



MINISTRY OF HEALTH OF ALBANIA



UNICEF ALBANIA

FIRST DRAFT

**HOUSEHOLD SURVEY ON
HEALTH BEHAVIOUR
ATTITUDES TOWARDS HEALTH CARE SERVICES
PAID HEALTH CARE AND EXPENDITURES ON HEALTH**

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EXECUTIVE SUMMARY

Household survey on “Health behavior, attitudes towards paid health care and expenditures on health” was carried out by UNICEF jointly with the Ministry of Health with an intention to elaborate the strategies for health intervention in one or two districts. The survey was carried out in three districts– Elbasan, Pogradec and Vlora, which were selected as potential sites for primary health care project.

Though the scale of the study was not nationwide, it gives some insights on the existing health practices in the society, health seeking behavior and consumer’s opinion on health care system which was obtained from the total of 2,014 households (with 9,778 individual family members) representing almost one sixth of the population of the country.

The application of the results to a wider than just three districts scale is supported by the fact that in most of the cases almost no significant differences were observed in the responses of households from different districts. On the contrary, analysis of the results by different layers, i.e. urban and rural, which in turn was also subdivided into rural close and rural far areas, showed that some inequalities exist in the access to health care within the districts.

The detailed analysis of household’s health expenditures gives an idea on affordability of health services by different groups of population. The information collected during survey allowed us to group the population according to their socioeconomic status and, similarly as above, some significant differences were observed in the responses of the households depending on which status they belong to.

It was also possible to extrapolate the expenditures of sample population to the district level in order to get some figures on per capita expenditures of households on health. This revealed that currently the contribution of households is almost half of the amount of public per capita expenditures on health. These findings coupled with the readiness of households to introduction of formal charges could help policy-makers in refining the interventions in health care financing.

Moreover, in line with the general policy of strengthening the institution of health insurance, the study could provide information on the opinion of people about this institution and what should be done in order to empower this body and increase the participation of the population in the health insurance contributions.

The Ministry of Health of Albania is currently in the process of preparation of strategy document on health care reform in the country and it is hoped that the results of the survey will be taken into consideration while finalizing a Policy Paper on Health.

I. INTRODUCTION

The survey on “Households health behavior, attitudes towards paid health care and expenditures on health” was carried out by the Ministry of Health with the technical and financial assistance of UNICEF in three districts of Albania – Elbasan, Pogradec and Vlora. The purpose of the survey was to obtain an information from the households on current health care, specifically on their health seeking behavior, attitudes towards changes and their expenditures on health, and based on the finding elaborate the strategies for intervention in one of these districts.

Though several surveys have been carried out by the Ministry of Health and international organizations, most of them were looking at health care delivery from the provider side. This study was almost the first attempt to look at the health care situation in Albania from consumer’s perspective.

Following the description of the methodology used, the results of the survey are presented in the third chapter. The chapter is divided into four parts. The chapter describes a socioeconomic status of interviewed households also looking at their general income and expenditures. This gives an opportunity to evaluate the responses of the households not only by different districts and urban/rural areas but also according to their socioeconomic status.

Attitudes of households towards paid health care and their willingness to participate in the development of health care are described in the second part. The description of the cases of illnesses with health seeking behavior and expenditures on health is presented in the part III. The last part of the chapter gives a brief overview on existing expenditures during deliveries.

Based on the findings of the survey in three districts we tried to make the extrapolations to the national level and compare the current per capita expenditures on health by the state and health expenditures of individuals. Some specific comments conclude the report and few general recommendations are put forward.

II. METHODOLOGY

1. Design

The survey was carried out in Elbasan, Pogradec and Vlora with total number of population of 535,630 (table 1). The districts were suggested by the Ministry of Health and agreed with UNICEF.

Each district was divided into three layers (strata): urban, rural close and rural far. Since most of the health services, especially specialized ones, are located in the district center, time spent by household to reach the district center was used as a criteria for attribution of sites to one or another strata.

Table 1. Number of population by districts and strata

District \ Strata	Elbasan	Pogradec	Vlora	Total
Urban	108896	31856	77333	218085
Rural Close	123183	40191	66550	229924
Rural far	27500	13808	46313	87621
Total	259579	85855	190196	535630

Calculation of sample size

The sample size for each stratum was calculated with margin of error as 0.1, which resulted in 224 households to be interviewed in each stratum. Consequently, 672 households was calculated to be interviewed in each district which gave 2,016 households as a total sample size (table 2). It was assumed that margin of error for each district and the total sample will be 0.06 and 0.03, accordingly.

The formula used for calculation of sample size was

$$n = 1.96^2 p(1-p) \cdot deff / e^2$$

where n – is the sample size, p – probability (0.5), deff – is design effect preliminary set as 2, e – margin of error (0.1). 10% was added to the calculated size for possible refusals.

Table 2. Summary of sample size

<i>Layers</i>	<i>Number of HH</i>	<i>Number of clusters</i>
Strata	224	16
District	672	48
Whole survey	2016	144

Cluster size and number of clusters

The fieldwork in each district was planned to be completed in 6 days with 7 working hours a day. The average length of one interview including travel time from one household to next one was defined as 1 hour. Accordingly, the number of households to be interviewed during one day by one team was defined as 7 (division of length of working day in hours by time spent per one household). Since two teams were working in each cluster, 14 households were interviewed daily in each cluster.

Number of clusters per each strata was 16 (target sample divided by number of households per cluster, which is $224/14 = 15.1$ rounded to 16). Consequently, total number of clusters per one district was 48 (16 multiplied by three strata) and for the whole survey 144 (product of number of clusters per district and number of districts).

Sampling

Sampling was done in two stages: first stage - random selection of clusters using PPS (Probability Proportional to Size) methodology and second – random systematic selection of households from the list of households in each cluster. The information on the number of population was available from the EPI survey carried out in 1999.

Weighting

Not implicit stratification was used in order to ensure the representativeness of data by each strata and district and compare the results between strata and districts. This implies that the sample was not self-weighted. For getting the aggregated results by all districts and by strata in all three districts we used the weighting factors as shown in the table 3 below.

Table 3. Weighting factors used for district and overall estimates

District	Stratum	Total No. of households (HH)	Sample size (SS)	Weighting factor (No of HH/ SS)
Elbasan	Urban	27,224	224	121.5
	Rural Close	24,637	224	110.0
	Rural Far	5,550	224	24.8
Pogradec	Urban	7,964	222	35.9
	Rural Close	8,038	224	35.9
	Rural Far	2,762	224	12.3
Vlora	Urban	19,333	224	86.3
	Rural Close	13,310	224	59.4
	Rural Far	9,263	224	41.4
Total		118,081	2,014	527.5

2. *Questionnaire*

Questionnaire consists of four parts (attached):

- I. Socioeconomic
- II. Attitudes towards paid health care and participation
At the end of this part there are three tables:
Table 1. Health status of the household
Table 2. Income of the household
Table 3. Expenditure of the household
- III. Medical Part
- IV. Delivery Part

First two parts and tables were asked in all households, while medical part was filled only for each sick member of the household, who experienced a case of illness during a period of one month back from the time of the interview. Delivery part was considered if there was a delivery in the household during a period of one year back from the time of the

interview. Most of the questions were close ended with a few open ended ones. The responses were obtained through the interview of head of households and in case of his/her absence - from one of the family members.

3. Training and Pre-testing

One week training session was organized for the fieldworkers. First two days were devoted to the training of supervisors who also participated in the session for interviewers during the following two days. A one-day pre-testing of the questionnaire as well as of the whole methodology was carried out on the fifth day of the week in Tirana. Two pilot clusters were selected in the city of Tirana and the rest 6 clusters were done in rural area. The final day of the training was devoted to the discussion of the findings during pre-testing. Apparently, fieldworkers came out with no major comments and the pilot study showed that both the survey tool and methodology are working smoothly in the field.

4. Fieldwork

The fieldwork was carried out by trained 32 interviewers and 8 supervisors, the employees of the Institute of Public Health and the Ministry of Health. Most of the involved staff had an experience in household interviews from the previous EPI coverage survey carried out in 1999. In total 40 fieldworkers grouped in 16 teams were involved in data collection (48 clusters multiplied by 2 teams in each cluster and divided by 6 working days equals to 16 teams). Each supervisor was monitoring the work of two teams. At the end of the survey in each district the collected data was being submitted to the Institute of Public Health for further data entry.

5. Data entry, verification and analysis

The data was entered, verified and analyzed in EPI-INFO-6 program. The team of six people at the Institute of Public Health performed data entry. Verification of data was done through structural and crosschecking, frequency distribution and listings.

III. RESULTS

PART I. SOCIOECONOMIC STATUS OF HOUSEHOLDS

SECTION I. DESCRIPTION OF HOUSEHOLDS

1.1. Number of households interviewed

2,014 households were interviewed in three districts out of planned 2,016. Only two households in Pogradec refused to participate in the survey.

1.2. Demographic characteristics of sample population

Age: 2014 households interviewed in all three districts represented 9,778 individual family members out of which 30.4% were children under 15 year of age (1% children

under one [0.7 – 1.2], 6.6% [5.7 – 6.9] children of 1 – under 5 year of age) which is close to the national average (33% under 15 in 1998, source – INSTAT).

As we can see the birth cohort for the age group of 1 – under 5 is around 1.65 % for each year of age while for the age group of under one this indicator is only 1%. This figure is even higher for the age group of 5 – 14, which is around 2.1%. This can indicate on the drop of birth rate during last decade. The distribution of sample population by age groups by districts is presented in table 4.

Table 4. Distribution of sample population by age groups by districts (weighted).

District \ Age group	Pogradec		Vlora		Elbasan		Total	
	Freq	%	Freq	%	Freq	%	Freq	%
Under 1	28	0.9	36	1.1	33	1	97	1
1 – under 5	207	6.6	211	6.5	224	6.6	642	6.6
5 – under 14	688	21.8	633	19.6	723	21.3	2044	20.0
14 – under 30	753	23.8	802	24.9	915	27	2470	25.3
30 – under 60	1072	33.9	1129	35	1126	33.2	3327	34
60 and above	412	13	418	12.9	368	10.9	1198	12.3
Total	3160	100	3229	100	3389	100	9778	100

Distribution of age groups by strata is presented in the table 5.

Table 5. Distribution of sample population by age group by strata (weighted).

Strata \ Age group	Urban		Rural close		Rural far		Total	
	Freq	%	Freq	%	Freq	%	Freq	%
Under 1	23	0.8	39	1.1	35	1.1	97	1
1 – under 5	153	5.4	239	7.2	250	6.5	642	6.3
5 – under 14	509	17.2	723	22.7	812	21.7	2044	20.1
14 – under 30	709	24.5	782	24.2	979	27.8	2470	24.9
30 – under 60	1132	38.6	1072	33.3	1123	31.6	3327	35.2
60 and above	405	13.5	399	11.5	394	11.3	1198	12.3
Total	2931	100	3254	100	3593	100	9778	100

In urban area the proportion of population in 5 -14 age group was less (17.2% [15.5 – 18.8]) than in rural areas (22.7% in rural close [21.6 – 23.9] and 21.7% in rural far [19.9 – 23.5]) while the proportion for the 30 – 59 age groups was more in urban (38.6% [37 – 40.1]) than in rural areas (33.3 % in rural area [31.7-34.6] and 31.6% in rural far [30.4 – 32.9]). There was no significant difference between strata in other age groups.

Gender: Males represented 50.3% of total sample and females - 49.7%. There was no significant difference in distribution by gender between districts and strata.

Pensioners and Persons with Disabilities: 13.1% of household members were pensioners (1,281 persons).

8.7% of households had person(s) with disability out of which 1.9% of families (36 households) had disable child, 6.6% had disable adult and 4 families had both disable child and adult (0.2%). Among children the disabilities due to in-born causes were in 46.3%, acquired disabilities were in 47.3% and combination of both was in 6.4% of cases. Among adults most of disabilities were acquired (74.2%) and 23.1% were in-born. Combination of both was in 2.7%.

Household Size: The average size of households was 4.75 [4.6 – 4.9]. 20.8% of households had 1-3 members. 13% of households had more than 6 members. This indicator differs if we analyze it by strata. In rural close and rural far areas we can find the average size of family as 5.0 and 5.2, respectively, while in urban area the average size was significantly lower and comprised 4.4 members per household.

1.3. Characteristics of respondents

50% of respondents were head of households and another 50% were household members. 49.8 % of respondents were female and 50.2% were male.

Age: The average age of respondents was 50.5. 21.2% of respondents were between 20 – 39 years of age, 50.1% were in 40 – 59 and 28.7% were 60 age and above.

Education: In total sample 11.2% of respondents had primary education up to 4 grades, 38.7% of respondents had primary education up to 8 grades, 38.1% had secondary and 7.8% high education. 4.2% of respondents had no education.

If we look at the level of education by strata we can see that the proportion of respondents with primary education up to 4 grades is higher in rural far area (18.2%) and lower in urban (7.3%) with significant difference. The same is applicable to the level of education up to 8 grades with lowest in urban strata (24% versus 51-52% in rural areas). On the contrary, the proportion of population with secondary (50.3% [45.5 – 54.9]) and high education 14.7% [11.4 – 17.9] is significantly higher in urban than in rural areas (with secondary education 28.3% in rural close and 25.6% in rural far; high education 2.1% and 2.6% in rural close and rural far, respectively).

1.4 Characteristics of head of households

90.2% of head of households was male and 9.8% female. The average age of head of households was 51.2.

19.4% of head of households were between 20 – 39 years of age, 50.8% were in 40 – 59 and 29.8% were 60 age and above.

1.5 Housing conditions

23% of households had private house and 46.2% had private house with garden.

