Out-of-Pocket Payments and Utilization of Health Care Services in Albania: Evidence from Three Districts

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Abstract

Like most countries in Central and Southeastern Europe, Albania is considering a number of alternative health sector reform strategies to improve the availability, quality, and use of primary health care services. However, in order to assess the likely success of such reforms, more needs to be known about the current levels, distribution, and determinants of household out-of-pocket spending on health. The purpose of this paper is to use the 2002 Albania Baseline Health Survey, a survey of 2,000 households in Berat, Kucova, and Fier, to understand the magnitude and distribution of out-of-pocket payments for health care services and to identify the factors that operate at the household and provider levels that determine whether individuals pay for health care and how much is paid within the month prior to the survey. Of particular interest in the study is examining the extent to which households incur out-of-pocket payments across a number of dimensions – including health insurance status, socioeconomic status, type of service, and type of facility. The findings suggest that out-of-pocket payments for care provided in government facilities are widespread, with marked differences in payment practices between inpatient and outpatient care. For outpatients using primary health centers, the type of facility that is the focus of the government's primary health care program, average payments appear to be nominal (0.6 percent of estimated total monthly household expenditure per capita). The multivariate findings indicate that insurance coverage significantly reduces the likelihood of paying for medicines to treat acute and chronic health problems, but not of paying for consultations. The policy implications of the findings on alternative health care financing reforms are briefly discussed.

Table of Contents

List of Tables

Acronyms

GP	General Practitioner
INSTAT	Institute of Statistics
MOH	Ministry of Health
OLS	Ordinary Least Squares
PHC	Primary Health Center
PHR*plus*	Partners for Health Reform*plus* Project
USAID	United States Agency for International Development

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Executive Summary

Like most countries in Central and Southeastern Europe, Albania is considering a number of health sector reforms in order to improve the availability, quality, and use of health care services. Among the reforms that are under consideration are separating financing and service provision, decentralizing management and financing responsibilities, introducing alternative provider payment systems, and mobilizing additional private resources through patient cost-sharing. However, before such reforms can be considered, more needs to be known about the role that households currently play in financing the health care system.

While very little research has been conducted on household out-of-pocket payments in Albania, a growing amount of research on this issue has been conducted in neighboring countries (Lewis 2000; Ensor 2004; Delcheva et al. 1999; Thomson and Witter 2000). This research suggests that a substantial portion of out-of-pocket payments are informal in nature, and that, whatever their origin, informal payments practices can cause several negative effects on health system performance. Such payments can have serious implications on the governance of the health system, can negatively affect service accessibility, and utilization (particularly among the poor), can lead to perverse incentives among managers and health care providers, and, if not accounted for, have the potential to limit the success of health system strengthening efforts (Lewis 2000; Ensor 2004). At the same time, health care delivery systems in transitional economies such as Albania's are often fragile. Public health care providers frequently earn very low and sometimes irregular salaries, and informal payments might play an important role in preventing the disintegration of the government-run health care system by ensuring that health workers do their jobs. Nevertheless, previous research suggests that informal payments, if ignored, can have a substantial but perhaps unpredicted influence on attempts at health sector reform (Ensor 2004).

The purpose of this paper is to describe health care utilization patterns and the levels and distribution of out-of-pocket payments on outpatient health care services among a sample of households interviewed in three areas of Albania (Berat, Kuçova, and Fier). In addition, the paper examines the following hypotheses: first, whether individuals covered by health insurance are less likely to pay for consultations (at primary health centers, or PHCs) and medicines, and pay less for consultations and medicines, than non-insured individuals; second, whether individuals from rural areas are less likely to pay for consultations, and pay less for consultations, at PHCs than individuals from urban areas; third, whether individuals from rural areas are more likely to pay for consultations, and pay more for consultations, at polyclinics and hospitals than individuals from urban areas. Finally, it examines whether household wealth is positively associated with out-of-pocket payments for curative health care.

Background

Although the government has not adopted a health policy that provides a comprehensive health sector strategy and an action plan that would guide implementation steps, in the last ten years, Albania has passed several laws and decrees related to health policy, some of which have led to substantial changes in the organization and financing of health care services. These changes include

the introduction of social health insurance in 1995. Managed by the Health Insurance Institute, the government-sponsored health insurance program is still limited both in terms of the population and services it covers. The scheme allows patients to obtain one free consultation with a general practitioner (GP) or family doctor in order to treat each illness episode, and to free consultations for care received at facilities where the patient has been properly referred. Patients who are not enrolled in the insurance program or use the referral system improperly are supposed to pay a fee of 200 Lek at PHCs and 300 Lek at polyclinics and hospitals. In addition, insurance enrollees receive subsidies on more than 300 drugs if prescribed by a GP or a family doctor. In order to receive benefits, an insured individual must present a "health license" or "health booklet" that documents their membership. Without such documentation, scheme members may find their access to free services or discounted drugs impeded.

Alongside these official fees that are charged for health care services are informal payments. Although no reliable estimates are available on the prevalence and magnitude of informal payments in Albania, a qualitative study in the same areas where our household survey was administered found anecdotal evidence that such payments are widespread and extensive, particularly for inpatient care (Vian, Gryboski, Sinolmeri, and Clifford 2004). Among the reasons given by providers and the public on why such payments occur include: low salaries of health staff; perceived low levels of quality and a desire to get better service; fear of being denied treatment, particularly among rural individuals seeking care in polyclinics and hospitals, which are located in urban areas; and traditional cultural beliefs about expressing appreciation.

The issue of salary levels of physicians and their importance in contributing to the practice of informal payments is complex. After the introduction of the social insurance program in 1995, the Health Insurance Institute became responsible for paying salaries to GPs and family doctors who staff ambulances and PHCs while the MOH remained responsible for paying the salaries of specialists, who staff polyclinics and hospitals. Not only do GPs and family doctors have a much higher base salary than specialists, they also receive extra compensation if they are posted in rural areas. As a result of both the higher salary base and the additional compensation for accepting rural assignments, GPs and family doctors earn salaries that are on average two to three times higher than those of specialists. The systems used to remunerate doctors can have two potentially important influences on out-of-pocket payments. First, specialists working in polyclinics and hospitals may demand higher payments than GPs and family doctors working in PHCs and ambulances. Second, GPs and family doctors working in urban areas may demand higher payments than GPs and family doctors working in rural areas. Both of these hypothetical effects are based on the proposition that salary levels contribute to the practice of informal payments, a proposition that is supported by the findings of Vian et al. (2004).

Data and Methodology

The data for the analysis comes from the Albania Baseline Health Survey, a survey of 2,000 households carried out December 2002 in Berat, Kuçova, and Fier by the Albania Institute of Statistics (INSTAT) with support from the PHR*plus* Project. A random sample of households was selected in each of six sample enumeration areas. The target number of households sampled was based on household population estimates and the average household size provided to the research team prior to the survey. The survey collected information on a wide range of topics, including: household demographic and economic characteristics; health insurance coverage; morbidity; utilization of preventive, reproductive, and curative health care services; out-of-pocket costs for health care; and perceptions of health care quality.

We test the main hypotheses regarding the payment of formal and informal fees using multivariate regression analysis. Multivariate regression approaches allow us to examine the effects of determinants of expenditures such as having health insurance while controlling for other factors that may directly or indirectly also affect expenditures. Maximum likelihood probit analysis is used to estimate the relationships between the likelihood of incurring specific types of acute and chronic care medical expenditures – including informal fees – and a set of individual- and facility-level covariates. Ordinary least squares analysis is used to estimate the relationships between the magnitude of levels of out-of-pocket payments and the same types of variables. The key individual-level factors hypothesized to affect the prevalence and magnitude of expenditures are health insurance status, urban/rural residence, and socioeconomic status. Several other variables are included as controls: age and sex of the individual, educational status, and characteristics of the household such as whether it is headed by a female.

Because it is believed that the charging of fees may depend upon both the type of health services being sought and the age of the health care seeker, separate estimations are conducted for children under the age of 17 and adults 18 and over. In the former case, the educational attainment of the household head is used as a proxy variable for the educational level of household members.

Results

Although findings from a facility survey in the same study area indicate that mandated user fees are rarely charged for curative health care services, the household survey findings suggest that out-of-pocket payments for care provided in government facilities are in fact widespread, with marked differences in payment practices between inpatient and outpatient care. For example, among those requiring hospitalization, over 45.2 percent reported paying fees for doctors' and nurses' services and 61.3 percent reporting making gift payments, and, among those using outpatient services for acute health problems, 44.6 percent reported paying consultation fees and 24.7 percent reported providing gifts. In addition, for inpatients, the magnitude of out-of-pocket payments appears to be substantial, as payments for doctor and staff services and gifts averaged 50 percent of average monthly per capita household expenditures and total payments for hospitalizations, which include consultation fees, gifts, drugs, laboratory tests, food, and transportation, averaged about 88 percent of average monthly per capita household expenditures. The survey data do not allow us to assess the impact of these health care expenditures on household living standards, but proportional payments of this magnitude may be catastrophic both for poor households and for many non-poor households.

On the other hand, for outpatients using PHCs, the type of facility that is the focus of the government's primary health care program, average payments appear to be nominal. Of the estimated total monthly household expenditure per capita, individuals spent an average of 0.6 percent on consultations during the month before the survey and 10.4 percent on the total cost of care. We also found that among the sample of ill individuals not using health care facilities, the percent of individuals who report that costs were a barrier to service use was very low (5.9 percent), even among those in the poorest wealth quintile (8.7 percent). This finding is consistent with a 2003 World Bank study that indicates that the responsiveness to marginal increases in service fees (price elasticity) among both the poor and non-poor is very low (inelastic).

The multivariate analysis offers a number of interesting findings regarding the determinants of private expenditures. Of particular interest are the findings on the effectiveness of Albania's social health insurance program, which, in addition to improving the availability of primary health care services by paying the salaries of GPs and family doctors, is designed to provide financial relief to enrollees through subsidies for PHC consultations and prescribed medicines. The results indicate that,

after controlling for other factors, insurance coverage significantly reduces the likelihood of paying for medicines to treat acute and chronic health problems, but not of paying for consultations received at PHC facilities. Although we cannot definitively explain why insurance coverage does not influence consultation expenditures at PHC facilities, a likely explanation concerns the role that informal payments play in the total amounts necessary to receive health care services. In addition, it is possible that insurance enrollees are unaware of their rights and pay what they believe to be the official fees (which are not accounted for by health staff).

The study did not find evidence to support the hypothesis that socioeconomic status significantly influences consultation costs for outpatient acute health care. In addition, among adult patients, socioeconomic status was not found to affect the likelihood of paying gifts nor the magnitude of payments for gifts, indicating that poor and non-poor are equally likely to make such payments. This finding is not surprising, as there are no formal mechanisms in place in government-run health facilities to protect the poor from out-of-pocket health payments. However, it is interesting to note that, for the sample of outpatients under 18 years of age, the poor were found to be 3.6 percentage points less likely to make such payments (18.4 percent versus 22.0 percent) and pay less than the non-poor.

