one is worse off" (First Paretto Efficiency theorem), which may be achieved if the one starts with the rights allocation of resources (Second Paretto Efficiency theorem). Thus, society needs "Solidarity" to collect resources through taxation. In the meantime, society must re-distribute resources taking care of the "right allocations" respecting "Equality". Hence, "Social solidarity is fundamental. Nonetheless, we admit that the question does not stand only on the "Social solidarity" per se.

Regardless of some grounds for optimism, there is a prevailing finding that health financing efficiency will have to be substantially improved. Albania can still rely for another decade on the demographic growth model, but in a changing context. Challenge of Informality is of utmost importance. Combined with cost-effective resource allocation policies, focused on the shared reformation of compulsory and private health insurance, the supply-side of society' ability to invest in health care, would increase. The demand-side, burdened by law enforcement, implies a continuous investment into civic and social education. Finally, Albania will be able to learn from the past mistakes and others historical experiences to shape more adaptive system responses in the future.

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