1.6% were renting a flat, 25% had a separate flat, 3.3% shared flat and 0.2% were living in a dormitory. 3.9% of population owned more than one flat/house. The proportion of population who owns private house with garden in urban area (21% [15.2 – 26.8]) is significantly lower than in rural areas (66.6% - 70.3%).

1.6 Private activities

Means of transportation: 72.6% of households have no private means of transportation, 12.5% of households owned a car, 14.9% - had other mean of transportation (horse, motorbike). There is a significant difference between urban and rural strata in owning the car with 16.4% [14 – 18.8] and 8.2% - 8.6%, respectively.

Agricultural assets: 35.9% of households own cattle (1.1% in urban, 61.8% in rural close and 75.6% in rural far). 86% of households who own the cattle have 1 piece of cattle.

15.9% of interviewed households own small cattle. In rural areas there is a significant difference between rural far (47.7%) and rural close (22.5%) strata. 75% of households own up to 14 pieces of ships.

41.1% of households have poultry (4.7% in urban, 67.6% in rural close and rural far 84%) and mainly (89.1%) up to 10 pieces of birds.

48.7% of households own land (5.4% in urban, 82.2% in rural close and 96% in rural far).

Trade/Business/Production: Most of the households who own the land (78.2%) produce something on their land for private use, only 1.4 % for sale, and the rest (2.4%) for private use and sale. Despite the fact that two districts (Pogradec and Vlora) are known for their fishing activities only 2.6% of households declared that they are fishing and mostly (2.2%) for private use. 10.7 % of households declared that they own or share a company, firm, shop (16.3% in urban, 7% in rural close and 4.2 in rural far strata).

When asked where they would place their family if the stair with 9 steps is given with lowest being poor and 9th – to be rich, most of respondents put their family on the 3-4 steps with average of 3.6. In urban area the households evaluate themselves better, placing their family on 4.1 step, in comparison with rural areas (with average of 3.3 in rural close and 3 in rural far).

Table 6. Selected socioeconomic variables by districts (% of households, weighted).

Variable \ District	Pogradec	Vlora	Elbasan
Have a car	9.3 [7.5 – 11.1]	15.7* [12.9 – 18.5]	10.3 [8.2 – 12.5]
Own cattle	41.3 [34.6 - 48]	24.7* [19.2 – 30.2]	42.3 [38.4 – 46.2]
Own land	54.6	44.8	49.8
Own/share company etc.	10.4	13.9	8.5

* Significant difference

1.7 Socioeconomic status by score

The information collected through socioeconomic part enabled us to group the households by their socioeconomic status. Each socioeconomic variable was given a point. The list of variables with the points is presented below in the table 7.

Table 7. Socioeconomic points

<i>Variable</i>	<i>Points</i>
INCOME	
Salary	1
Allowance/stipend/pension/compensation	1
Business/sale/service	2
Property/land	2
Total income ≤ 4,000 leks	1
Total income >4,000 – 18,000 leks	2
Total income > 18,000 leks	3
AGRICULTURAL ASSETS	
Cattle:	
1 piece	1
2- 5 pieces	2
> 5	3
Small cattle:	
≤ 3 pieces	1
4 - 14 pieces	2
> 14 pieces	3
Poultry:	
≤ 10 pieces	1
> 10 pieces	2
OTHER ASSETS	
Private house	1
Private house with land	2
Own other house	3
Car	2
Own/share company/shop/firm	3

The sum of all points results in the final score of each household. Further in the report the household will be classified by socioeconomic status according to the following scale:

< 4	–	low status
5 – 9	–	medium
More than 9	-	high

29.5% of surveyed households were found to be in the low, 53.4% in medium and 17.1% in high socioeconomic status group (graph 1).

The distribution of households according to socioeconomic status by districts and strata is presented in the table 8.

Table 8. Distribution of households by socioeconomic status by districts and strata (% weighted).

Score \ District	Low			Medium			High		
	Urban	Rural close	Rural far	Urban	Rural close	Rural far	Urban	Rural close	Rural far
Pogradec	39.6	45.5	7.6	50.9	44.6	76.3	9.5	9.8	16.1
Vlora	37.5	25.4	9.4	49.1	54	54	13.4	20.5	36.6
Elbasan	41.1	17.4	14.7	49.5	60.7	56.3	9.4	21.9	29
Total sample	39.6	24.6	10.8	49.6	56	58.2	10.8	19.4	31

In rural areas the proportion of population with high socioeconomic score is higher than in urban. There is also a difference between rural areas: in rural far the proportion of population with high score (31%) also is higher (with significant difference) than in rural close (19.4%). There is no significant difference in proportion of population with medium score between strata. The proportion of population with low score is significantly higher in urban (39.6%) than in rural areas (graph 2).

Among the districts the highest proportion of population with high socioeconomic score is in Vlora (20.8% [16.9 – 24.7]) which significantly differs from Pogradec (10.6% [7.2 – 13.9]) (table 9) (graph 3).

Table 9. Distribution of households by socioeconomic groups by district

District \ Score	Pogradec	Vlora	Elbasan
Low	37.5	27.4	28.4
Medium	51.9	51.8	55
High	10.6	20.8	16.6

SECTION 2. INCOME AND EXPENDITURES

2.1. Income and expenditures during one month in total sample

2.1.1. Income

In average the declared monthly income of households was 15,788 new leks. 11.2% of households declared no income.

Only 28.5% of households declared that they receive salary. As it is seen from the graph, salary accounts for 33.1% of household budget, which implies that mainly income comes from other sources than salary (table 10). This could be even less for majority of population because some households receive high salary, which increases overall proportion of salaries in income of total sample (table 11). In 51.9% of households their members receive pensions or any other allowances (stipend, compensation, etc).

Table 10. Total composition of income of sample population.

Components	Absolute figure (new leks)	% from total
Salary	8,868,600	33.1
Allowances/compensation/stipend/pension	4,933,630	18.4
Business/sale/service	8,584,000	32
Property/land	1,468,398	5.5
Other	2,969,303	11
Total	26,823,931	100

The proportional contribution of each source of income is presented on graph 4.

Table 11. Income components in total sample

Components	% of HH declared	Mean	25% percentile	Median	75% percentile	Minimum Value	Maximum value
Salary	28.5	15450	8000	12000	20000	100	110,000
Allowances/compensation/stipend/pension	51.9	4721	1500	4000	6200	300	30,000
Business/sale/Service	23.9	17,809	5,000	10,000	20,000	500	200,000
Property/land	9.2	7894	2,000	5,250	10,000	100	40,000
Other	10.5	14,627	5,000	10,000	15,000	900	300,000
Total sample	88.2	15,788	5,000	10,000	20,000	100	307,940

2.1.2. Expenditures:

In average the expenditures declared by households were 26,615 new leks.

Table 12. Composition of expenditures (absolute figures and proportion from total):

<i>Components</i>	<i>New Leks</i>	<i>% from total</i>
Food	20,971,238	43.3
Clothes	1,434,580	2.9
Private car	1,767,600	3.6
Transport	1,219,110	2.5
Preschool/School	692,260	1.4
Tobacco/alcohol	2,228,820	4.6
Agriculture	1,295,000	2.7
Drugs	1,418,950	2.9
Utility/taxes/rent	3,235,210	6.7
Paying debts	10,263,180	21.2
Other (entertainment etc)	3,951,600	8.2
Total	48,477,548	100

The biggest item of expenditures is food - 43.3% (table 13) (graph 5). It is interesting to note that paying debts accounts for 21.2% of total expenditures. In 6 cases people paid debts for the amount of more than 500,000 new leks which contributes to the high proportion of the item among total expenditure (table 13).

Table13. Expenditures components in total sample.

Components	% of HH declared	Mean	25% percentile	Median	75% percentile	Minimum Value	Maximum value
Food	93.6	11,624	5,000	10,000	15,000	100	70,000
Clothes	23.7	3,139	500	1,500	3,000	50	90,000
Private car	7.8	11,784	3,000	5,250	10,000	300	200,000
Transport	32.9	1,922	500	1,000	2,000	30	21,000
Preschool/School	18.6	1,928	200	500	1,500	30	50,000
Tobacco/alcohol	42.8	2,689	1,000	2,000	3,000	50	35,000
Farming	16.7	4,021	1,000	2,000	5,000	50	40,000
Drugs	32.5	2,266	50	1,000	2,000	30	50,000
Utility/taxes/rent	84.4	1,989	700	1,000	1,640	50	98,000
Paying debts	7.6	69,817	5,000	10,000	50,000	150	1,000,000
Other (entertainment, wedding etc)	25.5	8,048	1,000	2,000	5,000	100	400,000
Total	94.5	26,615	8,750	15,400	26,900	500	

2.1.3. Relative difference between income and expenditure (income–expenditure/income)

In majority of cases the declared income was less than expenditures (table 14).

Table 14. Relative difference between income and expenditures

	% of cases with negative difference	Mean	25%	Median	75%	Largest Difference
Relative difference	60%	-1,708	-2.2	-0.2	0.1	-314,700

The median of relative difference is 0.2 which means that in general the expenditures exceed income by 20%. In 7.9% the relative difference between income and expenditures was 10,000% which had an impact on the mean (-1,708). In these cases there was no income declared but expenditures and we should refer to median rather than on mean. 25% of population have an income by 10% more than expenditures and 25% of population have an income by 220% less than expenditures.

2.2. Income and expenditures by districts and strata

2.2.1. Income

As noted above the proportion of population in rural areas (especially in rural far) with high socioeconomic score is higher than in urban. On the other hand, while looking at the declared income in monetary terms by strata we can see that in urban areas the declared income is significantly higher than in rural areas (table 15). There is no significant difference in declared income between districts

Table 15. Average income by districts and strata (mean, in new leks).

District \ Strata	Urban	Rural close	Rural far	Average Total
Pogradec	21,872	6,397	6,680	13,943
Vlora	23,582	13,040	9,549	17,129
Elbasan	22,172	10,603	9,238	15,958
Average Total	22,631	10,816	9,006	16,104

2.2.2. Expenditures

In general the expenditures in rural areas are lower than in urban with significant difference between urban and rural close area (table 16). The expenditures do not differ much from district to district.

Table 16. Average expenditures by districts and strata (mean, in new leks).

District/Strata	Urban	Rural close	Rural far	Average Total
Pogradec	38,525	10,223	17,697	25,216
Vlora	34,157	27,661	26,403	30,380
Elbasan	28,620	19,288	19,526	23,737
Average Total	31,994	20,696	22,882	26,351

2.3. Income and expenditures by scores

2.3.1. Income

In low socioeconomic group the average declared total income was 9,323 new leks, in medium - 15,649 and in high - 28,556 new leks (table 17). Since income was taken as one of the criteria for dividing households by socioeconomic groups, the average declared income in each socioeconomic group significantly differs from each other in all districts.

Table 17. Average income by districts and scores (mean, in new leks).

District \ Strata	Low	Medium	High	Average Total
Pogradec	7,141	14,578	29,929	13,943
Vlora	9,924	17,554	25,410	17,129
Elbasan	9,616	14,631	31,151	15,958
Average Total	9,323	15,649	28,556	16,104
CL* of average total	[7884 – 10761]	[13,985 – 17,312]	[25,061 – 32,050]	

*CL – 95% confidence limit

When looking at the composition of income by socioeconomic groups we can see that there is a significant difference between high and other groups in the income from business/sale and property/land (table 18). The households from low socioeconomic

group more rely on salary as a major source of income and it comprises 55.1% of their total income (graph 6).

Table 18. Components of income by socioeconomic score.

Components \ Score	Low		Medium		High	
	Mean (New leks)	% from total income	Mean (New leks)	% from total income	Mean (New leks)	% from total income
Salary	4,635	55.1	5,656	36.3	5,012	17.9
Allowances/compensation/stipend/pension	2,338	26	3,198	21.8	2,182	9.3
Business/sale/service	181	21	4,396	26.1	17,056	55.2
Property/land	0	0	528	4	2,641	10.4
Other	1,749	16.8	1,624	11.8	1,571	7.2
Total average	9,323	100	15,649	100	8,556	100

Same as above the difference in income by socioeconomic groups is significant between all strata (table 19) (graph 7).

Table 19. Average income by strata and scores (mean, in new leks).

Strata \ Score	Low	Medium	High	Average Total
Urban	12,242	23,923	54,933	22,631
Rural close	4,140	10,073	20,227	10,816
Rural far	3,098	7,276	14,294	9,006
Average Total	9,323	15,649	28,556	16,104

2.3.2. Expenditures

Though while calculating the socioeconomic scores expenditures of households were not taken into consideration, a significant difference was observed in expenditures between low and high socioeconomic groups. There is also a significant difference between high and other scores in Pogradec, between high and medium groups in Vlora and between high and low groups in Elbasan (table 20).

Table 20. Average expenditures by districts and scores (mean, in new leks).

District \ Score	Low	Medium	High	Average Total
Pogradec	15,250	21,216	70,883	25,216
Vlora	29,362	26,552	40,226	30,379
Elbasan	18,994	22,207	36,870	23,736
Average Total	21,952	23,732	41,546	26,351

Composition of expenditures by scores

As for table 21 in all three socioeconomic groups food accounts for less than 50% of expenditures from the total household budget. Expenditures on tobacco and alcohol account for almost 4- 5% of household budget. In all three score categories paying debts is the second biggest item of expenditures after food (graph 8).