Study Limitations

There are a number of limitations to the study. First, the survey methods and data used in this analysis only allow us to partially uncover the situation regarding out-of-pocket health care expenditures. Like most surveys of household health expenditures, the survey data do not contain information that would allow us to disentangle private expenditures into the amounts spent on mandated payments vs. the amounts spent informally. Second, the health expenditure component of the survey only includes item-specific questions on one broad type of health care service – care associated with acute health problems. For this type of service, questions were asked on the amounts spent for consultations, gifts, tests, medicines, food and other items. For other types of health care services, questions were asked either on the amounts spent for certain types of items (i.e., medicines for those seeking treatment for chronic problems) or for the total amounts spent for all services and items associated with care (i.e., for maternity care). Finally, the survey does not include questions on the types and quantity of medicines prescribed and used. Not having this type of information prevents us from assessing whether health insurance enrollees received the appropriate level of subsidies for prescribed medicines.

Implications for Reform

Despite these limitations, the results have a number of implications for ongoing health reform efforts in Albania. First, strategies with the objective of addressing informal payments should first be focused at the hospital level, as the findings on the differences in charging practices between inpatient and outpatient care provides support to the premise that informal payments are a much greater problem for hospital care than for primary care. The finding that informal payments is a more severe problem for inpatient care than for outpatient is not surprising given the findings from other studies in Albania, which suggests that hospital physicians often use their monopolistic market position in order to extract payments from patients as a precondition to delivering potentially life-saving health care services (Vian et al. 2004) and that GPs and family doctors earn substantially higher salaries than specialists (Tabaku and Fairbank 2004). Primary health care physicians are less likely to be in a position to extract large payments, as consumers of primary services have more choices on which physician to seek treatment from, both within and across health care facilities.

Secondly, the effectiveness of many health system-strengthening efforts may be impeded unless the issue of informal payments is adequately addressed. For example, while insurance membership was found to be significantly associated with savings on medicine costs, after controlling for other factors, membership was not found to significantly affect PHC consultation expenses, a stated benefit of the insurance program. Although out-of-pocket payments at PHCs were not found to be substantial, informal payments might be playing a role in limiting the effectiveness of the Health Insurance Institute program, as physicians may lack motivation to collect official fees from non-enrollees. The ineffectiveness of health insurance coverage on consultation fees appears to be an example of a situation in which perverse incentives created by informal payments are thwarting a reform effort. It is also likely that alternative payment strategies may fail without changing the incentives faced by physicians and other health care staff, by raising salaries, and/or by offering performance incentives. Until the problem of informal payments is effectively addressed, it is unlikely that the social insurance program will have an impact on mandated consultation expenditures.

Third, the limited correlation between social economic status and out-of-pocket payments suggests that there is considerable potential for improving the targeting of the poor and other vulnerable populations. Again, the introduction of programs that effectively address the problem of informal payments, along with formal targeting strategies, are likely to be essential for protecting the poor against excessive private expenditures, and for improving access to primary health care service.

There are a number of available strategies for addressing the problem of informal payments, including increasing provider accountability by strengthening systems to detect and impose penalties on providers who charge informal payments, formalizing payments through user fee strategies, introducing provider incentive systems that include quality assurance and performance assessment, and improving knowledge and awareness about patient rights and responsibilities, particularly the benefits of health insurance. While identifying the strategies that are likely to be both feasible and effective in improving health system performance in the Albanian context is beyond the scope of this analysis, it should be recognized that many of these strategies may have unintended and adverse consequences on service provision and utilization. For example, enforcing penalties for charging informal payments could result in a decrease in the supply of services if health workers opt to leave their jobs in response, and user fee strategies could actually increase the total amount of out-of-pocket payments if they don’t replace informal payments. Further research is needed both to better quantify the problem of informal payments, and to monitor and evaluate the effectiveness of alternative strategies on program accountability and service efficiency, accessibility, quality, and utilization.

1. Introduction

Like most countries in Central and Southeastern Europe, Albania is currently considering a number of health sector reforms in order to improve the availability, quality, and use of health care services. Among the reforms under consideration are separating financing and service provision, decentralizing management and financing responsibilities, introducing alternative provider payment systems, and mobilizing additional private resources through patient cost-sharing. However, before such reforms can be considered, more needs to be known about the role that households currently play in financing the health care system.

While very little research has been conducted on household out-of-pocket payments in Albania, a growing amount of research on this issue has been conducted in neighboring countries (Lewis 2000; Ensor 2004; Delcheva et al. 1999; Thomson and Witter 2000). This research suggests that a substantial portion of out-of-pocket payments are informal in nature, and that, whatever their origin, informal payments practices can cause several negative effects on health system performance. Such payments can have serious implications on the governance of the health system, can negatively affect service accessibility and utilization (particularly among the poor), can lead to perverse incentives among managers and health care providers, and, if not accounted for, have the potential to limit the success of health system strengthening efforts (Lewis 2000; Ensor 2004). At the same time, health care delivery systems in transitional economies such as Albania's are often fragile. Public health care providers frequently earn very low and sometimes irregular salaries, and informal payments might play an important role preventing the disintegration of the government-run health care system by ensuring that health workers do their jobs. Nevertheless, previous research suggests that informal payments, if ignored, can have a substantial but perhaps unpredicted influence on attempts at health sector reform (Ensor 2004).

The purpose of this paper is to describe health care utilization patterns and the levels and distribution of out-of-pocket payments on outpatient health care services among a sample of households interviewed in three areas of Albania (Berat, Kuçova, and Fier). In addition, we investigate whether Albania's social health insurance program has been successful in reducing out-of-pocket expenditures for health care among program participants. Finally, we investigate the equity dimensions of out-of-pocket expenditures by assessing the influence of socioeconomic characteristics on health care expenditures. It is hoped that a better understanding of the prevalence, magnitude, and determinants of out-of-pocket payments can be used by the government of Albania to help evaluate the effectiveness of ongoing health reform efforts and to assess the likely effects of reforms that are under consideration to improve health system performance.

2. Background

Albania's Ministry of Health (MOH) accounts for nearly all health care service delivery in Albania, with primary health centers (PHCs) being the centerpiece of the government's strategy for primary health care. PHCs are located in both urban and rural areas, and are staffed by general practitioners (GPs), family doctors,[1] and/or pediatricians. Ambulances, a type of health post in rural areas, have a small number of non-specialized medical personnel, often with no formal training. Polyclinics and hospitals offer secondary and tertiary care, are located exclusively in municipalities, and are staffed by specialists.

Although the government has not adopted a health policy that provides a comprehensive health sector strategy and an action plan that would guide implementation steps, in the last ten years, Albania has passed several laws and decrees related to health policy, some of which have led to substantial changes in the organization and financing of health care services. These changes include the privatization of pharmacies and dental practices in 1993 and the introduction of social health insurance in 1995. Managed by the Health Insurance Institute, the government-sponsored health insurance program is still limited both in terms of the population and services it covers. The scheme allows patients to obtain one free consultation with a GP or family doctor in order to treat each illness episode, and free consultations for care received at facilities where the patient has been properly referred. Patients who are not enrolled in the insurance program or use the referral system improperly are supposed to pay a fee of 200 Lek at PHCs and 300 Lek at polyclinics and hospitals. (For hospitalized individuals, official policy does not stipulate that inpatients be charged fees for examinations, consultations, and diagnostic services other than the 300 Lek fee charged by specialists.) In addition, insurance enrollees receive subsidies on more than 300 drugs if prescribed by a GP or a family doctor. In order to receive benefits, an insured individual must present a "health license" or "health booklet" that documents their membership. Without such documentation, scheme members may find their access to free services or discounted drugs impeded.

Legally, all economically active individuals (employees, employers, the self-employed, or unpaid family workers) are obliged to contribute to the scheme, while the state bears responsibility for the contributions of children, full-time students, retirees, the disabled, the unemployed, pregnant women, and citizens under compulsory military service. Although all Albanians are supposed to be covered by the program, 2002 Living Standards Measurement Survey (conducted by INSTAT with assistance from the World Bank) shows that only 39 percent of the country's population reports having a health license.

Alongside the official fees that are charged for health care services (described above) are informal payments, which can be defined as "payments to institutions or individuals in cash or in kind made outside official payment channels for services that are meant to be covered by the public health system" (Lewis 2000). Although no reliable estimates are available on the prevalence and magnitude of informal payments in Albania, a qualitative study in the same areas where our household survey was administered found anecdotal evidence that informal payments are widespread and extensive,

[1] Family doctors refer to physicians who have a speciality in Family Medicine.

particularly for inpatient care (Vian, Gryboski, Sinolmeri, and Clifford 2004). Among the reasons given by providers and the public for why such payments occur include low salaries of health staff; perceived low levels of quality and a desire to get better service; fear of being denied treatment, particularly among rural individuals seeking care in urban facilities; and traditional cultural beliefs about expressing appreciation.

The issue of salary levels of physicians and their importance in contributing to the practice of informal payments is complex. After the introduction of the social insurance program in 1995, the Health Insurance Institute became responsible for paying salaries to GPs and family doctors who staff ambulances and PHCs while the MOH remained responsible for paying the salaries of specialists, who staff polyclinics and hospitals. Because of their higher base salary and because they receive extra compensation if they are posted in rural areas, GPs and family doctors earn salaries that are on average two to three times higher than those of specialists. The systems used to remunerate doctors can have two potentially important effects on out-of-pocket payments. First, specialists working in polyclinics and hospitals may demand higher payments than GPs and family doctors working in PHCs and ambulances. (That the costs of living and costs of services are likely to be higher in urban areas than in rural areas may also contribute to urban physicians charging more than rural physicians). Second, GPs and family doctors working in urban areas may demand higher payments than GPs and family doctors working in rural areas. Both of these hypothetical effects are based on the proposition that salary levels contribute to the practice of informal payments, a proposition that is supported by the findings of Vian et al. (2004).

The government has been attempting to deconcentrate financial and managerial authority to its 12 regional authorities and to local governments. Decentralization has moved very slowly because of a lack of clarity regarding which roles and responsibilities would be delegated and a lack of capacity at the subnational level. Meanwhile, the health sector has remained centralized, with the only impact of decentralization being that the MOH is no longer funding operations and maintenance of ambulances and PHCs. In addition, the introduction of social insurance and the decentralization efforts have led to fragmentation in the financing and management of primary health care services between the Ministry of Health, the Health Insurance Institute, and the Ministry of Local Government.

In order to improve the performance of the health care system, the government is considering a number of health reform strategies that focus on several guiding principles, including the separation of financing and service provision, increasing the legal, financial, and managerial autonomy of health care providers, single source financing, and the establishment of regional health authorities responsible for planning and monitoring service quality (Tomesh 2004). The government has appointed a working group of local lawyers to draft legislation focusing on the guiding principles of reform, leaving room for the government to consider which exact strategies will be implemented and determine how they will be implemented.