Table 21. Components of expenditures by score

Score Components	Low		Medium		High	
	Mean (New leks)	% from total	Mean (New leks)	% from total	Mean (New leks)	% from total
Food	10,689	45.1	11,944	46.9	16,747	36.1
Clothes	359	1.7	779	3.5	1,429	2.9
Private car	9	0.1	569	2.3	4,270	8.3
Transport	292	1.5	601	2.9	1,042	2.6
Preschool/School	220	1.2	465	1.7	524	1.2
Tobacco/alcohol	980	4.1	1,263	5.1	1,781	4.1
Farming	201	1.2	504	2.8	1120	3.4
Drugs	514	2.4	882	3.7	879	2.1
Utility/taxes/rent	1,337	5.9	1,743	6.9	3,251	7.0
Paying debts	6,313	32.7	3,219	17.2	5,840	19.7
Other (entertainment..)	1,038	4.4	1,763	7.1	4,661	12.5
Total average	21,952	100	23,732	100	41,546	100

SUMMARY OF PART I

- 2,014 households were interviewed which represented 9,778 individual family members
- In urban area the proportion of population in 5 -14 age group was less than in rural areas
- 29.5% of surveyed households were found to be in low, 53.4% in medium and 17.1% in high socioeconomic status group. The proportion of population in rural areas with high socioeconomic score is higher than in urban. On the other hand, the declared income in monetary terms in urban are is significantly higher than in rural areas
- Average monthly declared income of households was 15,788 leks. Only 28.5% of households declared that they receive salary and it accounts for 33% of household's budget, which implies that mainly income comes from other sources than salary. In low socioeconomic group the average declared total income was 9,323 leks, in medium - 15,649 and in high - 28,556 leks
- Households from low socioeconomic group more rely on salary as a major source of income and it comprises 55.1% of their total income whereas households from high socioeconomic groups have a significantly high income from business/sale and property/land.
- Average monthly expenditures declared by households were 26,615 new leks. The biggest item of expenditures is food (43.3%). Paying debts accounts for 21.2% of total expenditures. In general the expenditures in rural areas are lower than in urban with significant difference between urban and rural close area. Expenditures on tobacco and alcohol account for almost 5% of household budget.
- A significant difference was observed in expenditures between low and high socioeconomic groups. In all three score categories paying debts is the second biggest item of expenditures after food.
- In majority of cases the declared income was less than expenditures.

PART II. WILLINGNESS TO PAY AND PARTICIPATE

SECTION 1. ATTITUDES TOWARDS PAID CARE

1.1 Access to health care

87.5% of households live in a distance of less than 5 km to the nearest health center. There is a significant difference in accessibility to the health facility between all strata. In urban area 99.5% [98.9 – 100] of population have health facility in less than 5 km versus 85.5% [77.6 – 93.4] in rural close and 55.6% [45.8 – 65.5] in rural far areas.

In Elbasan there is a significant difference in accessibility to the health facility between urban and rural areas (99.6% of urban population live in a distance of less than 5 km versus 85.7% and 57% in rural areas). The same situation was observed in Vlora.

In Pogradec the significant difference in accessibility to health facility was revealed between rural far and other strata (99.1% in urban, 83.7 % in rural close and 47.8 % in rural far areas).

It should be noted that design effect in rural areas was quite high (from 7.2 to 10.4) which could indicate on the heterogeneity of selected sites and differences in accessibility inside these strata

The accessibility to health services by districts is presented in table 22.

Table 22. Accessibility to health services by districts (% of households, weighted).

Indicators	Urban				Rural close				Rural far			
	Pogradec	Vlora	Elbasan	All sample	Pogradec	Vlora	Elbasan	All sample	Pogradec	Vlora	Elbasan	All sample
Distance less than 5 km to health center	99.1	99.6	99.6	99.5	83.7	86.1	85.7	85.5	47.8	57.2	57	55.6
GP in less Than 1 hour	96.8	96.8	100	98.4	71.4	78.5	64.7	69.9	20.3	37.8	41.1	36.1
Pediatrician in less than 1 hour	96.8	95.1	100	97.8	40.7	52.7	46.9	47.5	5.4	17.9	9.9	13.4
Dentist in less than 1 hour	100	95.1	100	98.3	38.4	60.3	46	48.8	9.4	22.1	19.2	19.2
Ob-Gyn in less than 1 hour	97.7	93.3	100	97.3	32.7	38.4	43.8	40.3	2.2	15.5	6.3	10.4

Time to reach GP

78% of households need up to 1 hour to find general practitioner, 8% need up to 2 hours and 14% find GP in more than two hours. There is a significant difference between all strata. In urban 98.4% of population finds GP in less than one hour ([97.3 – 99.5]) versus

69.9% ([58.8 – 80.9]) in rural close and 36.1% [26.1 – 46.1] in rural far areas. Design effect is high for rural close, which could indicate on the differences inside the strata.

Time to reach Pediatrician

65.5% of households find a specialist pediatrician within one hour. In rural far area 73% of population need more than 2 hours [60.6 – 85.3] to find pediatrician and 13.6 need up to 2 hours. In rural close area 28.2% need more than two hours and 24.3% of population need up to 2 hours to find the specialist pediatrician.

In Pogradec only 5.4% of population from rural far area can find pediatrician within one hour.

Time to reach dentist.

67.2% of households reach dentist within one hour. There is a significant difference in time to reach dentist between all strata. Only 19.2% of households from rural far area can find dentist within one hour. 68.6% of households from rural far area can find dentists in more than two hours.

Time to reach obstetrician-gynecologist

62.2% find obstetrician-gynecologist within one hour. In rural far area 74.9% [62.4 – 87.4] of households need more than two hours to find ob-gyn versus 33.5% in rural close. There is no significant difference between districts.

Distance to the district center

Mainly the specialized health services are located in the district center. Overall 73.2% of households spend less than 1 hour to reach the district center and 26.8 % need more than an hour. This variable differs according to strata and districts (table 23). In rural close 39.7% of population spend more than one hour to reach district center versus 75.6% in rural far.

Table 23. Distribution of households according to distance to district center in hours (% , weighted)

District \ Strata	Urban		Rural close		Rural far	
	Less than 1 hour	More than 1 hour	Less than 1 hour	More than 1 hour	Less than 1 hour	More than 1 hour
Pogradec	99.6	0.4	60.3	39.7	13.5	86.5
Vlora	99.6	0.4	71.9	28.1	33.6	66.4
Elbasan	100	0	54	46	14.4	85.6
Total sample	99.8	0.2	60.3	39.7	24.4	75.6

➤ **Price and health services**

Only 15.7% of households admitted that the price for treatment never prevented them from applying for the health services. The cost of treatment was an obstacle always for 50% and partly for 34.3% households.

Analysis of the same question by districts and strata produced the results summarized in table 24.

Table 24. Price as an obstacle for application for health services by district and strata (% of households)

Strata & options District	Urban			Rural close			Rural far		
	Price always prevent	Price partly prevent	Price never prevent	Price always prevent	Price partly prevent	Price never prevent	Price always prevent	Price partly prevent	Price never prevent
Pogradec	35.3	37.6	27.1	52.7	33	14.3	67	25.9	7.1
Vlora	39.3	35.3	25.4	50.0	35.7	14.3	59.0	32.9	8.1
Elbasan	43.5	37.7	18.8	61.4	30	8.5	61.6	33.9	4.5
Total sample	40.8	36.8	22.4	56.6	32.2	11.2	61.1	3.1	6.8

The highest proportion of population for whom the price was always an obstacle was in rural far area with significant difference from urban strata. Accordingly, the highest proportion of population for whom the price was never an obstacle was in urban strata with significant difference from rural areas. And this situation is applicable to all three districts, where in rural areas there was a significant difference between the proportion of households for whom the price was always an obstacle compared to those whom the price partly and never prevented from medical care.

Table 25. Price as an obstacle for application for health services by district and scores (% of households)

District / score with options	Low			Medium			High		
	Price always prevent	Price partly prevent	Price never prevent	Price always prevent	Price partly prevent	Price never prevent	Price always prevent	Price partly prevent	Price never prevent
Pogradec	52.5	33.5	14	47.5	34.7	17.8	29.2	31	39.8
Vlora	58.9	29.5	12.1	48.4	36.6	15.0	28.0	38.2	33.8
Elbasan	66.55	27.9	5.5	49.9	36.1	13.9	39.7	37.5	22.8
Total sample	61.2	29.4	9.4	49.0	36.1	14.9	33.6	37.2	29.2

Comparison of population from different socioeconomic groups revealed that in general, the highest proportion of population (61.2%) whom the price always prevented from application for the medical care was in low score group, less in medium (49.0%) and least in high (33.6%) (with significant difference). Accordingly, the highest proportion of population for whom the price was never an obstacle was in high score group (29.2%), less in medium (14.9%) and least in low (9.4%) (with significant difference). It is worth noting that there was no significant difference between given options within high socioeconomic group (meaning that the proportion of population in this group for whom the price is an obstacle is almost the same as the one who applies for care regardless the price) while in low and medium socioeconomic groups most of the population do not

apply for care because of existing (even informal) price (with significant difference between all options).

Desegregation of this question by districts showed that in Elbasan in low socioeconomic group the proportion of population whom the price always prevented from application for medical care was significantly higher (61.2%) than the one for whom the price never or partly was an obstacle (9.4%). In Pogradec and Vlora the proportion of population in high score group whom the price always refrained from application for medical care is significantly lower than in all other score groups.

➤ ***Opinion on paid health care***

49.2% in no way could accept the paid health care and stated that everything in health care should be free (graph 9). 50.8% of interviewed households agree to pay for some services and these responses do not differ much from district to district and do not depend on the strata (table 26).

Table 26. Opinion of paid health care by district and strata (% of households)

Strata & options District	Urban		Rural close		Rural far	
	Everything should be free	Something should be paid	Everything should be free	Something should be paid	Everything should be free	Something should be paid
Pogradec	44.6	55.4	58.6	41.4	60.3	39.7
Vlora	36	64	52.3	47.7	49.8	50.2
Elbasan	48	52	54	46	59.5	40.5
Total sample	43.3	56.7	54.3	45.7	54.6	45.4

In high socioeconomic group there is a significant difference in responses and more people realize that something should be paid (no difference in other groups) (graph 10) while almost half of the population from medium and low socioeconomic groups still considers that health care services should be free. Opinion by district is presented in the table 27.

Table 27. Opinion of paid health care by district and strata (% of households)

Score & options District	Low		Medium		High	
	Everything should be free	Something should be paid	Everything should be free	Something should be paid	Everything should be free	Something should be paid
Pogradec	60.3	39.7	48.6	51.4	47.5	52.5
Vlora	52.6	47.4	43.6	56.4	34.3	65.7
Elbasan	57	43	52.1	47.9	41.1	58.9
Total sample	56.2	43.8	48.7	51.3	38.8	61.2

➤ **Conditions for payment**

Even when the respondent stated that he/she in no way can accept paid health care, the following question on the preferred conditions for payment (which contains the option “under no condition”) has been still asked. And in this case we see that the proportion of households, which refused to accept paid care in the previous question (49.2%), decreases to 27.7% still stating that under no conditions they agree to pay. Almost one third of the households (33.6%) selected the option of “if the performance of GP is good” as a condition for payment. The least preferred option (1.8%) was the participation to the development of health services. The preferences for conditions for payment by options are presented below:

Under no conditions:	27.7%
If the drugs are available in he nearest health facility	14.9%
If the performance of GP is good	33.6%
If income generated from our contribution remains in the health center	2.7%
If I can participate in health service delivery	1.8%
If I have right to choose doctor/facility	14.4%
Other	4.9%

In all three strata the most frequent preferred condition for payment was good performance of GP. Even though currently consumers have right to select facility and doctor the population from urban area still selects the option of “having the right to select facility and doctor” as a second preferred condition. In rural areas the people less concerned about the selection of facility but more about availability of drugs in the nearest facility (table 26).

Table 26. Conditions for payment by strata (% of households)

Options \ Strata	Urban	Rural close	Rural far
Under no conditions	28.1	27.1	27.9
If the drugs are available in he nearest health facility	12	18.2	15.4
If the performance of GP is good	32.6	36.3	30
If income generated from our contribution remains in he health center	2.7	2.3	3.9
If we can participate in health service delivery	3	0.6	1.1
If we have right to choose doctor/facility	17.4	11.1	13.2
Other	4.1	4.4	8.5

In all three districts as a condition for payment people prefer the improvement of GP performance and second frequent preference is the availability of drugs in the nearest health facility.

If above the proportion of population considering that health care should free significantly differs between socioeconomic groups, the proportion of population who still do not agree to pay under any conditions drops in all three groups and do not differ from group to group (table 27).

Table 27. Conditions for payment by socioeconomic scores (% of households)

Options \ Score	Low	Medium	High
Under no conditions	28.3	27.7	26.9
If the drugs are available in the nearest health center	16.9	11.1	13.5
If the performance of GP is good	33.3	33.6	34
If income generated from our contribution remains in the health facility	2.3	4.1	2.8
If we can participate in health service delivery	2.3	2.2	1
If we have right to choose doctor/facility	12.4	15.8	16.5
Other	4.4	5.5	5.4

➤ **Monthly contributions**

The interviewees were ready to contribute monthly the average amount of 252 new leks. The highest amount of monthly contribution was expressed in Pogradec (346 new leks) which significantly higher than in Elbasan (209 new leks). In Vlora people were ready to contribute 274 new leks.

The average accepted monthly contribution was stated as 316 new leks in urban strata, 192 and 184 new leks in rural close and rural far , respectively. The amount for monthly contribution in urban area was significantly higher than in rural areas.

The households related to high group of socioeconomic status agreed to contribute monthly the average amount of 366 new leks, from medium and low groups 249 and 185 new leks, respectively (with significant difference between high and low, and low and medium groups).

➤ **Pay for what**

In total sample, 27.8% of households prefer to pay only for drugs, 10.8 % of households agree to pay only for doctor’s consultation, 6.4% of households select the option of

payment for consultation and examination but not for drugs. 29.7% of households agree to pay for all items - drugs, doctor's consultation and examination and still 24.4% - do not agree to pay at all.

There were no significant differences between districts and strata in preferred item for payment and the choices corresponded to the one in the total sample. But in rural areas the first preferred item for payment is payment for drugs while in urban areas more people are ready to pay for everything. Efforts spent on finding drugs in rural areas could affect their choice (table 28).

Table 28 Preferred item of payment by strata (% of households)

Options \ Strata	Urban	Rural close	Rural far
Do not agree to pay at all	23.2	24.0	29
Agree to pay only for drugs	26.3	29.5	28
Agree to pay only for doctor's consultation	9.2	12.5	11.8
Agree to pay for doctor's consultation and examination, but not for drugs	7.1	5.8	5.7
Agree to pay for everything	34	26.5	24.4
Other	0.1	1.6	1.1

Again there is a significant difference between socioeconomic groups in the proportion of people who still do not agree to pay (in low score significantly lower than in high group). In high group more people agree to pay for everything, while in low and medium groups the most preferred item is payment for drugs (table 29). If we compare the proportion of population who initially stated that everything should be free we can see that this figure drops by 2.7 times in high socioeconomic group (from 38.8% to 14.4%) and twice in medium group (from 48.7% to 23.7%) when they are given some more options for consideration.

Table 29. Preferred item of payment by socioeconomic status (% of households)

Options \ Scores	Low	Medium	High
Do not agree to pay at all	31.9	23.7	14.4
Agree to pay only for drugs	25.5	30	24.8
Agree to pay only for doctor's consultation	9.9	10.7	13.9
Agree to pay for doctor's consultation and examination, but not for drugs	5.7	6.1	8.3
Agree to pay for consultation, drugs and examination	25.5	28.8	39.4
Other	1.5	0.7	0.2

➤ **Pay how**

In total sample: 72% of households preferred to pay once a month as a kind of insurance. Another 16.4% selected the option of paying for every service needed during the period of illness. Only 3.2% of interviewees chose the one time payment for the whole period of illness. 8.3% of population selected some other options. Analysis of this question by strata showed that though the option of payment once a month is the most preferred one in all strata, in rural far area significantly less population selected this way of payment (62%) compared to the population in urban area (76.7%) (table 30).

Table 30. Way of payment by strata (% of households).

Options \ Strata	Urban	Rural close	Rural far
Payment once a month	76.7	70.1	62.0
For every service	14.8	17.1	19.9
For a whole period of illness	3.4	3.0	3.2
Other	5.1	9.8	14.9

In Elbasan higher proportion of population prefer to pay once a month compared to Pogradec.

Most of the households preferred to pay in cash (95.5%) rather than any sort of in-kind payment (4.5%). The preferences differ if we desegregate the responses by strata with a significant difference between urban and rural areas in preferred mode of payment: the proportion of people preferring to pay in-kind increases in rural areas. 6.1% in rural close and 11.8% in rural far areas prefer to pay in kind versus only 0.2% in urban strata. The “payments” by gifts or by products of the farming activity is practiced in rural areas where money is not always available for informal payments.

There was no significant difference in the preferred mode of payment between socioeconomic groups.

➤ **Opinion about Health Insurance**

Total sample: Health insurance institution was established in Albania in 1995. Almost one third of interviewed households (33.7%) did not know what is health insurance. 7.3% considered that health insurance is not helpful and 59% thinks that it is helpful.

When asked why it is not helpful the most frequently selected reason was that they have to pay for drugs anyway. 30.4% of people stated that they do not know their rights and regulations. More detailed results of the responses are presented below:

It is not helpful because:	
I have to pay for drugs anyway	48.1%
It requires time to get prescription from doctor for reimbursement	3.2%
I do not know regulations and my rights	30.4%
Other reasons	5.3%

Those who think that health insurance is helpful particularly like that it is established by the government and they feel themselves more secure (59.5%). Fewer people (39.5%) consider that health insurance is helpful because it covers expenditures on drugs (with significant difference). Taking into account that currently health insurance (besides paying the salary of GPs) is dealing only with the reimbursement of drugs expenditures, the selection of this option by only 39.5% of households could indicate on the fact that most of the people who think that health insurance is helpful did not really have benefited from it yet but only believe that it is helpful because it is established by the government.

No significant difference was observed in responses among three districts .

More people in rural far and rural close areas do not know what is health insurance with significant difference from urban strata (graph 11). Less people in rural far considers health insurance being helpful compared to urban strata (table 31).

Table 31. Opinion about health insurance by strata (% of households).

Opinion \ Strata	Urban	Rural close	Rural far
Do not know	25.3	39.8	44.1
Helpful	65.3	55.4	48.9
Not helpful	9.4	4.8	7

➤ Exemptions

Total sample: Only 2.1% of interviewed households consider that in case of compulsory payment for health care nobody should be exempted from payment. 97.9% of population thinks that there should be an exempted groups. The households were given a choice to select the category of population, which they would exempt from the payment. This opportunity was given twice in order to have an idea of their first and second priorities.

	First choice	Second choice
Everybody	9.6	4.6%
Disabled	41.1%	23.8%
Pregnant	4.8%	7%
Children up to 1	1.8%	5.5%
Children up to 5	1.3%	1.7%
Children up to 14	3.5	6.4%
Chronic patients	7.3	14.2%
Poor	27.2	32.7%
Other	3.5	4.3%

As a first choice majority of households (41.1%) would exempt disabled and 27.2% of households considered poor as their first choice for exemption. The preference to disable people as a first priority could be partly explained by the fact that in 8.7% of households (see above) there was at least one person with disability. Other groups were selected with lower frequency. When they were given a second attempt to select the groups for exemption the households still consider poor and disable people as a priority categories for receiving free care but the proportion of other categories (pregnant, children, chronic patients) also increases.

Evaluation of these responses by socioeconomic groups shows that only 4.8% of the households in high socioeconomic group consider that everybody should be exempted from the payment, while in low socioeconomic group this proportion of households is significantly higher (12.1%).

➤ ***Conditions for health status improvement***

Most of the households (51.4%) think that for improvement of their health status the economic situation of household should be improved. Less (15.8%) gives a priority to the improvement of water and sanitation services. The options were selected as follows:

Improve the economic situation	51.4%
Improve the quality of nutrition	11.7%
Improve health care	9.6%
Improve working conditions	1.9%
Get rid of unhealthy habits	4.3%
Improve environment	3.7%
Improve water and sanitation	15.8%
Other	1.6%

By strata: In urban strata more people (6.1%) consider that the improvement of environment could positively impact on the improvement of their health status compared to rural areas (1.5% in rural close and 2.2% in rural far).

The conditions for improvement of the health status differ among socioeconomic groups: in low group more people thinks that the improvement of economic condition of their family could positively impact their health (54% versus 42.4% in high group with significant difference). Households from high group are more concerned about the improvement of water and sanitation services as a condition for improving their health status (23.5%) than in low group (12.5%).

SECTION 2. PARTICIPATION

Community participation

In general 52.5% of people expressed their willingness to participate in the development of health care.

When asked how they can contribute they picked the suggested options at following rates (graph 12):

Take part in health education activities	40.5%
Assist in water and sanitation activities	24.2%
Contribute in-kind (minor repair, etc)	21.5%
Monitor the budget raised through community contribution	12.5%
Other	1.2%

40.5% of households want to be a member of health council.

In Elbasan district less people want to participate in the development of health system (43.7% want versus 56.3% do not want). In this district 63.7% do not want to be a member of health council (in Pogradec 46.3%. and in Vlora 59%).

In urban strata less people want to participate (45.3%) in the development of health system (versus 54.7% who do not want to participate with significant difference).

In general, there is no difference in selection of options of how to participate depending on strata and score. In urban more people (48.9%) want to take part in health education activities compared to rural close (32.8% with no significant difference). More people in rural close want to assist in water and sanitation activities (28.7 %) and contribute in – kind (26.4%) compared to urban (19.2 and 16.3%, respectively, with no significant difference).

In urban area 61.3% of people do not want to be a member of health council. In rural far and rural close the distribution of people who wanted to be a member and who do not was almost equal.

In low socioeconomic group less people want to participate in the development of health system (58.2% versus 41.8% of those who want to participate with significant difference) and this significantly differs from high socioeconomic group where 55.4% expressed willingness to participate.

In high score 48.7% - want to be a member while in low only 37.6% of respondents want to be a member and in medium 39.3%.

So, the population from urban strata and low socioeconomic group are less willing to participate in the development of health care.

SUMMARY OF PART II

- 87.5% of households live in a distance of less than 5 km to the nearest health center (by strata - 99.5% in urban area versus 85.5% in rural close and 55.6% in rural far areas).
- 14% find GP in more than two hours and this also differs between all strata. In urban 98.4% of population finds GP in less than one hour versus 69.9% in rural close and 36.1% in rural far areas.
- Only 15.7% of households admitted that the price for treatment never prevented them from applying for the health services. The highest proportion of population for whom the price was always an obstacle was in rural far area (with significant difference from urban) and low socioeconomic group (with significant difference from high and medium groups).
- 49.2% in no way could accept the paid health care. (significantly lower in high socioeconomic group than in medium and low groups). The proportion of households, which previously refused to accept paid care (49.2%) decreases to 27.7% when the options with the conditions for payment are suggested. Good performance of GP was the most frequently selected condition for payment (33.6%). The next preferred condition, in rural areas is the availability of drugs in the nearest facility.
- The interviewees were ready to contribute monthly the average amount of 252 new leks. The significant difference in the amount of monthly contribution was observed among strata and socioeconomic groups (higher in urban and high socioeconomic group and lower in rural and low score groups)
- In total sample, 27.8% of households prefer to pay only for drugs, 29.7% of households agree to pay for all items - drugs, doctor's consultation and examination. In rural areas the first preferred item for payment is payment for only drugs while in urban areas more people are ready to pay for everything. In high group more people agree to pay for everything, while in low and medium groups the most preferred item is payment for drugs
- The proportion of people preferring to pay in-kind increases in rural areas (6.1% in rural close and 11.8% in rural far areas versus 0.2% in urban strata).
- 72% of households preferred to pay once a month (as a kind of insurance). At the same time one third of interviewed households (33.7%) didn't know what is health insurance (more in rural areas). 7.3% considered that health insurance is not helpful and 59% thinks that it is helpful. When asked why it is not helpful the most frequently selected reason was that they have to pay for drugs anyway. 30.4% of people stated that they do not know their rights and regulations. Those who think that health insurance is helpful particularly like that they feel themselves more secure because it is established by the government (59.5%). Less people (39.5%) consider that health insurance is helpful because it covers expenditures on drugs (with significant difference). This shows that most of the people who consider that health insurance is helpful have not benefited from it yet but believe that it is helpful.
- Only 2.1% consider that in case of compulsory payment for health care nobody should be exempted from payment. As a first choice 41.1% of households would exempt disabled people. The preference to disabled people as a first priority could be explained by the fact that in 8.7% households there was person/s with disability.
- 51.4% of the households think that for improvement of their health status the economic situation of household should be improved (more in low group). Households from high group are more concerned about the improvement of water and sanitation services as a condition for improving their health status than other (23.5% versus 12.5% in low group).
- In general 52.5% of people expressed their willingness to participate in the development of health care

PART III. MEDICAL PART

SECTION 1. DESCRIPTION OF CASES

1.1. General picture and demography of cases

Out of 2,016 interviewed households in 303 (14.3%) of them at least one member experienced a case of disease during last month. Out of those families 22 households have more than one ill member during last month. In total there were 341 ill persons during last month. There was no significant difference between districts in the number of ill persons (table 32).

Table 32. Households with ill person during one month before interview by districts.

Districts	Total number of		N of		% from total N of	
	HH	Population	HH with ill member	Ill persons	HH	Population
Pogradec	670	3160	122	138	19.9	4.5
Vlora	672	3229	90	102	12.8	3.1
Elbasan	672	3389	91	101	14.1	3.2

➤ Disease occurrence by strata, score and gender

There was no significant difference in occurrence of illness by strata, score and gender. The disease occurrence rate was almost equal across the strata: 2.9% in urban area, 4.0% in rural close and 3% in rural far. There was also no association between the cases of illness and the socioeconomic groups. Disease occurrence in low socioeconomic score was 4%, in medium 3.4% and in high – 2.4%. (with slight tendency of higher rate in low versus high group but with no significant difference).

The morbidity among male population was the same as among female (3.5% versus 3.3%).

➤ Disease occurrence and age

There was a strong association between age categories and cases of illness (graph 13). 3% of children under five were reported to be ill during last month, 1.6% of children from 5 to 14 year of age, 1.1% of people between 15 and 29, 2.5% between 30 and 39, 4.6% between 40 and 49, 6.4% between 50 and 59 and 8.4% above 60 year of age.

1.2. Morbidity pattern

➤ Diagnosis

The highest proportion in overall morbidity was due to respiratory (28.2%) and cardiovascular (23.3%) diseases, which accounted for almost half of the cases (table 33,

graph 14). Analysis of the diagnosis by age showed that according to the respondents 59.3% of all cases of illness among children U5 was due to respiratory disease and 16.6% - due to gastrointestinal disorders.

Table 33. Disease occurrence by diagnosis.

Diagnosis	%	95% CL
Cardiovascular	23.3	[16.4 – 30.2]
Respiratory	28.2	[21.6 – 34.7]
Gastrointestinal	9.0	[5.2 – 12.7]
Ob-Gyn disorders	3.6	[1.4 – 5.8]
Oncological	2.4	[0.1 - 4.7]
Professional	1.4	[-0.1 – 2.9]
Trauma	2.7	[0.4 – 4.9]
Do not know	1.3	[-0.1 – 2.7]
Other	28.2	[22.7 – 33.8]

➤ **Severity**

Most of the population stated that the case was severe (55.8%), 36% told that it was moderate and 8.2% - mild (the group of interviewers had medical background and they could also assess the severity of illness).

When the people were asked to evaluate their condition during illness the options were selected with the following frequency:

Minor Fatigue	14.3%
Lost ability to work	69.3%
Feel that the life is under threat	16.4%

➤ **Outcome**

Most of the people stated that they are partly recovered after illness (48.8%). 16.8% were fully recovered, 30.5% had chronic disease, 3.9% - disabled. There was no case of mortality as an outcome of disease.