The effectiveness of many of the reform strategies being considered by the government could be influenced by the practice of informal payments. In addition to providing estimates of the prevalence and magnitude of out-of-pocket payments, this paper examines the following hypotheses: first, whether individuals covered by health insurance are less likely to pay for consultations (at PHCs) and medicines, and pay less for consultations and medicines, than non-insured individuals; second, whether individuals from rural areas are less likely to pay for consultations, and pay less for consultations, at PHCs than individuals from urban areas; third, whether individuals from rural areas are more likely to pay for consultations, and pay more for consultations, at polyclinics and hospitals than individuals from urban areas. And finally, we examine whether household wealth is positively associated with out-of-pocket payments for curative health care.

3. Data and Methods

The data for the analysis come from the Albania Baseline Health Survey, a survey of 2,000 households carried out December 2002 in Berat, Kuçova, and Fier by the Albania Institute of Statistics (INSTAT) with support from the Partners for Health Reform*plus* (PHR*plus*) Project. This survey and a follow-up survey planned for autumn 2004 will be used to assess the impact of a primary health care pilot supported by PHR*plus*. The primary aim of the intervention is to improve the utilization of primary health care services through changes in the management, financing, and service quality of primary health care services.

The study has a quasi-experimental research design with intervention and control groups. In consultation with the United States Agency for International Development (USAID), four PHCs in Berat and Kuçova were purposely selected as the PHCs that would receive assistance from PHR*plus* to implement the primary health care pilot. Two of these facilities are located in municipalities and two in communes, and each had been recently renovated with financial and technical assistance from USAID and the government of Albania.

In selecting the two control facilities, the following criteria were used. First, like the four facilities in the intervention areas, the PHC facilities in the control areas must have been recently renovated. Second, both a municipality and a neighboring commune facility should be selected. Third, the socioeconomic characteristics of the populations in the municipality and commune control areas must be similar to the populations in the intervention areas with respect to selected social and demographic characteristics, including educational status, age structure, and ownership of specified household assets. Based on these criteria, two PHCs in Fier and their catchment areas were selected as the controls for the study.

A random sample of households was selected in each of the six areas. The target number of households sampled was based on household population estimates and the average household size provided to the research team prior to the survey. The survey collected information on a wide range of topics, including: household demographic and economic characteristics; health insurance coverage; morbidity; utilization of preventive, reproductive, and curative health care services; out-of-pocket costs for health care; and perceptions of health care quality. To gauge curative health care utilization, individuals were asked questions on whether they had a chronic illness and/or disability and whether they had experienced an acute illness or problem in the month prior to the survey. For those individuals who report that they suffered from a chronic or acute health problem, questions were asked on whether care from a trained health care provider was utilized, the type of facility visited, the types of services utilized, out-of-pocket expenditures, and opinions regarding the quality of care that was received. Those who report seeking health care for chronic problems were asked about their out-of-pocket costs for medicines, while those seeking care for acute problems were asked not only about expenditures on medicines, but also on consultations, tests, and food and transportation associated with seeking health care. Because more complete data were collected on out-of-pocket expenditures for acute health care, we focus principally on this type of health care utilization in the study.

As mentioned above, previous research suggests that gift giving (voluntary) and forced payments (involuntary) for publicly provided health services are common. While the survey included questions

on the amounts paid in the form of in-kind or monetary gifts and whether these gifts were voluntary or involuntary, we suspect that our estimates of payments for consultations, laboratory tests, and even medicines may combine officially sanctioned payments with informal payments. This is supported by findings from a separate survey of health facilities in the same areas where the household survey was administered (PHR*plus* 2004). Results from the survey showed that, despite the official policy that calls for the collection of user fees, almost all of the government facility directors reported that services are offered free of charge. This suggests that most if not all of the consultation payments reported by our sample are informal. While medicines are purchased in private pharmacies, there are some reports that some physicians receive kickbacks from pharmacists on some prescription purchases. Given these measurement issues, the analysis presented in this paper focuses on all out-of-pocket health care payments, and not just on informal payments.

To assess household wealth, questions were asked on the type of dwelling where the household resides, access to water and electricity, and ownership of several types of assets, such as a car, television, satellite dish, and refrigerator. A number of studies have demonstrated the validity of using wealth-based indicators for categorizing households (Filmer and Pritchett 1999, Filmer and Pritchett 2001, Montgomery et al. 2000). The information on dwelling conditions and asset ownership were used to construct a composite measure of economic well-being or wealth ownership by applying principal component analysis along the lines suggested by Filmer and Pritchett (2001). These indices are often referred to as household wealth scores. More details on the research design, sampling procedures, the types of data collected, and variable construction, can be found in PHR*plus* 2004.

In order to test the main hypotheses of this analysis, we examine the likelihood that individuals make out-of-pocket payments, and the magnitude of those payments, for several different types of health care expenditures: (1) consultation costs at PHCs for outpatient acute care, (2) consultation costs at hospitals and polyclinics for outpatient acute care, (3) consultation and gift payments for outpatient acute care at any type of government health facility, and (4) expenditures on medicine for outpatient acute and chronic care at any type of government health facility. Because few individuals included in the household survey reported being hospitalized, we investigate the hypotheses only using the sample of individuals who reported outpatient care.

We test the main hypotheses regarding the payment of formal and informal fees using multivariate regression analysis. Multivariate regression approaches allow us to examine the effects of determinants of expenditures such as having health insurance while controlling for other factors that may directly or indirectly also affect expenditures. Unfortunately, modeling the determinants of medical care expenditure is a less-than-straightforward endeavor. Several factors complicate attempts to obtain unbiased estimates of the impact of variables that influence health care expenditures. First, data on medical care expenditures typically exhibit a large number of observations clustered at zero, with the rest of the observations being positive and highly skewed. As a result, a commonly used estimator for limited dependent variables, the Tobit model, may produce biased parameter estimates (Manning et al. 1987). Second, ordinary least squares (OLS) analysis base on a sample that excludes individuals who did not report paying for health care is problematic because of potential sample selection bias.

In order to address the sample selection issue, we estimated a Heckman selection model that included an equation to predict whether an acutely ill individual reported paying anything for medical care and a second equation to predict how much an individual reported paying. We tested whether rho was statistically different than zero, indicating sample selection bias, and found that there was no evidence of sample selection. Based on this result, we then modeled health expenditures using two separate equations. First, maximum likelihood probit analysis was used to estimate the relationships between the likelihood of incurring specific types of acute and chronic care medical expenditures –

including informal fees – and a set of individual- and facility-level covariates. Second, OLS analysis was used to estimate the relationships between the magnitude of levels of out-of-pocket payments and the same types of variables. The key individual-level factors hypothesized to affect the prevalence and magnitude of expenditures are health insurance status, urban/rural residence, and socioeconomic status. Several other variables are included as controls: age and sex of the individual, educational status, and characteristics of the household such as whether it is headed by a female.

Because it is believed that the charging of fees may depend upon both the type of health services being sought and the age of the health care seeker, separate estimations are conducted for children under the age of 17 and adults 18 and over. In the former case, the educational attainment of the household head is used as a proxy variable for the educational level of household members.

4. Descriptive Results: Morbidity and Health Care Utilization

This section presents survey findings on the prevalence of morbidity and health care utilization patterns by household wealth status and urban/rural status. Table 1 presents results on the prevalence of self-reported morbidity and the percent of ill individuals that report utilizing health care services. Overall, 8.9 percent of survey individuals reported having a chronic health problem that has lasted three months or longer, with heart and lung problems being the leading types of problems reported, and 9.5 percent of individuals reported having an acute health problem that occurred within the one-month period prior to the survey, with cold and the flu being the most frequently reported problems. The prevalence of self-reported chronic and acute health care problems did not vary substantially by household wealth or by urban/rural status. As expected, chronic morbidity increased substantially by the age of the respondent (not reported in the table). The prevalence of acute morbidity was "U-shaped," with respondents 14 years and younger and 65 years and older reporting higher average levels of morbidity than respondents 15 to 64 years of age.

Table 1: Prevalence of Self-reported Morbidity, and Percent Who Report Using Health Care from a Trained Provider, by Place of Residency and Household Wealth Quintile

Self-reported morbidity/health care use	Total	Place of residency		Household wealth quintiles				
		Urban	Rural	Poorest	Second	Third	Fourth	Richest
	n=8,142	*n*=3,208	*n*=4,934	*n*=1,694	*n*=1,676	*n*=1,610	*n*=1,554	*n*=1,608
Ill or injured								
Total	17.3	18.2	16.7	18.6	16.8	16.2	16.5	18.4
Chronic	8.9	10.3	7.9	9.2	8.2	7.9	9.3	9.8
Acute	9.5	9.3	9.6	10.2	9.7	9.0	8.5	9.8
Used health care								
Total	50.0	59.8	43.1	36.5	50.9	51.0	54.9	58.6
Chronic	53.3	63.9	44.4	41.7	44.2	56.7	64.8	59.5
Acute	44.2	50.5	40.3	30.1	53.4	44.8	39.4	53.8

Overall, 53.3 percent of individuals with chronic morbidity and 44.2 percent of individuals with acute morbidity reported utilizing health care services from a trained health care provider in the one month prior to the survey (Table 1). Service utilization rates varied substantially by household wealth and geographic location. For example, among those with acute morbidity, 50.5 percent of urban respondents vs. 40.3 percent of rural respondents reported seeking care, and 53.8 percent of respondents in the highest wealth quintile vs. 30.1 percent of respondents in the lowest wealth quintile reported seeking care. Among non-users, the leading reasons given for why medical assistance was not sought out was they did not think the problem was serious (73.3 percent) and they self-treated themselves at home (31.0 percent). Only a small percentage (5.4 percent) reported that the cost of

services was a reason for not using health care, and surprisingly, this finding did not vary significantly by the wealth status of the household.

Table 2 presents information on the type of health care facility that was reportedly utilized by those with health problems. The sequencing of health care utilization is difficult to gauge for those with chronic problems as opposed to those with acute problems. For those with chronic morbidity, recent health care utilization is likely to be influenced by how the individual previously used facilities and providers in response to their problem. As a result, for the chronically ill who reported utilizing health care services in the past six months, we asked individuals where they "usually" go for treatment. For the acutely ill, we asked about the type of facility that was reportedly first utilized.