➤ **Chronic/acute**

Desegregation of data by chronic and acute cases shows a typical inverse trend: more chronic cases among adults versus more acute cases among children (graph 15)

If we consider only acute cases (graph 16) the general picture of disease pattern (which is influenced by high number of chronic illnesses) changes (graph 13).

Table 34. Morbidity pattern by age groups

Age group	Total population	Cases of illness		Age specific rate (%)	
		Acute	Chronic	Acute	Chronic
U5	739	11	11	1.5	1.5
5-14	2044	8	14	0.4	0.7
15 – 29	2470	6	19	0.2	0.8
30 – 39	1271	7	27	0.5	2.1
40 – 49	1290	4	57	0.3	4.4
50 –59	766	5	39	0.7	5.1
60 and above	1198	7	86	0.6	7.2

1.3. Presentation of responses

➤ *Intention for treatment*

38.3% of households prefer to rely on their family and themselves when they are ill while 69.5% prefer to go and see a doctor (10.7% would go directly to the district center, 14% - directly even to Tirana and 1.3% abroad). Only 0.7% selected the option of seeing only nurse when they are ill and there were few cases who believe that they can get help from traditional healer (0.2%) or from somebody from community but not medical personnel (0.3%).

The analysis of this question by strata and scores showed no significant difference in intentions for treatment among population from different areas and socioeconomic groups. In rural far area only 2.3% and in rural close 0.3% of households told that they should go to see only nurse when they are ill.

➤ *Who assisted*

Total sample: When asked who assisted them when they actually fall ill, significantly less households got the assistance from their family (20.6% compared to 38.3% in the previous question). Nobody went to traditional healer, the proportion of households who got the assistance from the specialists from district center significantly increases (29.8% compared to 10.7% their intention when they are not ill) and the people got an assistance from a doctor from their local health center with the same frequency as from a doctor from district center. The proportion of nurses also increases from 0.7% to 8.7%. On the contrary, the proportion of people who thought that the assistance in case of illness should come from Tirana specialists (14%) actually got assistance from them in 6.6% of cases.

By strata: Despite their intentions and more trust to doctors expressed in the previous question, the people in rural areas (especially from rural far area) got more assistance only from nurses than in urban area (11.8% in rural close and 16.3% in rural far versus

0.6% in urban areas). As for doctors (even the specialists from Tirana) they appear with the same frequency across the strata (table 35).

Table 35. Health assistance by strata (% of households).

Options	Urban	Rural close	Rural far
Not medical specialist	20.5	20	22.6
Nurse/midwife	0.6	12.5	16.3
Doctor from health center	41.4	31.4	27.3
Specialist from district center	33.8	27.5	27.3
Specialist from Tirana	3.7	8.7	6.6

➤ *Action of patient*

This question was dealing more with the preferred level of health care facility than with the level of health staff.

In general, 7.1 % of ill persons didn't go anywhere and were treated or self-treated at home.

18.6% of patients went to ambulance where there is no doctor but nurse or midwife (9.6% was then referred to health center, 1.1% after ambulance went to district hospital bypassing local health center and 2.6% followed the referral chain from ambulance to health center and then to district hospital).

22.1% went first to health center where there is a doctor (4.1% was then referred to regional). It should be noted that there was no significant difference between ambulance and health center as a first place for destination: people go to ambulance with the same frequency as to health center with GP.

50.8% of ill people by-passed the local health units: 11.3% went directly to a specialized outpatient facility in the district center – polyclinic, 16.5% went directly to the district hospital, 17.7% - to the regional hospital, 5.3% seek the care in Tirana. 1.4% went abroad

By severity: 12.2% of ill persons with mild cases have not done anything or used self treatment, while only 5.9% of patients with severe cases stayed at home (0.4% with severe cases also went to see healer).

14.2% of persons with mild cases went first to ambulance (5.2% of them were afterwards referred to health center with doctor and 8% of them were then referred to health center and even to the district hospital). And almost with the same frequency ambulance was the first place of destination for moderate (19.3%) and severe cases (18.8%).

There is slight tendency that people with severe cases used health center less (15.3%) than with moderate (30.7%) and mild (28.5%) cases but they more went directly to hospital (40%) than other cases (28% in moderate and 33.6% in mild). Note that 33.6% of persons with mild cases went directly to hospital bypassing their local health unit.

Absence of significant difference shows that the behavior of ill person doesn't depend on the level of severity (table 36).

Table 36. Destination for health care depending on severity of disease.

Severity \ Destination	Mild	Moderate	Severe
Home	12.2	7.2	6.3
Ambulanca	14.2	19.3	18.8
Health center	28.5	30.7	15.3
Hospital	33.6	28	40
Tirana	0.9	2.7	6.2
Polyclinic	10.7	12.2	11
Abroad	0	0	2.6

By strata: Analysis of action by strata shows that there is a slight tendency for people from rural far to stay at home more (13.5%) than in urban area (4.8%). In general, there was no significant difference in place of destination across strata except for polyclinic: People from urban area selected ambulanca as their first place of destination much less (11.7%) and they prefer to go to specialized outpatients clinic – polyclinic (21.4%) while this level was used only by 2.9% of persons from rural far area (table 37):

Table 37. Action of patients by strata (% of patients).

Strata \ Destination	Urban	Rural close	Rural far
Home	4.8	6.9	13.5
Ambulanca	11.7	24.1	18
Health center	18.3	25.2	21.7
Hospital	35.8	31.3	39.5
Tirana	4.2	6.4	4.4
Polyclinic	21.4	6.1	2.9
Abroad	3.7	0	0

Action of patient by age: Of those who stayed at home 3.3% were children under 5. Caregivers prefer to take ill child to medical facility rather than cure them at home and in 63.6% they take them directly to the hospital (23.2% went first to ambulanca and 9.1% - to health center). Mostly the people who stayed at home when they are ill were above 30 year of age (78.8%).

➤ ***Self-treatment***

19.5% stated that they practice self-treatment (25.1% from urban, 13.6% and 24.5% from rural close and rural far areas, respectively). Those who were practicing self-treatment most frequently (55%) bought drugs without consultation with medical specialist but which were prescribed them before. Among other options were home remedies (22%), bought drugs without consultation with medical doctor (13.1%) and bought drugs which were advised by somebody who was not a medical person (9.5%).

➤ ***Visits to doctor***

Most of the people (46.8%) regularly go to see a doctor because they are chronically ill and 0.6% because of hazards at work place. 41% go only when they are ill.

➤ ***Hospitalization***

50.5% of patients were advised to be hospitalized and 24.2% of them actually stayed at hospital. Those who should stay but didn't, could not do it because:

Could not afford it	40.2%
There was no place	0.9%
There was no specialist	0%
Other reasons	58.9%

There is a tendency that more people from rural far area could not stay in hospital because could not afford it (55.4%) than in urban area (29.4%).

➤ ***Reason for not taking actions***

In urban area 8.8%, in rural close 14.1% and in rural far 23% of patients have not done anything during the period of illness. 21.3% of ill persons from rural far didn't take action because they could not afford treatment (versus 8.4% in rural close and this option was not applicable for urban strata).

In high socioeconomic group more people takes action while they are ill (96.4) compared to medium (86.5%) and low (85%) groups.

➤ ***Satisfaction / Dissatisfaction***

Total sample: 85.4% of people who took some actions during their illness admitted that they were satisfied by care and 14.6% were not (82.5% of them were the patients with severe case).

Those who were satisfied specifically liked that the medical professionals were good experts (40.6%), the attitude of health professionals was good (29.8%), they did not pay anything (5.9%), were just glad because they felt better (18.6%), did not loose time (3.8%) and some other reasons (1.2%).

The most frequent reason for dissatisfaction (65.7%) was that care was expensive. Among other reasons were: attitude of health personnel was not good (4.3%) or their qualification was not at a required level (6.2%), were upset because the patient didn't feel better (6.3%) and lost time (5.5%).

There was a significant difference in the proportion of patients who were or were not satisfied by care according to severity of cases. 25.7% of patients with severe cases were not satisfied by care versus 2.4% with moderate cases and they mostly didn't like that the care was expensive (69.5%). All people with mild case were satisfied by received care.

There was no significant difference between satisfaction and dissatisfaction depending on the destination of care and level of health personnel provided care.

➤ *Coverage of drugs expenses*

Only 1% of patients didn't need drugs. 5% got everything at the facility free of charge, 13.4% partly got at the facility free of charge but had to buy the rest.

Total sample: Those who had to buy everything (80.5%) paid for:

Everything themselves	60%
Only part of drugs and borrowed money for other part	1.9%
Only part of drugs and rest was covered by health insurance	18.4%
Only part of drugs and couldn't afford the rest	7%
Could not afford anything	0.3%

Health insurance partly covered the expenditures on drugs only in 18.4% cases. And if we look by strata we see that this happens more in urban area (29.6%) than in rural close (13.9%) and rural far areas (2.9%).

In rural far more people had to borrow money to buy drugs (7.1%) than in rural close (1.9%) and urban areas (0%).

➤ *Availability of drugs in pharmacies*

95.7% of patients found all needed drugs in the pharmacy with no significant difference by strata. In rural areas, usually the private pharmacies are located within health centers and doctors know which drugs are available there.

Most of people (64.2%) spent less than one hour to find all drugs they needed, 28.5% found them within one day, only 3.4% had to look for them two days and 3.9% - more than two days.

Across the strata, people from urban area spent significantly less time to find the drugs than in rural far area (table 38).

There was no significant difference between districts.

Table 38. Time spent to find drugs by strata (% of patients)

Options \ Strata	Urban	Rural close	Rural far	Total sample
Less than 1 hour	82.9	56.9	35.1	64.2
Within one day	15.2	32.4	53.5	28.5
2 days	0	5.3	6.7	3.4
More than two days	1.8	5.5	4.7	3.9

➤ *Assessment of health status*

58.9% of patients stated that they feel better, 24.2% do not see any difference, 4% feel worse. Some of them (12.9 %) had difficulties in assessment of their current health status. Less people with severe cases (47%) felt themselves better compared to moderate (72.4%) and mild (79.2%) cases and more of them were feeling worse (4.8%) than in other cases (1.5% and not applicable to mild case).

SECTION 2. EXPENDITURES ON HEALTH

Only 2.1% of ill persons had no expenditures on health and they were excluded from further analysis. 92.7% of all sick people had expenditures on drugs. 74.3% had also other expenditures.

The interviewees were asked to give an information on the following items of expenditures occurred during the period of illness:

- Drugs
- Transport
- Personnel
- Medical examination
- Food
- Other

Total expenditures occurred during case of illness in total sample was 2,162,848 new leks with average amount of 6,872 new leks spent by each individual (note that median is only 2,400 new leks and quite high expenditures in some cases influenced on this difference between mean and median). If we look at the portion of health expenditures in the total budget of households (presented in the first part) who had the case/s of illness during last month, we can see that it accounts for 20.5% of total household expenditures.

The expenditures on one item occurred in 24.3%, on two items in 23.6 %, on three – in 23.7 % of cases, more than three in 25.6%.

In 49.9% of cases people had to spend on transport, 54.6% on personnel, 27.8% on medical examinations and in 21.8% - on food.

In Pogradec district it was observed the lowest amount of expenditures (average of 3,782 leks) compared with two other districts (in average 8,394 leks in Vlora and 9,445 leks in Elbasan).

No significant difference in the level of expenditures was observed across the strata (in average 7,766 leks in rural far, 9,188 leks in rural close and 6,489 leks in urban area).

Similarly, the amount of expenditures did not depend on the socioeconomic status (average of 6,276 leks in low, 8,519 leks in medium and 9,446 leks in high groups).

The expenditures by different items in total sample are summarized in the table 39 (see also graph 18).

Table 39. Composition of expenditures on health.

Item	N of cases	Mean (leks)	25% (leks)	Median (leks)	75% (leks)	Maximum (leks)	Minimum (leks)	Total (leks)	% from total
Drugs	296	2,661	660	1,200	3,000	46,000	90	787,718	36.4
Transport	175	1,805	300	600	1,200	50,000	50	315,970	14.6
Personnel	170	2,524	200	500	2,000	30,000	100	456,500	21.2
Examinations	81	1,681	200	500	2,000	20,000	100	136,200	6.3
Food	82	4,781	1,000	2,000	5,000	60,000	50	390,060	18.0
Other	18	3,850	200	1,000	3,000	35,000	100	76,400	3.5
Total cases	314	6,872	1,000	2,400	6,000	88,000	100	2,162,848	100

As for table 39, expenditures on drugs account for a biggest proportion of expenditures (36.4%), personnel is the second biggest item of expenditures (21.2%). Expenditures on food and transport account for 18% and 14.6%, respectively. 6.3% from total expenditures were spent on medical examinations.

In some cases expenditures for a certain item were very high which affected the final result of mean for those expenditures. (for ex., 2/3 of the patients who had the expenditures on transport spent 3,000- 50,000 leks and this account for almost 67% of the total expenditures for transport).

The proportion of different items of health expenditures did not differ between on strata.

Expenditures on drugs

92.7% of patients had expenditures on drugs. The average expenditures on drugs were 2,661 leks. Total amount spent on drugs was 787,718 (which are 36.5% from total expenditures during illness).

In the first part, while talking about general expenditures, we noted that expenditures on drugs from total amount of household expenditures was 2.9%. This becomes 7.5% for those who experienced a case of illness during last month.

There was a significant difference between expenditures on drugs depending on the severity of illness: the persons with severe cases spent on drugs higher amount (mean 4,296 leks) than the ones with moderate (mean 1,613 leks) and mild (mean 2,004 leks) cases.

If we consider the destination of care, people who were treated at hospitals spent significantly higher amount on drugs (mean 4,000 leks) than those treated at health center (mean 1,992 leks). The average expenditures on drugs of people who went to ambulance (2,178 leks) was the same as the ones who used self-treatment (2,154 leks)

The average amount spent on drugs did not differ across the strata and districts.

Expenditures by age group

In average the expenditures for children under 5 were significantly less than for adults (15-59 age group) (table 40).

Table 40. Expenditures by age group (new leks).

Age group	Mean	Standard deviation	Maximum	Minimum
0-4	3,842	905	13,200	300
5-14	8,266	2066	37,400	200
15-29	13,443	3751	50,000	300
30-59	8,540	1752	88,000	100
60 and above	6,453	1243	81,600	180

No difference was observed in expenditures on drugs by age groups (table 41). But in proportional terms drugs account for more than half of total expenditures among children U5, people between 30 to 59 year of age and elderly persons above 60, while for children from 5 to 14 year of age and adults of 15 – 29 year of age, because of other expenditures, drugs account for 20 – 25% of total expenditures.

Table 41. Expenditures for drugs by age group (new leks).

Age group	Mean	Standard deviation	Maximum	Minimum
0-4	1859	225	4,000	300
5-14	2101	421	10,000	200
15-29	2800	580	10,000	300
30-59	3276	716	46,000	90
60 and above	3097	657	35,000	150

By diagnosis

Expenditures occurred for people with oncological diseases (mean 42,619 leks) and trauma (30,300 leks) were significantly higher than for people with other diseases (table 42).

Table 42. Expenditures by diagnosis (new leks).

Diagnosis	Mean	Standard deviation	Maximum	Minimum
Cardiovascular	4,852	1,188	42,200	100
Respiratory	7,238	2,110	82,200	200
Gastrointestinal	9,545	2,990	53,700	300
Gynecological	8,033	2,960	27,300	900
Oncological	42,619	15,655	88,000	3,600
Professional	2,576	370	5,200	880
Trauma	30,300	7,724	50,000	4,500
Do not know	2,819	529	5,500	500
Other	6,580	1,040	40,000	100

By severity

Desegregation of data by severity of illness revealed significance difference in expenditures occurred for patients with severe cases (mean 13,371 new leks) than for people with mild and moderate cases (table 43). The proportion of drugs from total expenditures was significantly lower in severe cases (56% versus 67.1% in moderate and 68.6% in mild cases) which indicates that they have more other expenses in addition to drugs than two other groups.

Table 43. Expenditures according to severity of disease

Severity	Mean	Standard deviation	Maximum	Minimum
Mild	4,930	1,480	26,000	300
Moderate	3,739	830	40,000	200
Severe	13,371	1,788	88,000	100

By level of care

The highest expenditures occurred when patient went to the hospital (mean 10,444 leks compared to a lower level of care), went directly from the district to Tirana (mean 221,798 leks) and abroad (mean 53,600 leks). No difference in expenditures was observed in specialized outpatient clinic, ambulanca and health center (table 44).

Table 44. Expenditures according to level of care

<i>Level of care</i>	<i>Mean</i>	<i>Standard deviation</i>
Home	4,237	1,536
Ambulanca	2,658	878.5
Ambulanca with reference to health center	6,775	1,604
Health center	3,767	922
Health center with reference to hospital	7,263	3,615
Ambulanca with reference to health center and hospital	7,516	2,824
Polyclinic	2,123	544
Hospital	10,444	1,529
Tirana	21,798	5,796
Abroad	53,600	25,511

If in ambulanca mostly the expenditures account for drugs (79%), their proportion decrease as the level of care become higher (68% in health center and 46% in hospital) (table 45).

Table 45. Components of expenditures by level of care (mean, new leks).

	Ambulanca	Health center	Hospital
Drugs	2,178	1,992	4,205
Transport	693	814	2,050
Personnel	828	1,270	3,562
Examination	426	819	2,057
Food	0	0	5,750
Other	0	2,000	3,295
Total average	2,658	3,767	10,444

➤ *Coverage of expenses*

2.1% of people did not spend anything during the period of illness. Other 46.4% had money available to cover the expenses. 43.4% had to borrow money, 3.6% sold something, in 2.7% the expenses were covered by health insurance, other – 1.7%. In urban strata most of the people (62.3%) had money available to cover their expenditures while in rural areas they had to borrow money (50.5% in rural close and 59.8% in rural far with significant difference from urban area) (table 46).

Table 46. Coverage of expenses by strata (% of people)

Option \ Strata	Urban	Rural close	Rural far
Did not pay	2.6	2.2	0.5
Had money	62.3	37.7	34.8
Borrowed	27.8	50.5	59.8
Sold something	0	6.1	4.9
Covered by health insurance	4.4	2.2	0
Other	2.9	1.3	0

Significantly more people from low socioeconomic group did not pay anything compared to two other groups (table 47).

Table 47. Coverage of expenses by score (% of people)

Option \ Score	Low	Medium	High
Did not pay	5.1	1	0
Had money	45.4	44.5	55.7
Borrowed	43.1	46.3	33.1
Sold something	1.1	4	7.5
Covered by health insurance	1.9	2.9	3.7
Other	3.3	1.3	0

SUMMARY OF PART III

- 14.3% of households had at least one member who experienced a case of disease during last month (in total, 341 ill persons). The highest proportion in morbidity was due to cardiovascular and respiratory diseases (half of all cases)
- As an intention, the households mostly prefer to go and see a doctor when they are ill (69.5%). 38.3% of households prefer to rely on their family and themselves. Only 0.7% selected the option of seeing only nurse when they are ill. On the other hand when they actually fall ill, significantly less households got the assistance from their family, 60.8% got the assistance from doctor (with the same frequency from a doctor from their local health center as from district center). The proportion of nurses increases from 0.7% to 8.7%. Despite their more trust to doctors, the people in rural areas (especially from rural far area) got more assistance only from nurses than in urban area.
- Looking at the action of people by the level of health facility, 18.6% of patients went to ambulance where there is no doctor but nurse or midwife, 22.1% went first to health center with GP. People go to ambulance with the same frequency as to health center. 50.8% of ill people by-passed the local health units. Absence of significant difference shows that the behavior of ill person doesn't depend on severity of disease
- Of those who stayed at home 3.3% were children under 5. Care-givers prefer to take ill child to medical facility rather than cure them at home and mainly (63.6%) directly to the hospital
- 50.5% of patients were advised to be hospitalized and 24.2% of them actually stayed at hospital. 40.2% of those who should stay, didn't not do it because could not afford it
- 21.3% of ill persons from rural far (out of 23%) didn't take action because they could not afford treatment (versus 8.4% in rural close and this option was not applicable for urban strata). In high socioeconomic group more people takes action while they are ill (96.4) compared to medium (86.5%) and low (85%) groups.
- 25.7% of patients with severe cases were not satisfied by care versus 2.4% with moderate cases and they mostly didn't like that the care was expensive (69.5%).
- Only 1% of patients didn't need drugs. 5% got everything at the facility free of charge. Health insurance partly covered the expenditures on drugs only in 18.4% cases. And this mainly happens in urban area (29.6%) than in rural close (13.9%) and rural far areas (2.9%).
- 95.7% of patients found all needed drugs in pharmacy with no difference by strata. Most of people (64.2%) spent less than one hour to find all drugs they needed. Only 3.4% had to look for them two days and 3.9% - more than two days. Across the strata, people from urban area spent significantly less time to find the drugs than in rural far area
- Only 2.1% of ill persons had no expenditures on health. 92.7% of all ill persons had an expenditure on drugs. 74.3% had also other expenditures. The amount of expenditures did not depend on the socio-economic status and strata.
- Expenditures on drugs account for a biggest proportion of expenditures (36.4%), personnel is the second biggest item of expenditures (21.2%). Expenditures on food and transport account for 18% and 14.6%, respectively. 6.3% from total expenditures were spent on medical examinations. The average expenditures on drugs of people who went to ambulance (2,178 leks) were the same as the ones who used self-treatment (2,154 leks).
- The highest expenditures occurred when patient went to the hospital (mean 10,444 leks compared to a lower level of care), directly to Tirana (mean 221,798 leks) and abroad (mean 53,600 leks). No difference in expenditures was observed in specialized outpatient clinic, ambulance and health center. If in ambulance mostly the expenditures account for drugs (79%), their proportion decrease as the level of care become higher.
- 46.4% had money available to cover the expenses and 43.4% had to borrow. In 2.7% the expenses were covered by health insurance, other – 1.7%. In urban strata most of the people had money available to cover their expenditures while in rural areas they had to borrow money

PART IV. DELIVERIES

Because of the small number of delivery cases, in this part we will more speak about tendencies rather than statistically significant differences. As in all previous parts, all results are weighted by strata and districts.

➤ ***Outcome of deliveries***

Total sample:

In total 101 women were found to have a delivery during last year. 91.7% of them safely delivered. Deliveries with complications for mother were in 8.3% of cases. No cases were found to be with infant or maternal death.

By strata:

In urban area there were 27 deliveries, in rural close and rural far - 37 in each. The complications for mother in urban area were in 2 cases (3.4%), in rural close and rural far in 4 cases (7.6%) and 7 cases (20%), respectively.

By districts:

In Elbasan there were 34 cases (with 3 cases of complications for mother), in Pogradec and Vlora – 31 and 36 deliveries, respectively (with 5 complications in each district).

➤ ***Home deliveries***

10 women (6.5%) delivered at home. When they asked about the reason of home delivery the responses were:

There was no facility close to the place of residence	60.4% (8 cases)
The care is expensive	0
Do not trust to quality of care	0
Family didn't allow delivering in the facility	32.9% (1 case)
Other	6.7% (1 case)

5 women in Pogradec, 2 women in Elbasan and 1 woman in Vlora delivered at home since there was no facility close to their place of residence.

All 8 women who delivered at home because of no facility close to their place of residence were from rural area (3 from rural close and 5 from rural far). The woman who didn't deliver at medical facility because family didn't allow was from urban area of Elbasan district.

➤ ***Attended deliveries***

Those who delivered at home 90.3% (9 cases) had attended deliveries, 9.7% (1 case) - not attended. Again, the figure is weighted, which reflects the general picture for all three districts meaning that in all three districts in total 9.7% of all deliveries at home are not

attended. It should be noted that taking into account the small number of cases we cannot make an accurate conclusions but there is a clear indication that the problem of unattended deliveries exists. All attended deliveries at home (9 cases) were with presence of midwife.

Among those who delivered at medical facility 17.1% had an attended delivery by only midwife, 16.7% by only doctor and 66.2% – by both, doctor and midwife. There is a tendency that in rural far area less deliveries are attended with presence of doctor (68.1% out of which 16.7% by only doctor and 51.7% by both - doctor and midwife) compared to rural close (75.8% out of which 17.3% by only doctor and 58.5% - by both) and urban areas (84.4% with 71.1% attended by both, doctor and midwife).

➤ ***Deliveries at health facility***

60% of women spent less than 1 hour to reach a medical facility. Other 20.9% needed two hours and 19.1% of women traveled more than two hours to reach the facility for delivery. All women in urban strata spent less than one hour while this happened only in 36.7% and 36.2% cases of deliveries in rural close and rural far areas. In rural close area 35.6% of women reached health facility within two hours and 27.7% spent more than two hours compared to 26.6% and 37.2% in rural far area.

Most of the women (85.8%) delivered at closest facility where maternal services are available. The women who didn't deliver at the closest facility have different reasons for that like:

By time of delivery the woman was out of the place of residence	50.6%
The quality of care at the nearest facility is low	6.9%
The care is expensive	6.9%
Other reasons	35.6%

All women from urban area delivered at closest facility compared to 80.4% in rural close and 67.8% in rural far. All women who told that they didn't deliver at closest facility because of low quality or high price of service (though informal) were from rural far strata (18.9% and 9.4% from those deliveries in rural far, respectively). These options were not picked up in urban and rural close areas.

➤ ***Expenditures***

15.6% (17 cases) of women had no expenditures during delivery. The occurrence of free cares decreases from urban (16.4%) to rural far (7.5%) areas. There is also a clear tendency of increase of cases with free care from high socioeconomic group (only 8.5%) to medium and low groups (15.1% and 23.6%, accordingly).

Composition of expenditures in total sample is shown in the table 48.

Table 48. Composition of expenditures in total sample

<i>Item</i>	<i>N of Cases</i>	<i>Mean</i>	<i>Standard error</i>	<i>Minimum</i>	<i>Maximum</i>	<i>Total Sum</i>	<i>% from total</i>
Transport	50	1,843	344	100	10000	93,700	12
Drugs	18	2,190	652	100	7000	31,050	4
Personnel	78	5,571	588	500	30,000	399,500	51.1
Examination	16	1,853	402	200	5,000	26,550	3.4
Food	43	2,899	554	306	10,000	120,306	15.4
Other	12	7,825	4,425	100	60,000	110,700	14.1
Average total	91	8,810	1,207	200	72,200	781,806	100

54% of all expenditures is going to personnel, 15.4 – on food, 12% - on transport only 4% - on drugs and 3.4 on examination. 14.1% of expenditures go to some other items.

There was no significant difference in expenditures between strata (table 49).

Table 49. Expenditures on deliveries by strata (in new leks)

<i>Strata</i>	<i>N of Cases</i>	<i>Mean</i>	<i>Standard error</i>	<i>Minimum</i>	<i>Maximum</i>
Urban	25	6,482	1,470	306	20,300
Rural close	33	11,287	2,339	200	72,200
Rural far	33	7,871	1,663	200	56,000

When looking at the expenditures on delivery in association with the place of delivery (table 50) there is a significant difference between expenditures on home deliveries and deliveries at medical facility.