Table 2: Percent Distribution of Individuals Who Used Health Care, by Place Where Care Was Received, Place of Residency and Household Wealth Quintile

Place where care was received	Total	Place of residency		Household wealth quintiles				
		Urban	Rural	Poorest	Second	Third	Fourth	Richest
Chronic	*n*=635	*n*=300	*n*=335	*n*=129	*n*=119	*n*=115	*n*=125	*n*=147
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ambulance	5.4	NA	10.2	7.8	4.2	9.6	3.2	2.7
Primary Health Center	37.0	58.3	17.9	22.5	23.5	26.1	55.2	53.7
Maternity	0.8	0.0	1.5	0.8	1.7	0.9	0.8	0.0
Polyclinic	38.3	27.3	48.1	51.2	47.9	43.5	20.0	30.6
Hospital	15.8	12.3	18.8	17.1	19.3	16.5	17.6	9.5
Private clinic	2.8	2.0	3.6	0.8	3.4	3.5	3.2	3.4
Acute	*n*=341	*n*=151	*n*=190	*n*=52	*n*=87	*n*=65	*n*=52	*n*=85
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ambulance	11.7	0.0	21.1	5.8	24.1	18.5	1.9	3.5
Primary Health Center	28.7	42.4	17.9	30.8	17.2	23.1	38.5	37.7
Polyclinic	22.6	17.9	26.3	28.9	19.5	24.6	25.0	18.8
Hospital	25.5	17.9	31.6	32.7	32.2	27.7	21.2	15.3
Private clinic	5.6	11.3	1.1	1.9	2.3	3.1	5.8	12.9
Home visit	5.9	10.6	2.1	0.0	4.6	3.1	7.7	11.8
Total	*n*=944	*n*=434	*n*=510	*n*=177	*n*=200	*n*=174	*n*=171	*n*=222
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Ambulance	7.7	0.0	14.3	7.3	13.0	12.6	2.9	3.2
Primary Health Center	34.2	52.8	18.4	25.4	20.5	25.3	49.7	48.7
Maternity	0.5	0.0	1.0	0.6	1.0	0.6	0.6	0.0
Polyclinic	32.7	24.7	39.6	44.1	36.0	36.8	22.2	25.7
Hospital	19.1	14.1	23.3	21.5	24.5	20.1	18.1	12.2
Private clinic	3.6	4.8	2.6	1.1	3.0	3.5	4.1	5.9
Home visit	2.1	3.7	0.8	0.0	2.0	1.2	2.3	4.5

NA: Not Applicable
Note: For individuals acutely ill, numbers above reflect where care was first received. For individuals chronically ill, numbers reflect where care was "usually received."

Among the chronically ill, polyclinics (38.3 percent) and PHCs (37.0 percent) were the most commonly reported sources of "usual" care. However, there are differences between urban and rural inhabitants in terms of where care is obtained. In urban areas, PHCs are the most commonly reported place for seeking treatment (58.3 percent), followed by polyclinic at 27.3 percent. By contrast, almost half (48.1 percent) of commune dwellers reported that they usually go to polyclinics, and only 17.9 percent reported that they usually utilize PHCs.

There are also important differences in health care utilization practices among individuals who sought treatment for acute illnesses. In urban areas, the most frequently reported place for treatment are PHCs, where 42.4 percent of the urban sample first sought treatment, compared to 17.9 percent of the rural sample. In rural areas, the most commonly reported place for treatment are hospitals, where 31.6 percent of health care clients reported first visiting compared to about 17.9 percent of urban health care clients. Rural residents are also more likely to use polyclinics than their urban counterparts (26.3 percent vs. 17.9 percent).

As implied by these findings, bypassing was found to be very extensive among sample individuals, as 48 percent of all public clients reported going straight to a polyclinic or hospital rather than an ambulance or PHC. If the analysis is restricted to those public clients who reported having only a cold or flu, more than 38 percent went directly to polyclinics or hospitals. It is interesting to note that bypassing is higher among individuals living in rural areas, even though they must travel further distances to receive care in polyclinic or hospital. On average, rural individuals in the sample must travel 5.8 kilometers to reach a polyclinic (vs. 0.2 kilometers for urban households) and 6.2 kilometers to reach a hospital (vs. 0.9 kilometers for urban individuals). This increased travel distance may not be significant for all rural users, depending on the individual's mode of transportation. Those who went directly to polyclinics and hospitals cited unavailability of services and unsuitable facility hours of the closest lower-level facility as the leading reasons for bypassing. In part, this phenomenon may be due to some dynamics of care seeking common to rural areas in general (not just limited to Albania). Because rural residents are usually poorer and less well educated than their urban counterparts, they may not be as attuned to health problems as urban dwellers. For this reason, they may not become aware of the scope of a health problem until it becomes more severe, at which point it is logical for them to seek the specialized treatment available (in Albania) only at hospitals and polyclinics.

5. Descriptive Results: Out-of-Pocket Expenditures

This section presents descriptive findings on the frequency and magnitude of out-of-pocket health care expenditures. The results are disaggregated by socioeconomic status, by urban/rural status, and by the type of facility utilized. We focus on the sample of individuals who sought treatment for acute health problems, as we have more detailed expenditure information for this sub-sample.

5.1 Consultation Expenditures for Acute Problems

Tables 3 and 4 present results on the percentage of individuals who paid for services. Overall, 95.2 percent reported paying anything for health care, including consultations, gifts, laboratory tests, medicines, food and/or other items. There were no significant differences between urban and rural clients nor between rich and poor clients in the percent who paid.

Table 3: Proportions of Acutely Ill Outpatients Who Paid Anything for Consultations, Gifts, Tests, Drugs, Food, and Other Expenditures, by Place Where Care Was Received and Urban/Rural Status

Payments	Total	Place where care was received					
		Ambulance	PHC	Polyclinic	Hospital	Priv. clinic	Home visit
Total	*n*=326	*n*=40	*n*=93	*n*=77	*n*=61	*n*=19	*n*=23
Proportion of acutely ill outpatients seeking care who paid for anything	95.2	90.0	93.5	98.7	98.4	94.7	90.9
Proportion of acutely ill outpatients seeking care who paid for:							
Consultation	44.6	25.0	28.7	57.9	58.3	61.1	45.0
Gifts and other payments	24.7	16.7	40.2	15.8	23.3	22.2	15.0
Laboratory tests	24.0	11.1	16.1	27.6	41.7	38.9	5.0
Medicines	92.2	97.2	94.3	92.1	95.0	94.4	65.0
Food and transportation	44.3	22.2	24.1	64.5	76.7	38.9	5.0
Urban	*n*=153		*n*=60	*n*=27	*n*=20	*n*=17	*n*=18
Proportion of acutely ill outpatients seeking care who paid for anything	95.7	NA	95.0	96.3	100.0	94.1	94.1
Proportion of acutely ill outpatients seeking care who paid for:							
Consultation	35.8	NA	28.1	34.6	45.0	56.3	37.5
Gifts and other payments	30.6	NA	45.6	19.2	30.0	25.0	6.3
Laboratory tests	31.3	NA	24.6	46.2	45.0	43.8	6.3
Medicines	89.6	NA	93.0	92.3	95.0	93.8	62.5
Food and transportation	23.9	NA	21.1	23.1	45.0	37.5	0.0

Rural	*n*=172	*n*=40	*n*=33	*n*=50	*n*=41	*n*=2	*n*=5
Proportion of acutely ill outpatients seeking care who paid for anything	94.7	90.0	90.9	100.0	97.6	100.0	80.0
Proportion of acutely ill outpatients seeking care who paid for:							
Consultation	51.9	25.0	30.0	70.0	65.0	100.0	75.0
Gifts and other payments	19.8	16.7	30.0	14.0	20.0	0.0	50.0
Laboratory tests	17.9	11.1	0.0	18.0	40.0	0.0	0.0
Medicines	94.4	97.2	96.7	92.0	95.0	100.0	75.0
Food and transportation	61.1	22.2	30.0	86.0	92.5	50.0	25.0

NA: Not Applicable

Table 4: Proportions of Acutely Ill Outpatients Who Paid Anything for Consultations, Gifts, Tests, Medicines, Food, and Other Items, by Household Wealth Quintile

Acutely ill outpatients	**Total**	**Household wealth quintiles**				
		Poorest	**Second**	**Third**	**Fourth**	**Richest**
	n=326	*n*=49	*n*=78	*n*=64	*n*=49	*n*=86
Proportion seeking care who paid for something	92.0	93.9	88.5	96.9	93.9	89.5
Proportion seeking care who paid for:						
Consultation	44.7	56.5	46.4	43.5	37.0	41.6
Gifts and other payments	24.7	13.0	15.9	32.3	28.3	31.2
Laboratory tests	24.0	15.2	15.9	29.0	32.6	27.3
Medicines	92.3	97.8	92.8	96.8	95.7	83.1
Food and transportation	44.7	76.1	44.9	48.4	41.3	24.7

While government policy stipulates that user fees should be charged to all clients in polyclinics and hospitals and all non-insured clients in ambulances and hospitals, results from a survey of facility directors in the sample areas found that almost all facility directors report that official user fees are not charged. However, the results of the household survey tell a different story, as a substantial proportion of outpatient clients reported paying for consultations. Of those persons who sought treatment in the one-month period prior to the survey, 44.6 percent reported paying for consultations and 24.7 reported giving either in-kind or monetary gifts. For those individuals who reported making gift payments, the survey included a question on whether the payment was voluntary or explicitly requested by health care staff. Almost all outpatients (95 percent) who reported paying gift payments reported that the gifts were voluntary.

As indicated by Tables 3 and 4, the proportion of clients who paid for consultations varied by the type of health care facility utilized, by the urban/rural status of the client, and by socioeconomic status. In terms of facility type, clients of polyclinics and hospitals were much more likely to have paid than clients of PHCs and ambulances. For example, 57.9 percent of polyclinic clients and 58.3 percent of hospital clients paid vs. 28.7 percent of PHC clients. Moreover, the percent of polyclinic and hospital clients that paid was very similar to that of private clinic clients. With respect to geographic location, rural clients reported paying more frequently for consultations for each type of health care facility observed than urban clients. Overall, 51.9 percent of rural clients reporting paying for the consultation compared to 35.8 percent of urban clients. The finding that a greater proportion of rural clients reported paying for consultations in polyclinics and hospitals is interesting because these

types of facilities are located exclusively in municipalities and serve both urban and rural populations. There are a number of possible explanations for this finding. First, as suggested in the qualitative study, rural individuals seeking care at polyclinics and hospitals, which are located solely in municipalities, may feel more vulnerable and, as a response, are more likely to pay informal payments in polyclinics and hospitals than are urban clients, perhaps as a strategy to help ensure they are seen by a doctor and to make sure they receive good quality care. Another possibility is that providers may be more likely to demand payments from rural clients, perhaps as a result of provider bias or because rural clients are perceived as being less likely to provide gifts. Unfortunately, the data do not allow us to test these possible explanations.

The results from Table 3 also suggest that the proportion of rural clients of urban-based polyclinics and hospitals who paid for food and/or transportation is much higher than among urban clients. For example, 86 percent of rural clients of polyclinics paid for food and transportation compared to 23 percent of urban clients. These costs could potentially be a barrier to access to those living in rural areas if the services are only delivered in urban-based facilities.

While providers interviewed in the qualitative study maintained that there is no discrimination in charging practices according to the socioeconomic status of clients, the survey findings provides conflicting evidence. Of those who used health care services to treat acute health problems, the poor were found to be more likely to pay for consultations, but were less likely to make gift payments than better-off clients. For example, 56.5 percent of clients in the poorest wealth quintile reportedly paid for consultations vs. 41.6 percent of clients in the richest wealth quintile, but 13.0 percent of poorest clients provided gifts vs. 31.2 percent of the richest clients. One possible explanation for this finding is that providers are more likely to demand consultation payments from the poor than from better-off clients, perhaps as a response to the poor being not as likely to give gifts.

Tables 5 and 6 provide results on the average amounts paid for health care services and the share of health care expenditures paid for consultations, gifts, laboratory tests, medicines, food and other items. Again, the results presented in these tables are based on the sample of acutely ill individuals reporting to have used outpatient services, regardless of whether they report paying for services. As can be seen from Table 5, medicines make up the largest share of out-of-pocket expenditures among outpatients (59.9 percent), followed by food and transport (16.3 percent), consultations (10.9 percent), laboratory tests (7.5 percent), and gifts (5.5 percent). The reported share of expenditures spent on consultations and gifts are markedly lower than findings from studies from other countries using similar research methods. For example, nationally representative household survey data from Tajikistan indicate that of the total amounts spent for outpatient care, on average, 20 percent is spent on consultation fees and 38 percent is spent on informal gifts (Falkingham 2004).

Expenditures for consultations are observed to vary by the type of facility used, with private clinics being the most expensive, on average, followed by hospitals, polyclinics, ambulances (located in rural areas), and PHCs. This finding could be a result of a number of factors, including the possibilities that (1) expenditures on officially mandated fees might be higher in polyclinics and hospitals than in lower-level facilities (a possibility that is inconsistent with findings of the survey of facility directors), and (2) informal payment levels might be higher in polyclinics and hospitals than in lower-level facilities due to differences in official salary levels between specialists and GPs and/or differences in perceived quality of care between higher- and lower-level facilities. Also as can be seen from the table, the average value of gifts that the sample reported giving in higher-level facilities are considerably higher than the average value reported in lower-level facilities.

Table 5: Mean Levels and Shares of Total Payments for Consultations, Gifts, Tests, Medicines, Food, and Other Items Among Acutely Ill Outpatients, by Place Where Care Was Received and by Urban/Rural Status (in Lek)*

Payments	Total	Place where care was received					
		Ambulance	PHC	Polyclinic	Hospital	Priv. clinic	Home visit
Total	*n*=312	*n*=40	*n*=93	*n*=77	*n*=60	*n*=19	*n*=23
Total	1,765	1,595	1,125	1,836	2,208	4,684	840
Consultations	192	166	60	206	268	642	151
Gifts	97	18	102	56	88	368	148
Laboratory tests	133	73	60	201	184	332	9
Medicine	1,058	911	806	1,047	1,319	2,463	523
Food and transport	287	428	102	326	349	879	9
Total	100.09	100.00	100.48	100.00	100.00	100.00	100.00
Share for consultations	10.9	10.4	5.4	11.2	12.2	13.7	18.0
Share for gifts	5.5	1.1	9.1	3.0	4.0	7.9	17.6
Share for laboratory tests	7.5	4.5	5.4	10.9	8.3	7.1	1.0
Share for medicines	59.9	57.1	71.6	57.0	59.7	52.6	62.4
Share for food and transport	16.3	26.8	9.1	17.7	15.8	18.8	1.0
Urban	*n*=141		*n*=60	*n*=27	*n*=19	*n*=17	*n*=18
Total	1,843	NA	1,314	1,874	2,285	4,359	717
Consultations	180	NA	65	130	363	512	132
Gifts	127	NA	128	48	89	412	11
Laboratory tests	189	NA	93	381	221	371	11
Medicine	1,120	NA	919	1,176	1,325	2,106	563
Food and transport	230	NA	117	138	286	959	0
Total	100.19	0.00	100.63	100.00	100.00	100.00	100.00
Share for consultations	9.8	NA	4.9	6.9	15.9	11.7	18.4
Share for gifts	6.9	NA	9.8	2.6	3.9	9.4	1.5
Share for laboratory tests	10.2	NA	7.1	20.4	9.7	8.5	1.5
Share for medicines	60.8	NA	69.9	62.8	58.0	48.3	78.5
Share for food and transport	12.5	NA	8.9	7.4	12.5	22.0	0.0
Rural	*n*=171	*n*=40	*n*=33	*n*=50	*n*=41	*n*=2	*n*=5
Total	1,700	1,595	782	1,816	2,172	7,450	1,280
Consultations	202	166	52	248	224	1,750	220
Gifts	72	18	55	60	88	0	640
Laboratory tests	87	73	0	103	167	0	0
Medicine	1,006	911	601	978	1,316	5,500	380
Food and transport	333	428	75	427	377	200	40
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00
Share for consultations	11.9	10.4	6.6	13.7	10.3	23.5	17.2
Share for gifts	4.2	1.1	7.0	3.3	4.0	0.0	50.0
Share for laboratory tests	5.1	4.5	0.0	5.7	7.7	0.0	0.0
Share for medicines	59.2	57.1	76.9	53.8	60.6	73.8	29.7
Share for food and transport	19.6	26.8	9.6	23.5	17.4	2.7	3.1

* 1US$=135 lek in December 2002 (Source: Bank of Albania)
NA: Not Applicable

Table 6: Mean Levels and Shares of Total Payments for Consultations, Gifts, Tests, Medicines, Food, and Other Items among Acutely Ill Outpatients, by Household Wealth Quintile (in Lek)*

Payments	Total	Household wealth quintiles				
		Poorest	Second	Third	Fourth	Richest
	n=325	*n*=48	*n*=78	*n*=64	*n*=49	*n*=86
Percent of monthly income spent on outpatient care	16.9	20.2	19.6	18.3	16.0	11.8
Total	1,713	1,472	1,649	1,783	1,821	1,792
Consultations	185	127	198	172	155	232
Gifts	93	33	73	94	73	155
Laboratory tests	128	98	76	170	184	128
Medicine	1,025	895	1,060	965	1,118	1,060
Food and transport	284	318	242	391	291	217
Total	100.1	100.0	100.0	100.4	100.0	100.0
Share for consultations	10.8	8.6	12.0	9.6	8.5	13.0
Share for gifts	5.4	2.3	4.4	5.3	4.0	8.6
Share for laboratory tests	7.5	6.7	4.6	9.5	10.1	7.1
Share for medicines	59.9	60.8	64.3	54.1	61.4	59.1
Share for food and transport	16.5	21.6	14.7	21.9	16.0	12.1

*1US$=135 leke in December 2002 (Source: Bank of Albania)

Turning to the findings on differences in payments between the urban and rural sample, on average, rural clients of PHCs pay less for consultations than their urban counterparts, and rural clients of polyclinics pay more for consultations than their urban counterparts. These findings are consistent with the study hypotheses on the influence of physician salary levels and urban/rural status on out-of-pocket expenditures. Not consistent with the hypotheses is the finding that urban hospital clients pay more, on average, than their rural counterparts.

Finally, as indicated in Table 6, average payment levels were found to vary by the household wealth status of clients. In general, total payments and payments for item-specific services and items increase with the wealth status of the client. For example, clients in the richest wealth group paid an average of 1,792 Lek on all costs associated with care, while the poorest group of clients paid an average of 1,472 Lek. For consultations, clients in the richest group paid an average of 232 Lek vs. 127 paid by the poorest group.

In order to assess the magnitude of these payments, we calculated the share of total monthly expenditures that was spent on care associated with the acute illness. Because this study did not collect household expenditure data (other than for health care), we estimated total expenditures using the following method. First, using the 2002 Livings Standards Measurement Survey, a national household survey administered by INSTAT that collected information on household expenditures and the same types of information on household wealth as the current study, we regressed monthly household expenditures on measures of assets and housing conditions. Second, we used the estimated coefficients from this regression to predict monthly household expenditures for this sample. As indicated in the top row in Table 6, we estimate that, on average, 16.9 percent of total monthly household per capita expenditures were spent on health care among outpatients who used health care services to treat acute illnesses and problems in the past month. Also, the share of total monthly expenditures declines with increases in household wealth (20.2 percent for the poorest quintile vs. 11.8 percent for the richest quintile).

5.2 Medicine Expenditures for Acute and Chronic Problems

As mentioned in the background section, one of the benefits of Albania's social health insurance system are subsidies for prescribed medicines. If a patient is prescribed medicines that have been approved for subsidies, the patient can purchase the medicine at a discount or receive it for free, depending on the drug prescribed. Tables 7 and 8 present results on the percent of acutely and chronically ill individuals who were prescribed medicines, the percent that paid for medicines, and the average amounts paid for both the insured and non-insured sample who used health care services. The results indicate that insurance is associated with savings in medicine expenditures among the chronically ill sample, but not among the acutely ill sample. For example, among the chronically ill, the insured paid 36 percent less, on average, than the non-insured for the most recent prescription (1,093 Lek vs. 1,717 Lek). On the other hand, among the acutely ill, there was no significant difference between the insured and uninsured in the average amounts paid for prescriptions received within the month before survey (1,177 Lek vs. 1,198 Lek). Average expenditure levels were not found to vary by the household wealth levels.

Table 7: Percent of Acutely Ill Individuals Who Were Prescribed Medicines, the Proportion Who Paid Anything, and Average Payment, by Household Wealth Quintile and Health Insurance Status

Acutely ill	Total	Household wealth quintiles				
		Poorest	Second	Third	Fourth	Richest
Percent of acutely ill outpatients who were prescribed medicines						
	n=316	*n*=49	*n*=75	*n*=63	*n*=48	*n*=81
Total	89.6	91.8	86.7	95.2	93.8	84.0
	n=155	*n*=8	*n*=27	*n*=25	*n*=33	*n*=62
Insured	87.7	87.5	85.2	92.0	97.0	82.3
	n=161	*n*=41	*n*=48	*n*=38	*n*=15	*n*=19
Uninsured	91.3	92.7	87.5	97.4	86.7	89.5
Proportion of acutely ill outpatients that paid for medicines						
	n=283	*n*=45	*n*=65	*n*=60	*n*=45	*n*=68
Total	97.9	100.0	98.5	100.0	97.8	94.1
	n=136	*n*=7	*n*=23	*n*=23	*n*=32	*n*=51
Insured	95.6	100.0	95.7	100.0	96.9	92.2
	n=147	*n*=38	*n*=42	*n*=37	*n*=13	*n*=17
Uninsured	100.0	100.0	100.0	100.0	100.0	100.0
Average payment for medicine among acutely ill outpatients who were prescribed medicines						
	n=283	*n*=45	*n*=65	*n*=60	*n*=45	*n*=68
Total	1,188	1,021	1,272	1,029	1,217	1,340
	n=136	*n*=7	*n*=23	*n*=23	*n*=32	*n*=51
Insured	1,177	471	1,165	979	1,227	1,338
	n=147	*n*=38	*n*=42	*n*=37	*n*=13	*n*=17
Uninsured	1,198	1,123	1,330	1,061	1,192	1,348