Table 50. Expenditures on delivery in association with the place of delivery

<i>Place of delivery</i>	<i>Mean</i>	<i>Standard error</i>	<i>Minimum</i>	<i>Maximum</i>
Home	2,383	537	700	5,000
Medical facility	9,296	1,271	200	72,200

There is also a tendency in increase of expenditures from the deliveries attended only by midwife to the one attended by doctor or by both (table 51).

Table 51. Expenditures by personnel attended

<i>Personnel attended</i>	<i>Mean</i>	<i>Standard error</i>	<i>Minimum</i>	<i>Maximum</i>
Only midwife	5,191	1,347	200	23,750
Only doctor	10,758	2,958	2,000	56,000
Doctor & midwife	9,443	1,739	306	72,220

➤ *Satisfaction from care during delivery*

In most of the cases (85.5%) the women were satisfied by the care provided during delivery. No significant difference in satisfaction from care by strata, by place of delivery and attendance.

SUMMARY OF PART IV

- 10 women (6.5%) delivered at home. 60.4% of them delivered at home because there was no facility providing maternal care close to the place of residence (all of them were from rural area)
- 9.7% of those who delivered at home had an unattended delivery. Because of the small number of cases it is difficult to make definite conclusions but there is a clear indication that the problem of unattended deliveries exists.
- Among those who delivered at medical facility 17.1% had an attended delivery by only midwife (mostly in rural far area).
- 19.1% of women traveled more than two hours to reach the facility for delivery. (37.2% in rural far area).
- All women who told that they didn't deliver at closest facility because of low quality or price of service were from rural far strata (18.9% and 9.4% from those deliveries in rural far, respectively).
- 15.6% of women had no expenditures during delivery. The occurrence of free care decreases from urban (16.4%) to rural far (7.5%) areas.
- Composition of expenditures during delivery shows that 54% of all expenditures is going to personnel, 15.4 – on food, 12% - on transport, only 4% - on drugs and 3.4 on examination. 14.1% of expenditures goes to some other items. Expenditures on home deliveries are significantly lower than for the deliveries occurred at medical facility.

IV EXTRAPOLATIONS

In this chapter we will try to make some extrapolations to the district level on the basis of data obtained from sample population.

SURVEY SAMPLE AS A FRACTION OF DISTRICT POPULATION

Total number of population surveyed in Pogradec was 3,160, in Elbasan 3,389 and in Vlora – 3,229 people. Knowing the total population in each district we can calculate the fraction of sample of population in each district. This results in the fraction of 27.2 in Pogradec, 76.5 in Elbasan and 58.9 in Vlora. For simplicity reason we can round the figures to the nearest number and get 27 for Pogradec, 77 for Elbasan and 59 - Vlora. These numbers will be used as multiplier in further calculations.

EXTRAPOLATION OF TOTAL HEALTH EXPENDITURES OCCURRED DURING ONE MONTH TO THE DISTRICT LEVEL

We know the total health expenditures and total expenditures on drugs of sample population in each district. Multiplying these figures by the fraction got above we can have an idea of households health expenditures occurred during one month period in each district (table 52).

Table 52. Expenditures on health of districts' population during one month

District	Expenditures on health of sample population		Expenditures on health of district population		Expenditures on drugs of sample population		Expenditures on drugs of district population	
	Leks	USD	Leks	USD	Leks	USD	Leks	USD
Pogradec	466,538	3,332	12,596,526	89,975	17,1768	1,227	4,637,736	33,127
Vlora	811,630	5,797	47,886,170	342,044	333,720	2,384	19,689,480	140,639
Elbasan	870,380	6,217	67,019,260	478,709	278,030	1,986	21,408,310	152,917

EXTRAPOLATION OF TOTAL HEALTH EXPENDITURES AT THE DISTRICT LEVEL TO THE PERIOD OF ONE YEAR

Multiplying the figures above by 12 we can get the expenditures on health over one year period (table 53).

Table 53. Expenditures on health of districts' population during one year (USD)

District \ Expenditures	Expenditures on health of district population	Expenditures on drugs of district population
Pogradec	1079702	397520
Vlora	4104529	1687670
Elbasan	5744508	1834998

PER CAPITA EXPENDITURES ON HEALTH BY POPULATION

From the calculations above we can assume that per capita expenditures of households on health in Pogradec was 12.6 USD, in Vlora 21.5USD and Elbasan 22.1USD. For comparison, in 1999 the general per capita expenditure on health in Albania was 29.3 USD (MOH). Similarly, we can say that per capita expenditures of households on drugs was in Pogradec 4.6 USD, in Vlora 8.9 USD and 7.1 USD in Elbasan.

V CONCLUSIONS

Socioeconomic status

The average monthly declared income of households was 15,788 new leks. Salary contributes 33% to the household budget and mainly the source of income comes from other than salary sources. Food accounts for less than half of the households' expenditures and, surprisingly, paying debts is the next biggest item of declared expenditures. In majority of cases the declared income was less than expenditures.

Access to health care services

Overall, the accesibility of population to the health care is quite good and 87.5% of population lives in a distance of less than 5 km to the nearest health facility. On the other

hand this is not always the case for population of rural far areas where this proportion decreases to 55.6%. There is also good coverage of population by GP. The majority of households (78%) need less than one hour to find GP but this again differs from strata to strata. 47.5% of people from rural far area need to travel for more than two hours to reach GP.

While the physical accessibility in majority of cases is not a problem, only 15.7% of households admitted that the price for treatment never prevented them from applying for the health services. Though in general there are no formal charges for health services, the practice of informal payments (by cash or in kind) is widespread. The highest proportion of people for whom a price of health service was always an obstacle was in rural far area (61.1%). This was also the case for 61.2% of poor people with significant difference from other socioeconomic groups (49.0% in medium and 33.6% in high groups). 43.4% had to borrow money to cover health expenses and this is more applicable to rural rather than urban areas.

Paid care

It is interesting to observe how the acceptability of paid health care changes from question to question. When the respondents were given only two options of whether they agree or do not agree to pay for health services, almost half of the respondents (49.2%) stated that in no way could accept paid health care (significantly lower in high socioeconomic group than in medium and low groups). When they are given the opportunity to select the conditions under which they would have agreed to pay the proportion of people who refused to accept paid care decreases to 27.7% and this even goes further down to 24.4% when they are given a choice to select the item of payment.

Improvement of the performance of health personnel is the primary condition for the majority of people who agree to pay (33.6%). People are less concerned about availability of drugs in the nearest facility and this is the next preferred condition in rural areas (15% – 18%).

In total sample, 27.8% of households prefer to pay only for drugs and 29.7% of households agree to pay for all items - drugs, doctor's consultation and examination and here again we can observe the differences in responses between areas and socioeconomic groups. In rural areas people more prone to pay only for drugs while in urban areas more people expressed their readiness to pay for everything. Similarly, in high socioeconomic group more people agree to pay for everything, while in low and medium groups the most preferred item is payment for drugs

The interviewed households were ready to contribute monthly the average amount of 252 new leks though with significant difference in the amount of monthly contribution among strata and socioeconomic groups (higher in urban and high socioeconomic group and lower in rural and low score groups)

Only 2.1% consider that in case of compulsory payment for health care nobody should be exempted from payment. As a first choice majority of households (41.1%) would exempt

disable people. The preference to disable people as a first priority could be partly explained by the fact that in 8.7% of households there was person/s with disability.

Health insurance

72% of households preferred to pay once a month (as a kind of insurance) rather than to pay for health services when they are ill. At the same time one third of interviewed households (33.7%) didn't know what is health insurance and this was found mainly in rural than in urban areas. 89% of people who are aware about health insurance considers that health insurance is helpful and 11% thinks that it is not. When asked why it is not helpful the most frequently selected reason was that they have to pay for drugs anyway but also that they do not know their rights and regulations.

The people particularly likes that with health insurance they feel themselves more secure because it is established by the government (59.5%). Less people (39.5%) considers that health insurance is helpful because it covers expenditures on drugs (with significant difference). This could imply that most of the people have not benefited from this institution yet but only believe that it is good.

Only 28.5% of households declared that they receive salary and consequently make a contribution to health insurance fund.

Participation

In general 52.5% of people expressed their willingness to participate in the development of health care and mainly they want to take part in health education activities and assist in water and sanitation activities.

Health-seeking behaviour

The people prefer to see a doctor when they are ill but also a large proportion of respondents (38.3%) prefer to rely on their family and themselves. Only 0.7% selected the option of seeing only nurse when they are ill. On the other hand when they actually fall ill, significantly less households stay at home and they get assistance from doctor (60.8%) or a nurse (8.7%).

Looking at the action of people by the level of health facility, 18.6% of patients went first to ambulanca where there is no doctor but nurse or midwife and with the same frequency their first place of destination was health center with GP (22.1%). Half of ill people bypassed their local health units and went directly to a higher levels of care. The selection of destination didn't depend on severity of disease. By-passing local units was more the case for care-givers with ill child U5 who do not keep child at home (only 3.3%) but takes them directly to the hospital (63.6%).

Hospitalization

The study revealed a heavy reliance on hospitalisation. Half of all patients were advised to be hospitalised and 24.2% of them actually stayed at hospital. 40.2% of those who should stay, didn't do it because could not afford it

Drugs availability

Only 1% of patients didn't need drugs. All others were either prescribed drugs or they bought without consultation with doctor. The accessibility to drugs is also very high and 95.7% of patients found all needed drugs in pharmacy with no difference by strata. Most of people (64.2%) spent less than one hour to find all drugs they needed, and only 3.9% - more than two days. Across the strata, people from urban area spent significantly less time to find the drugs than in rural far area.

There are still some drugs available in the facility and 5% got everything at the facility free of charge. It should be noted that though 95.7% of people need to buy drugs, Health insurance partly covered the expenditures on drugs only in 18.4% cases. And this mainly happens in urban area (29.6%) than in rural close (13.9%) and rural far areas (2.9%).

Expenditures on health

Only 2.9% of ill persons had no expenditures on health. The amount of expenditures did not depend on the socio-economic status and strata. If we look at the portion of health expenditures in the total budget of households (presented in the first part) who had the case/s of illness during last month, we can see that it accounts for 20.5% of total household expenditures.

Expenditures on drugs account for a biggest proportion of expenditures (36.4%), personnel is the second biggest item of expenditures (21.2%). Expenditures on food and transport account for 18% and 14.6%, respectively. 6.3% from total expenditures were spent on medical examinations.

No major differences were observed on the amount of expenditures depending on the level of outpatient care (ambulanca, health centre and polyclinic) while there is a significant difference in the expenditures occurred on hospital. If in ambulanca mostly the expenditures account for drugs (79%), their proportion decreases as the level of care become higher.

Extrapolations of data obtained from sample population to the district level showed that per capita expenditures of households on health was 12.6 USD in Pogradec, 21.5USD in Vlora and 22.1USD Elbasan. For comparison, according to MOH, per capita expenditure on health in Albania in 1999 (total of government budget, secondary revenues, foreign financing, health insurance contribution) in 1999 was 29.3USD.

Deliveries

Because of the few number of cases (101 deliveries) it was difficult to make definite conclusions but have a general picture on the situation with deliveries. 10 women (6.5%) delivered at home and 60.4% of them (all from rural area) delivered at home because there was no facility providing maternal care close to the place of residence. 19.1% of women traveled more than two hours to reach the facility for delivery (37.2% in rural far area). There was only one case with unattended delivery but speaking in proportional terms this makes 9.7% from those who delivered at home. Still difficult to make any conclusions but there is a clear indication that the problem of unattended deliveries exists.

15.6% of women had no expenditures during delivery. The occurrence of free care decreases from urban (16.4%) to rural far (7.5%) areas. Composition of expenditures during delivery shows that 54% of all expenditures is going to personnel, 15.4 – on food, 12% - on transport, only 4% - on drugs and 3.4% on examination. 14.1% of expenditures go to some other items.

VI LESSONS LEARNED FROM THE STUDY

Health insurance institution is going to play an important role in the health system of Albania. In general the population want to secure themselves by monthly contributions rather than payments during illness. In order to increase participation of population to the scheme the increase of awareness among population is important. It seems like currently this institution is working mainly for the population of urban areas, while almost half of the people from rural areas do not know what the health insurance is. Also consumer's rights and regulations should be transparent and people should know more about their benefits while contributing to the scheme.

Though people more like to see only a doctor when they are ill, the level of care they select as their first place of destination at local level doesn't depend on the availability of doctor. People perceive the quality of care provided by ambulance and local health center as almost the same. This become clear then one look at the services provided by these levels (especially in rural areas) and find not much difference between service provided by doctor from local health center or by nurse/midwife in ambulance: both of them in majority of cases have not gone through the refreshment training and there is lack of basic equipment at both levels. Half of ill persons prefer to by-pass the local health units and apply for higher levels of care. In order to make health centers with GPs more attractive more attention should be paid on the upgrading of the services at this level. And this coincides with demand of population who agree to pay for services if the performance of GP is good.

There is also heavy reliance on hospitalization. This not only has a certain impact on health system in general but in the first turn puts a burden on population who experiences high expenditures while applying to this level of care.

Though the drugs availability is not a problem the prescription practices should be further investigated.

The introduction of user fees should be carefully examined. Despite the fact that currently per capita health expenditure of population is almost half and of the amount spent by government there is still a big group of population who think twice before applying for care because of price (though informal).