Table 8: Percent of chronically Ill Individuals Who Were Prescribed Medicines, the Proportion Who Paid Anything, and Average Payment, by Household Wealth Quintile and Health Insurance Status

Chronically ill	Total	Household wealth quintiles				
		Poorest	Second	Third	Fourth	Richest
Percent of chronically ill outpatients who were prescribed medicines						
	n=1,064	*n*=214	*n*=206	*n*=201	*n*=221	*n*=221
Total	96.7	93.0	96.6	98.0	98.6	97.3
	n=674	*n*=71	*n*=98	*n*=128	*n*=179	*n*=198
Insured	97.8	93.0	98.0	97.7	98.9	98.5
	n=390	*n*=143	*n*=108	*n*=73	*n*=43	*n*=23
Uninsured	94.9	93.0	95.4	98.6	97.7	87.0
Proportion of chronically ill outpatients that paid for medicines						
	n=1,064	*n*=214	*n*=206	*n*=201	*n*=221	*n*=221
Total	94.0	98.1	95.1	91.5	95.0	90.0
	n=674	*n*=71	*n*=98	*n*=128	*n*=179	*n*=198
Insured	91.1	97.2	90.8	86.7	94.4	88.9
	n=390	*n*=143	*n*=108	*n*=73	*n*=43	*n*=23
Uninsured	99.0	98.6	99.1	100.0	97.7	100.0
Average payment for medicine among chronically ill outpatients who were prescribed medicines						
	n=1,064	*n*=214	*n*=206	*n*=201	*n*=221	*n*=221
Total	1,321	1,426	1,666	1,313	1,235	993
	n=674	*n*=71	*n*=98	*n*=128	*n*=179	*n*=198
Insured	1,093	1,245	1,514	821	1,167	939
	n=390	*n*=143	*n*=108	*n*=73	*n*=43	*n*=23
Uninsured	1,717	1,515	1,805	2,176	1,522	1,459

Although the insured are entitled to receive certain types of medicines for free, the proportion of the insured sample that reported paying something for the most recent prescription is high. For example, among the insured who were prescribed medicines, 88.9 percent of the chronically ill and 92.2 percent of the acutely ill reported paying some money for their prescriptions. (All non-insured individuals who were prescribed medicines paid). However, it should be noted that because the survey did not gather information on the types of medicines prescribed, it is not known whether patients were prescribed drugs that should have been received at a reduced price or for free.

5.3 Inpatient Visit Expenditures for Acute Problems

Table 9 provides expenditure results on those acutely ill individuals who reported being hospitalized in the month prior to the survey. The table shows the proportion of individuals who report paying for health care services, the average amounts spent, average cost shares, and the average percent of total monthly per capita expenditures spent for the hospitalization. As can be seen, all individuals paid at least something for care, and, in terms of the proportion of total household expenditures that were incurred, average payments are considerable. Of the 31 individuals who were hospitalized, an average of 102.0 percent of total per capital monthly expenditure was spent on the total costs of hospitalizations, and, of this amount, an average of 16.8 percent was spent on doctors' services and another 39.8 percent was spent on gifts. Over 61 percent of inpatients reported making

gift payments, and, of these individuals, 80 percent reported that the gifts were voluntary and not explicitly requested by hospital staff. This may be an oversimplified representation of why informal payments are made, as the qualitative survey in the same study areas indicated that informal payments take many forms, ranging from voluntary gifts to express gratitude for services to compulsory payments demanded by a wide variety of hospital staff members, including doctors, nurses, and lower-level staff responsible for care. Unfortunately, we do not have the information to investigate the types of staff that were paid – both for doctors' services and for gifts – and how and why they were paid.

Table 9: Percent of Inpatients Who Paid for Care, and Mean Levels and Shares of Total Payments For Inpatient Health Care Services by Household Wealth Quintile (in Lek)*

Payments	Total	Household wealth quintiles				
		Poorest	Second	Third	Fourth	Richest
	n=31	*n*=3	*n*=14	*n*=4	*n*=5	*n*=5
Proportion of acutely ill inpatients seeking care who paid for something	100.0	100.0	100.0	100.0	100.0	100.0
Proportion of acutely ill inpatients seeking care who paid for:						
Consultations	45.2	66.7	35.7	25.0	40.0	80.0
Gifts	61.3	100.0	64.3	75.0	20.0	60.0
Laboratory tests	58.1	33.3	57.1	100.0	20.0	80.0
Medicine	80.6	66.7	85.7	75.0	80.0	80.0
Food and transport	87.1	100.0	100.0	75.0	60.0	80.0
Percent of monthly income spent on inpatient care	102.0	165.4	149.0	47.9	26.2	51.4
Total	8,850	17,233	10,704	5,923	2,720	7,100
Consultations	1,490	3,567	957	1,500	400	2,820
Gifts	3,519	10,000	4,964	1,000	400	720
Laboratory tests	858	1,167	850	625	100	1,640
Medicine	1,627	1,233	2,132	1,148	1,500	960
Food and transport	1,355	1,267	1,800	1,650	320	960
Total	100.0	100.0	100.0	100.0	100.0	100.0
Share for consultations	16.8	20.7	8.9	25.3	14.7	39.7
Share for gifts	39.8	58.0	46.4	16.9	14.7	10.1
Share for laboratory tests	9.7	6.8	7.9	10.6	3.7	23.1
Share for medicines	18.4	7.2	19.9	19.4	55.1	13.5
Share for food and transport	15.3	7.4	16.8	27.9	11.8	13.5

* 1US$=135 lek in December 2002 (Source: Bank of Albania)

As expected, the percentage of poor clients that paid is substantially higher than the percentage among better-off clients. The poorest quintile also pays more relative to per capita household expenditure. For example, among individuals in the poorest quintile, it is estimated that an average 165.4 percent of total per capita expenditures was spent on hospitalizations vs. 51.4 percent among individuals in the top household wealth group. Notice the sample sizes listed in the heading of the table. These wealth breakdowns should be considered cautiously, as the sample of hospitalized

individuals in each of the household wealth groups is extremely small, ranging from only three individuals in the poorest quintile to 14 individuals in the next poorest quintile.

6. Multivariate Results

As noted previously, maximum-likelihood probit and ordinary least squares regression estimations were performed to test the effects of health insurance status, socioeconomic status (SES), and urban/rural residence on the prevalence and magnitude of several different types of health care expenditures: (1) consultation costs at PHCs for outpatient acute care, (2) consultation costs at hospitals and polyclinics for outpatient acute care, (3) consultation and gift payments for outpatient acute care at any type of government health facility, and (4) expenditures on medicine for outpatient acute and chronic care at any type of government health facility. Each expenditure outcome will be addressed in turn.

6.1 Consultation Costs at PHCs for Outpatient Acute Care

Table 10 presents results for total consultation costs for acute care for individuals who used PHCs. Only a few factors are associated with either the likelihood of incurring expenditures or the magnitude of those expenditures, though it should be noted that the sample of users of PHCs is small – only 45 children under the age of 18 and 47 adults over the age of 18. This is particularly problematic for the under-18 sample, where only 12 percent of the variation in expenditures is explained by the statistical model, approximately half that of the model for the over-18 sample. Even so, the results indicate that insurance has a statistically significant effect on the likelihood of incurring consultation costs, but in the opposite direction as that hypothesized. Simulations using the predicted probabilities from the probit estimation results indicate that having health insurance increases the likelihood that individuals 18 years and over will incur medical expenditures by 9 percentage points, from 26 percent of the uninsured to 35 percent of the insured. Similarly, the OLS results indicate that the magnitude of the effect is an additional 80 Lek relative to those who do not have health insurance, although this result is not statistically significant. In contrast, having health insurance has the hypothesized effect of decreasing the likelihood of medical expenditures for children under the age of 18, but this result is statistically significant at only the 20-percent level.

Socioeconomic status affects consultation costs in the hypothesized directions, at least for adults. Holding everything else constant, being in the poorest two socioeconomic quintiles reduces the likelihood of incurring consultation costs by 19 percentage points, from 37 percent of those in the upper three quintiles to only 18 percent of users in the lowest two quintiles, while being in the lowest socioeconomic quintile reduces consultation costs by 129 Lek. These effects are not apparent for the under-18 sample.

The null hypothesis that rural residents pay the same amount as urban residents at PHCs is not rejected in the OLS models for either age group. In neither OLS estimation are the coefficients on urban residence statistically different from 0. In the probit estimations for the adult sample, however, it was found that urban residents were 3 percentage points less likely to incur consultation costs than rural residents – 31 percent versus 34 percent. Interestingly, it was also found that better educated individuals, particularly those with secondary or higher education, spent less on consultation costs than those with less schooling.

Table 10: Total Consultation Costs for Acutely Ill Individuals Who Used PHCs And Were Not Hospitalized

Explanatory variables	OLS		Probit	
	0 to 17 years old[a]	18+ years old	0 to 17 years old	18+ years old
Have health insurance	-31.5563	80.1233	-0.8335	1.4168**
	(-1.190)	(1.210)	(-1.450)	(2.020)
Male	-7.7492	64.4735	-0.1138	1.3737***
	(-0.340)	(1.120)	(-0.230)	(2.740)
Age				
Under 5 years of age	16.9261		0.0785	
	(0.720)		(0.140)	
60 years of age and older		-81.5639		-1.3627**
		(-1.530)		(-2.260)
Wealth status of household				
Poorest SES quintile	29.2797	-128.5287	0.8323	
	(0.790)	(-1.650)	(1.170)	
Poorest two SES quintiles				-2.1262***
				(-2.650)
Female household head	26.8843	149.6308	1.2305	1.2328
	(0.640)	(1.290)	(1.550)	(1.590)
Live in an urban area	21.6121	-13.4582	1.0609	-1.7023**
	(0.710)	(-0.190)	(1.320)	(-2.340)
Educational attainment (reference category is no education)				
Elementary school	-29.5259	-123.7104	0.0080	-0.9480
	(-0.580)	(-1.200)	(0.010)	(-1.280)
Secondary school or higher education	-45.5233	-209.6551*	-0.5457	-3.2064***
	(-1.010)	(-1.810)	(-0.780)	(-3.940)
Constant	62.2973	177.6398*	-1.0646	1.6769*
	(1.250)	(1.890)	(-1.280)	(1.900)
Number of observations	45	47	45	47
R^2	0.1268	0.2521	0.1231	0.3714
Log likelihood	NA	NA	-19.7468	-18.5018

[a] Education of individuals younger than 18 years old is represented by completed household head's education
*** p<0.01; ** p<0.05; * p<0.10; t-statistics and z-statistics shown in parentheses
NA: Not Applicable

6.2 Consultation Costs for Acute Care at Hospitals and Polyclinics

The main hypothesis to be tested regarding consultation costs at hospitals and polyclinics referred to whether individuals from rural areas were more likely to pay for consultations and to pay more than urban residents. The estimation results in Table 11 tend to support the hypothesis that rural residents are more likely to pay for consultation costs though the magnitude of the differences between urban and rural residents are not large nor statistically significant. Socioeconomic status was not found to be associated with acute care costs after controlling for other factors in the statistical model.

Table 11: Multivariate Results of the Determinants of Total Consultation Costs for Acutely Ill Individuals Who Used Hospitals or Polyclinics and Were Not Hospitalized

Explanatory variables	OLS		Probit	
	0 to 17 years old[a]	18+ years old	0 to 17 years old	18+ years old
Have health insurance	100.8220	105.2013	-0.3617	0.3879
	(0.470)	(1.060)	(-0.700)	(0.930)
Male	-55.0467	92.1434	-0.1397	0.5478*
	(-0.410)	(1.380)	(-0.330)	(1.730)
Age				
Under 5 years of age	-91.9318		-0.4157	
	(-0.460)		(-0.830)	
60 years of age and older		-189.4298		-1.4028***
		(-1.650)		(-2.610)
Wealth status of household				
Poorest SES quintile	-106.9537	143.3581	0.4774	0.5712
	(-0.760)	(0.930)	(0.910)	(1.220)
Poorest two SES quintiles	0.0905	-107.9927	-0.5076	-0.6395
	(0.000)	(-1.200)	(-0.610)	(-1.280)
Live in an urban area	-30.4749	-28.5690	-1.4500**	-0.7381*
	(-0.210)	(-0.180)	(-2.180)	(-1.820)
Went to a hospital	32.3309	115.1339	-0.2575	0.2095
	(0.180)	(1.650)	(-0.550)	(0.670)
Educational attainment (reference category is no education)				
Elementary school	142.9333	-106.6139	-0.5361	-1.5529***
	(0.700)	(-1.170)	(-0.960)	(-3.070)
Secondary school or higher education	284.1703	-68.1454	0.9484*	-1.0363*
	(1.010)	(-0.550)	(1.660)	(-1.810)
Constant	144.0221	226.9483**	1.0801	1.2848***
	(0.650)	(2.380)	(1.530)	(2.670)
Number of observations	48	90	48	90
R^2	0.0522	0.0906	0.2411	0.1717
Log likelihood	NA	NA	-24.4527	-51.2107

[a] Education of individuals younger than 18 years old is represented by completed household head's education.
*** p<0.01; ** p<0.05; * p<0.10; t-statistics and z-statistics shown in parentheses
NA: Not Applicable

6.3 Costs of Consultations and Gifts for Outpatient Acute Care

Consistent with the results presented above, socioeconomic status did not have measurable effects on consultation costs for outpatient acute care for the sample of individuals who used formal health care (Table 12). Socioeconomic status does not affect the likelihood of paying nor the magnitude of payments for gifts for adults, indicating that poor and non-poor are equally likely to make such payments. This does not hold for the under-18 sample, in which the poor are 3.6 percentage points less likely to make such payments (18.4 percent versus 22.0 percent) and who pay 107 Lek less than non-poor.

Several other findings are also worth noting. Perhaps unsurprisingly, relative to PHCs, users of polyclinics pay 208 and 90 Lek more, users of hospitals pay 252 and 201 Lek more, and users of private clinics pay 374 and 646 Lek more for the under-18 and over-18 samples, respectively. Similarly, the predicted probabilities of making a gift payment for the under-18 sample are highest at PHCs (32.1 percent), followed by hospitals (26.1 percent), private clinics (25.3 percent), polyclinics (17.6 percent), and ambulances (4.8 percent).

6.4 Medicine Costs for Acute and Chronic Care

An important component of medical expenditure is expenditure on drugs, which constitute 50 to 70 percent of total expenditures on acute outpatient care (Table 5). According to the multivariate regression results, health insurance has a sizable effect on expenditures for medicines, lessening the overall burden that households face for medical care (Table 13). All other things equal, having health insurance reduces both the probability of paying for medicines for acute and chronic care and the amount spent on medicines by 256 Lek for chronic care. There is limited evidence that the burden of drug expenditures may be higher for the poorest; 9.9 percent of chronically ill individuals in the poorest socioeconomic quintile pay for medicines as compared with 9.4 percent of the non-poor, though they pay approximately 148 Lek less for the last prescription received. No significant differences are apparent in drug expenditures for the poor and non-poor for acute care.

As with consultation costs, drug expenditures are higher among clients of private clinics – approximately 2,369 Lek higher – relative to costs among PHC clients, while hospital drug expenditures are approximately 819 Lek higher and ambulance drug expenditures are approximately 907 Lek higher. For chronic care, relative to care associated with PHCs, drug expenditures are 384 Lek higher at polyclinics, 565 Lek higher at private clinics, and 677 Lek higher at hospitals. Urban residents pay higher amounts for drugs for acute care but lesser amounts for drugs for chronic care.

Table 12: Multivariate Results of the Determinants of Total Consultation and Gifts Costs for Acutely Ill Individuals Who Used a Health Care Facility (Ambulance, PHC, Polyclinic, Hospital, Clinic or Home Visit) and Were Not Hospitalized

Explanatory variables	Consultation				Gifts			
	OLS		Probit		OLS		Probit	
	0 to 17 years old [a]	18+ years old	0 to 17 years old	18+ years old	0 to 17 years old [a]	18+ years old	0 to 17 years old	18+ years old
Have health insurance	28.4637	42.8601	-0.2466	0.0267	5.8489	69.7615	-0.2063	-0.3158
	(0.340)	(0.340)	(-0.830)	(0.100)	(0.100)	(0.520)	(-0.530)	(-0.990)
Male	-25.4245	-16.5633	-0.1543	0.1967	43.8619	41.4625	0.6013**	-0.2661
	(-0.340)	(-0.310)	(-0.590)	(0.880)	(1.420)	(0.390)	(2.230)	(-1.040)
Age								
Under 5 years of age	-6.2330		0.0960		17.7781		0.0299	
	(-0.080)		(0.340)		(0.420)		(0.100)	
60 years of age and older		-142.3268		-0.8761**		-143.4008		0.0410
		(-1.540)		(-2.520)		(-0.910)		(0.110)
Wealth status of household								
Poorest SES quintile	-60.3109	-29.7075	0.1955	-0.0708	-107.2860***	188.7794	-1.4246***	-0.2105
	(-1.090)	(-0.220)	(0.620)	(-0.230)	(-2.960)	(0.880)	(-2.720)	(-0.590)
	-37.4674	13.9328	0.3292	-0.0224	-81.1744**	-143.0200**	-1.1773**	-0.7632*
Poorest two SES quintiles								
	(-0.540)	(0.170)	(0.570)	(-0.070)	(-2.130)	(-2.100)	(-1.990)	(-1.930)
Live in an urban area	-42.9770	-87.9912	-0.6219*	-0.3734	-31.6854	107.5375	-0.1246	0.4652
	(-0.730)	(-0.680)	(-1.840)	(-1.210)	(-0.550)	(0.500)	(-0.290)	(1.330)
Type of care utilized (reference category is care from provider in primary health center)								
Ambulance	1.3819	154.1901	-0.5642	-0.3131	-101.4655***	-29.3407	-0.8679*	-1.0430**
	(0.020)	(0.790)	(-1.290)	(-0.760)	(-2.770)	(-0.250)	(-1.900)	(-1.990)
Polyclinic	208.2683**	90.6436*	1.0213***	0.3737	-49.3307	-15.6766	-1.2278**	-0.3823
	(2.250)	(1.800)	(2.800)	(1.390)	(-1.360)	(-0.250)	(-2.590)	(-1.320)
Hospital	252.0977	200.8597**	0.8785**	0.5004	-14.9003	114.7815	-0.8799**	-0.0426
	(1.500)	(2.210)	(2.550)	(1.620)	(-0.290)	(0.810)	(-2.420)	(-0.130)
Private clinic	374.2905*	646.0511**	1.2596**	0.5774	-49.5105	379.6768	-1.0798	-0.3377

	(1.810)	(2.060)	(2.300)	(1.330)	(-0.650)	(1.120)	(-1.600)	(-0.720)
Home visit	100.4164	86.8583	0.4035	0.3176	-80.5919*	151.1507	-1.0387**	-1.0474*
	(1.190)	(0.910)	(0.830)	(0.700)	(-1.930)	(0.620)	(-1.980)	(-1.810)
Educational attainment (reference category is no education)								
Elementary school	32.6604	-147.5592	-0.1291	-0.9546***	19.0528	-56.2439	-0.0678	-0.2812
	(0.580)	(-1.380)	(-0.370)	(-2.820)	(0.570)	(-0.430)	(-0.170)	(-0.730)
Secondary school or higher education	96.1519	-117.6868	0.1692	-0.8528**	42.5648	-145.8207	0.1209	-0.0853
	(1.120)	(-0.980)	(0.500)	(-2.160)	(1.550)	(-0.810)	(0.340)	(-0.200)
Constant	16.4470	275.1729*	-0.4189	0.7026*	94.0027**	93.6786	0.0167	-0.2637
	(0.200)	(1.790)	(-0.920)	(1.780)	(2.190)	(0.540)	(0.030)	(-0.630)
Number of observations	130	181	130	181	130	181	130	181
R^2	0.1021	0.1261	0.1952	0.0949	0.1455	0.0973	0.1972	0.0894
Log likelihood	NA	NA	-68.9017	-113.1300	NA	NA	-59.9755	-85.8852

[a] Education of individuals younger than 18 years old is represented by completed household head's education.

*** p<0.01; ** p<0.05; * p<0.10; t-statistics and z-statistics shown in parentheses

NA: Not Applicable

Table 13: Multivariate Results of the Determinants of Total Medicine Costs for Those Individuals Acutely and Chronically Ill, 18 Years and Older Who Used a Health Care Facility (Ambulance, PHC, Polyclinic, Maternity, Hospital, Clinic or Home Visit) and Were Not Hospitalized

Explanatory variables	Prescribed medicine				Prescribed and filled medicine prescription			
	Acutely ill		Chronically ill		Acutely ill		Chronically ill	
	OLS	Probit	OLS	Probit	OLS	Probit	OLS	Probit
Have health insurance	-174.6374	-1.2245**	-255.9534**	-0.9778***	-159.2824		-255.9534**	-0.9778***
	(-0.780)	(-2.470)	(-2.100)	(-3.410)	(-0.690)		(-2.100)	(-3.410)
Male	164.9771	-0.2864	-74.3703	-0.7096***	198.8570	-0.1301	-74.3703	-0.7096***
	(0.850)	(-0.700)	(-0.670)	(-4.340)	(1.000)	(-0.320)	(-0.670)	(-4.340)
Age								
Under 5 years of age	-221.3965	0.0905	-421.0923***	0.1934	-203.3588	-0.6766	-421.0923***	0.1934
	(-0.900)	(0.200)	(-3.540)	(1.180)	(-0.820)	(-1.360)	(-3.540)	(1.180)
60 years of age and older	4.8473	-0.0729	-147.8099	0.8661**	-23.0081		-147.8099	0.8661**
	(0.020)	(-0.170)	(-1.260)	(2.170)	(-0.100)		(-1.260)	(2.170)
Female household head	-552.6695**	-1.2987**	-91.1983	-0.3110	-489.8409*		-91.1983	-0.3110
	(-2.210)	(-2.150)	(-0.800)	(-1.400)	(-1.780)		(-0.800)	(-1.400)
Live in an urban area	428.7173**	2.0821***	-210.0258*	-0.0680	382.3945*	1.1040	-210.0258*	-0.0680
	(1.990)	(2.720)	(-1.790)	(-0.350)	(1.710)	(1.640)	(-1.790)	(-0.350)
Type of care utilized (reference category is care from provider in primary health center)								
Ambulance	906.7888**		5.8230	-0.2000	880.5181**		5.8230	-0.2000
	(2.550)		(0.040)	(-0.580)	(2.430)		(0.040)	(-0.580)
Maternity			326.9156				326.9156	
			(1.260)				(1.260)	
Polyclinic	243.1389	-1.1059**	384.3806***	0.1693	255.4740		384.3806***	0.1693
	(1.180)	(-2.560)	(3.570)	(0.880)	(1.190)		(3.570)	(0.880)
Hospital	819.0175***	-0.2201	677.4375***	-0.2188	834.2341***		677.4375***	-0.2188
	(3.350)	(-0.400)	(3.560)	(-1.080)	(3.260)		(3.560)	(-1.080)
Clinic	2,369.4030**		565.2661***		2,393.9880**		565.2661***	
	(2.300)		(2.850)		(2.320)		(2.850)	

Home visit	-38.3552	-1.5835**			-28.0585	-1.3228*		
	(-0.140)	(-2.380)			(-0.100)	(-1.650)		
Educational attaiment (reference category is no education)								
Elementary school	31.0070	0.2031	-126.3018	-0.0170	82.4384		-126.3018	-0.0170
	(0.100)	(0.460)	(-1.020)	(-0.090)	(0.250)		(-1.020)	(-0.090)
Secondary school or higher education	13.2490	-0.3422	-114.6729	0.0223	32.9885	-1.0455**	-114.6729	0.0223
	(0.040)	(-0.720)	(-0.890)	(0.110)	(0.090)	(-2.540)	(-0.890)	(0.110)
Constant	771.8213*	2.8746***	1,631.5630***	2.7054***	743.0882	2.4132***	1,631.5630***	2.7054***
	(1.750)	(4.590)	(10.010)	(7.530)	(1.630)	(6.520)	(10.010)	(7.530)
Number of observations	168	168	972	972	165	165	972	972
R^2	0.2333	0.3531	0.0897	0.1575	0.2279	0.1948	0.0897	0.1575
Log likelihood	NA	-20.8046	NA	-166.0251	NA	-18.0409	NA	-166.0251

Education of individuals younger than 18 years old is represented by completed household head's education.
*** p<0.01; ** p<0.05; * p<0.10; t-statistics and z-statistics shown in parentheses
NA: Not Applicable

7. Summary, Limitations, and Implications for Reform

7.1 Summary

There is growing recognition among health sector decision makers in former communist countries in Central and Southeastern Europe of the importance of out-of-pocket payments in health care financing and of the potential role that informal payments can play in thwarting the success of health system strengthening efforts (Mossialos and McKee 2000). The purpose of this study has been to assess the prevalence and magnitude of private health care expenditures for outpatient care in Albania, and to identify their individual-, household-, and program-level determinants.

Although findings from an associated facility survey indicate that mandated user fees are rarely charged for outpatient or inpatient curative health care services, the household survey findings suggest that out-of-pocket payments for care provided in government facilities are in fact widespread, with marked differences in payment practices between inpatient and outpatient care. For example, among those requiring hospitalization, over 45.2 percent reported paying fees for doctors' and nurses' services and 61.3 percent reporting making gift payments, and, among those using outpatient services for acute health problems, 44.6 percent reported paying consultation fees and 24.7 percent reported providing gifts. In addition, for inpatients, the magnitude of out-of-pocket payments appears to be substantial, as payments for doctors and staff services and gifts averaged 50 percent of average monthly per capita household expenditures and total payments for hospitalizations averaged about 88 percent of average monthly per capita household expenditures. The survey data does not allow us to assess the impact of these health care expenditures on household living standards, but proportional payments of this magnitude may be catastrophic both for poor households, and for many non-poor households.

On the other hand, for outpatients using PHCs, the type of facility that is the focus of the government's primary health care program, average payments appear to be nominal. Of the estimated total monthly household expenditure per capita, individuals spent an average of 0.6 percent on consultations during the month before the survey and 10.4 percent on the total cost of care. We also found that among the sample of ill individuals not using health care facilities, the percent of individuals who report that costs – consultation costs and other costs – were a barrier to service use was very low (5.9 percent), even among those in the poorest wealth quintile (8.7 percent). This finding is consistent with a 2003 World Bank study that indicates that the responsiveness to marginal increases in service fees (price elasticity) among both the poor and non-poor is very low (inelastic).

The multivariate analysis offers a number of interesting findings regarding the determinants of private expenditures. Of particular interest are the findings on the effectiveness of Albania's social health insurance program, which in addition to improving the availability of primary health care services by paying the salaries of GPs and family doctors, is designed to provide financial relief to enrollees through subsidies for PHC consultations and prescribed medicines. The results indicate that, after controlling for other factors, insurance coverage significantly reduces the likelihood of paying for medicines to treat acute and chronic health problems, but not of paying for consultations received

at PHC facilities. Although we cannot definitively explain why insurance coverage does not influence consultation expenditures at PHC facilities, a likely explanation concerns the role that informal payments play in the total amounts necessary to receive health care services. In addition, it is possible that insurance enrollees are unaware of their rights and pay what they believe to be the official fees (which are not accounted for by health staff).

We tested two hypotheses regarding the influence of the urban-rural status of individuals on out-of-pocket costs. We hypothesized that rural clients of polyclinics and hospitals pay more for consultations than urban clients, but that rural clients of PHCs pay less for consultations than their urban counterparts. Regarding the first hypotheses, results indicate that rural clients of polyclinics and hospitals were indeed more likely to pay for consultations and to pay more for consultations than their urban counterparts, but only the former effect was found to be statistically significant. These results are interesting, particularly given that the sample of rural households was considerably poorer than the rural sample. While we cannot definitively explain the reasons for these findings, it is possible that rural individuals may not place as much trust in the care provided by providers in urban facilities, and, as a result, pay more than urban clients to make sure they receive good quality care. Regarding the second hypothesis, the results of the analysis did not provide any evidence that rural PHC clients pay less for consultations than urban clients, perhaps an indication that the extra compensation received by rural doctors does not influence charging practices.

The study did not find evidence to support the hypothesis that socioeconomic status significantly influences consultation costs for outpatient acute care. In addition, among adult patients, socioeconomic status was not found to affect the likelihood of paying gifts nor the magnitude of payments for gifts, indicating that poor and non-poor are equally likely to make such payments. This finding is not surprising, as there are no formal mechanisms in place in government-run health facilities to protect the poor from out-of-pocket health payments. However, it is interesting to note that for the sample of outpatients under 18 years of age, the poor were found to be 3.6 percentage points less likely to make such payments (18.4 percent versus 22.0 percent) and pay less than the non-poor.

7.2 Study Limitations

There are a number of limitations to the study. First, the survey data used in this analysis allow us to only partially uncover the situation regarding out-of-pocket health care expenditures. Like most surveys of household health expenditures, the survey data do not contain information that would allow us to disentangle private expenditures into the amounts spent on mandated payments vs. the amounts spent informally. Second, the health expenditure component of the survey only includes item-specific questions on one broad type of health care service – care associated with acute health problems. For this type of service, questions were asked on the amounts spent for consultations, gifts, tests, medicines, food and other items. For other types of health care services, questions were asked either on the amounts spent for certain types of items (i.e., medicines for those seeking treatment for chronic problems) or for the total amounts spent for all services and items associated with care (i.e., for maternity care). Finally, the survey does not include questions on the types and quantity of medicines prescribed and used. Not having this type of information prevents us from assessing whether health insurance enrollees received the appropriate level of subsidies for prescribed medicines.

7.3 Implications for Reform

Despite these limitations, the results have a number of implications for ongoing health reform efforts in Albania. First, strategies with the objective of addressing informal payments should first be focused at the hospital level, as the findings on the differences in charging practices between inpatient and outpatient care provides support to the premise that informal payments are a much greater problem for hospital care than for primary care. The finding that informal payments are a more severe problem for inpatient care than for outpatient is not surprising given the findings from previous studies in Albania, which suggest that hospital physicians often use their monopolistic market position in order to extract payments from patients as a precondition to delivering potentially life-saving health care services (Vian et al. 2004) and that GPs and family doctors earn substantially higher salaries than specialists (Tabaku and Fairbank 2004). Primary health care physicians are less likely to be in a position to extract large payments, as consumers of primary services have more choices on which physician to seek treatment from, both within and across health care facilities.

Second, the effectiveness of many health system-strengthening efforts may be impeded unless the issue of informal payments is adequately addressed. In fact, the social health insurance program appears to be an example in which the perverse incentives created by informal payments are partially thwarting the effectiveness of a reform, perhaps because physicians have the incentive of collecting informal payments but not official fees. It is likely that future reform efforts now being considered by the government, such as expanding the types of services covered by the social insurance program, single source financing through the Health Insurance Institute, the introduction of alternative provider payment mechanisms, and cost-sharing mechanisms, may not be as effective as planned without recognizing and addressing the informal payments issue.

Third, the limited correlation between socioeconomic status and out-of-pocket payments suggests that that there is considerable potential for improving the targeting of the poor and other vulnerable populations. Again, the introduction of programs that effectively address the problem of informal payments, along with formal targeting strategies, are likely to be essential for protecting the poor against excessive private expenditures, and for improving access to primary health care service.

There are a number of available strategies for addressing the problem of informal payments, including increasing provider accountability by strengthening systems to detect and impose penalties on providers who charge informal payments, formalizing payments through user fee strategies, introducing provider incentive systems that include quality assurance and performance assessment, and improving knowledge and awareness about patient rights and responsibilities, particularly the benefits of health insurance (Stillman and Hotchkiss 2004). While identifying the strategies that are likely to be both feasible and effective in improving health system performance in the Albanian context is beyond the scope of this analysis, it should be recognized that many of these strategies may have unintended and adverse consequences on service provision and utilization. For example, enforcing penalties for charging informal payments could result in a decrease in the supply of services if health workers opt to leave their jobs in response, and user fee strategies could actually increase the total amount of out-of-pocket payments if they do not replace informal payments. Further research is needed both to better quantify the problem of informal payments, and to monitor and evaluate the effectiveness of alternative strategies on program accountability and service efficiency, accessibility, quality, and utilization.

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