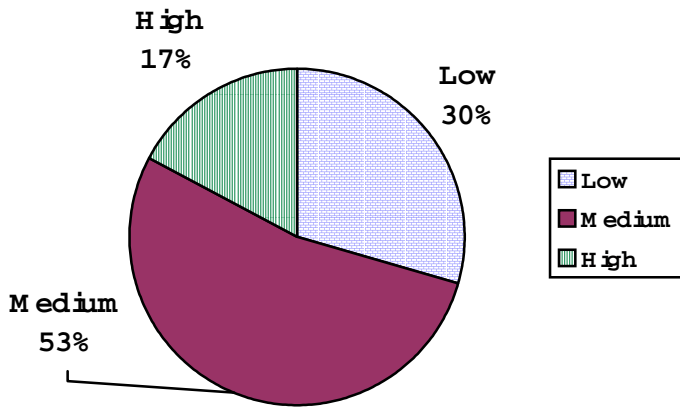
More attention should be given for raising the participation of community to the development of the health care delivery. It is encouraging that community is willing to participate and they especially like to be involved in health education and water and sanitation activities. Some certain activities should be undertaken in order to transfer this readiness into reality. Local health authorities jointly with the municipalities should take a lead in this process.

RECOMMENDATIONS FOR THE OFFICE

- The results of the survey should be widely presented to and discussed at different levels with the participation of all stakeholders in health sector, starting from the community, health service providers up to the national policy-makers and international actors involved in the health sector reform
- At national level, UNICEF, not necessarily being involved in major reorganization and restructuring of health sector, should ensure that rights of child, adolescent and woman to essential health services are preserved despite of the direction of the reform and its major concerns in terms of health are on agenda of all key actors, which are influencing the reform process. To this end a number of round table meetings with the involvement of all major partners in health sector reform should be organized where the potential impact (threats and benefits) of current direction of health reform process on provision of basic health services (in terms of equity, accessibility, coverage and quality) is discussed
- At local level, UNICEF, (provided the availability of enough resources both human and financial), in line with other nationwide activities specified in country program recommendation (CPR), could assist MOH in maximizing its efforts to upgrade the provision of primary health care services focusing in one or two districts. Involvement of NGOs, both national and international, to this process should be envisaged. Keeping in mind the survey results several focus group discussions should be organized in the selected district/s with wide involvement of community and service providers for closer comprehension of reality and finding possible solutions according to a specific situation in each community. The main efforts should be directed towards upgrading of case management of childhood illnesses, improvement of the quality of preventive activities for children, adolescents and women, health promotion for care-givers, pregnant women and adolescents. The availability of all necessary items (basic equipment, health education materials etc) for implementing of these activities should be ensured.

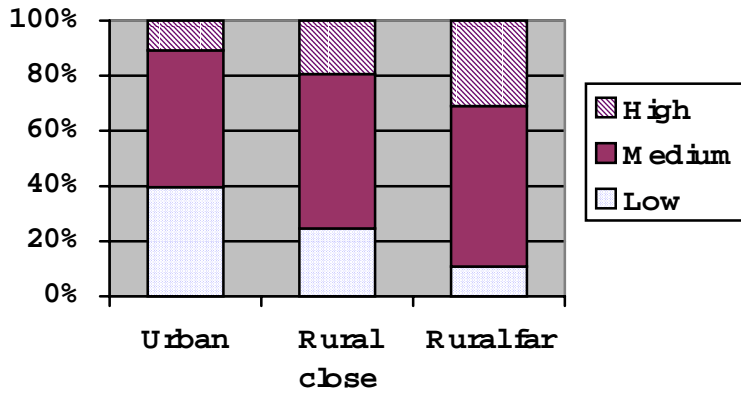
Graph 1

Distribution of households by socioeconomic score



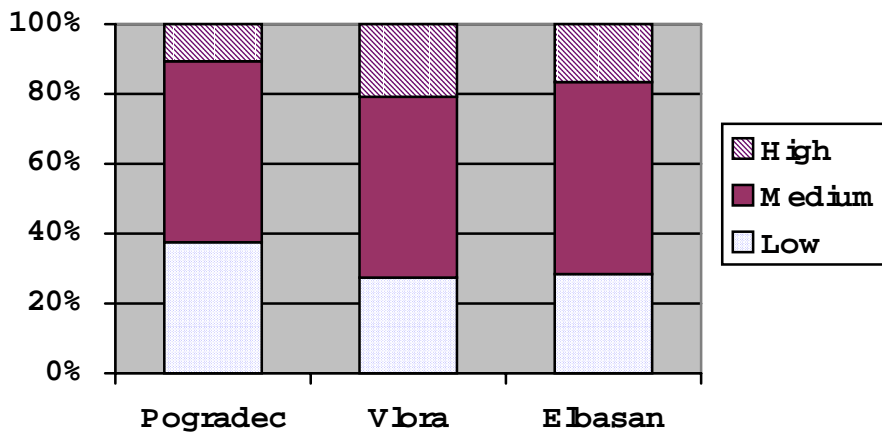
Graph 2

Socioeconomic score by strata



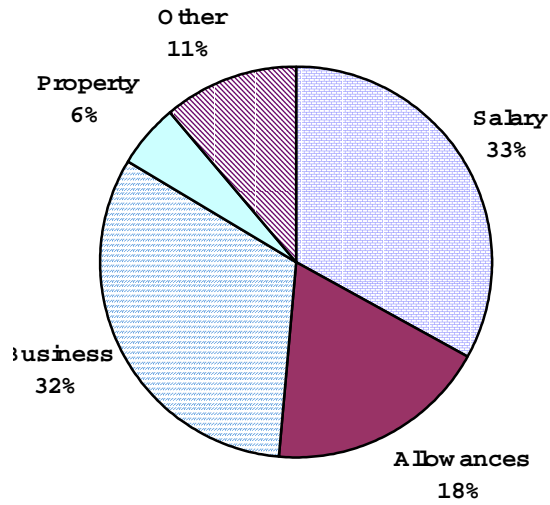
Graph 3

Socioeconomic score by districts



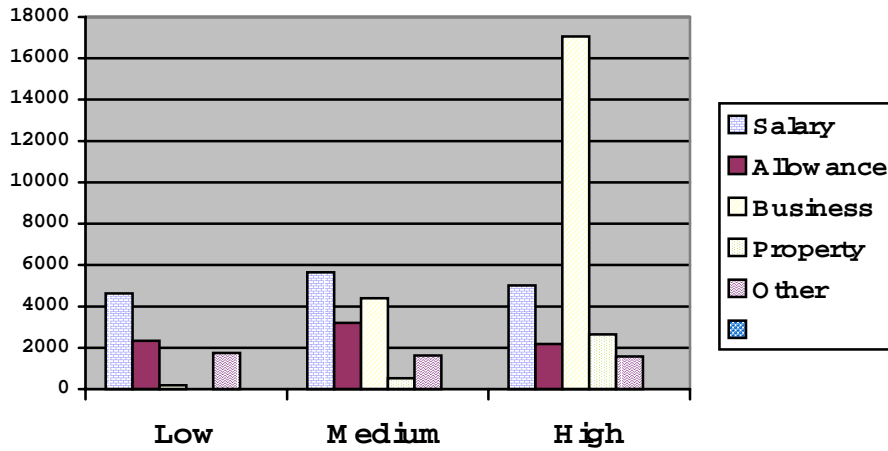
Graph 4

Com position of incom e

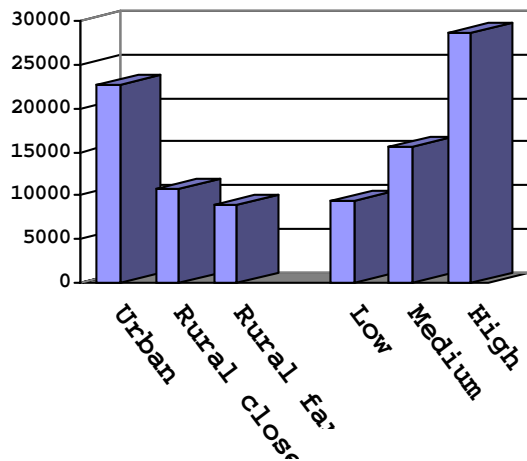


Graph 5

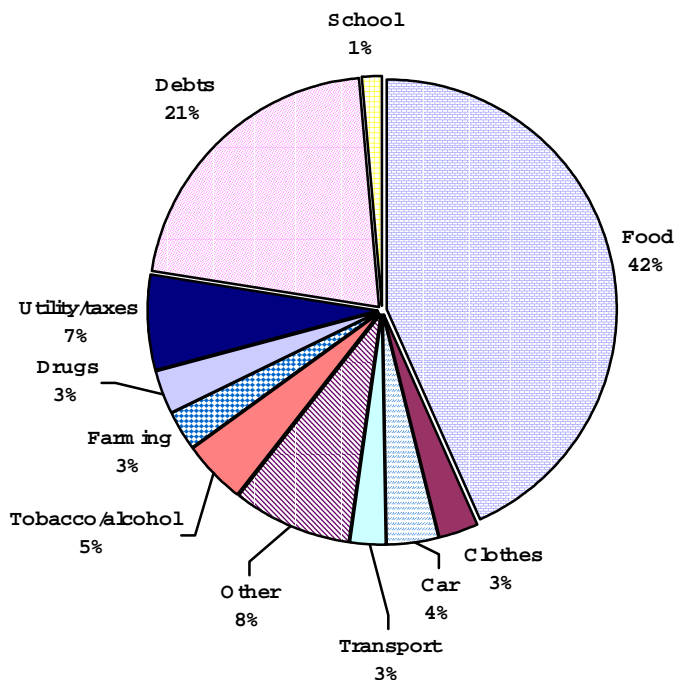
Com position of incom e by scores



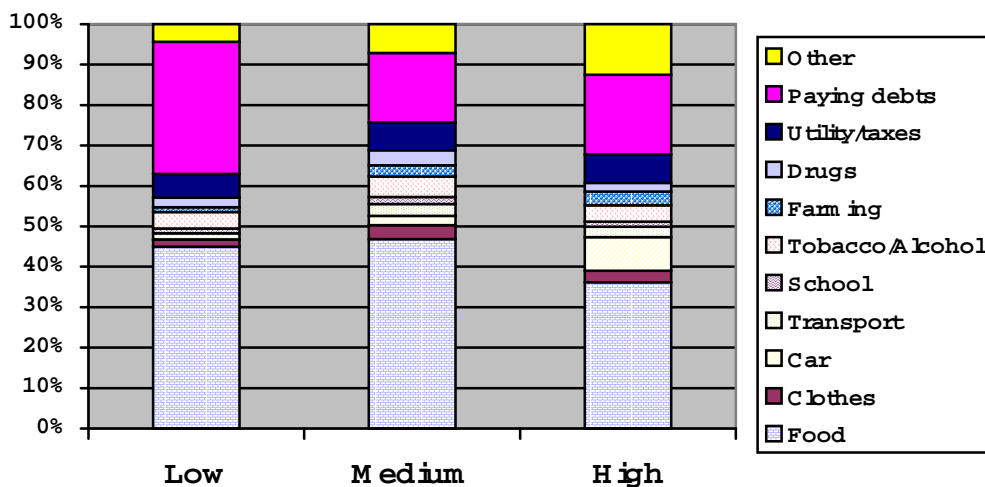
Graph 7 Average incom e by strata and score



Graph 5 **Com position of expenditures**

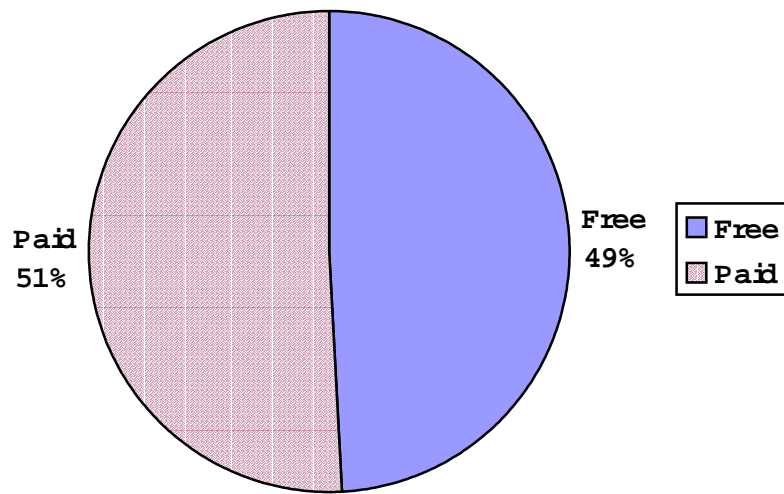


Graph 8 **Com position of Expenditures by score**



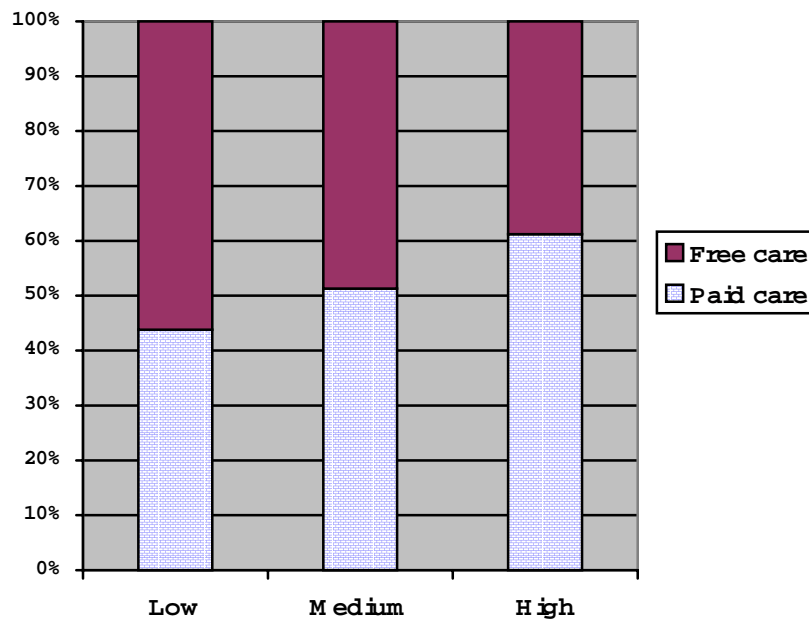
Graph 9

Opinion on paid care



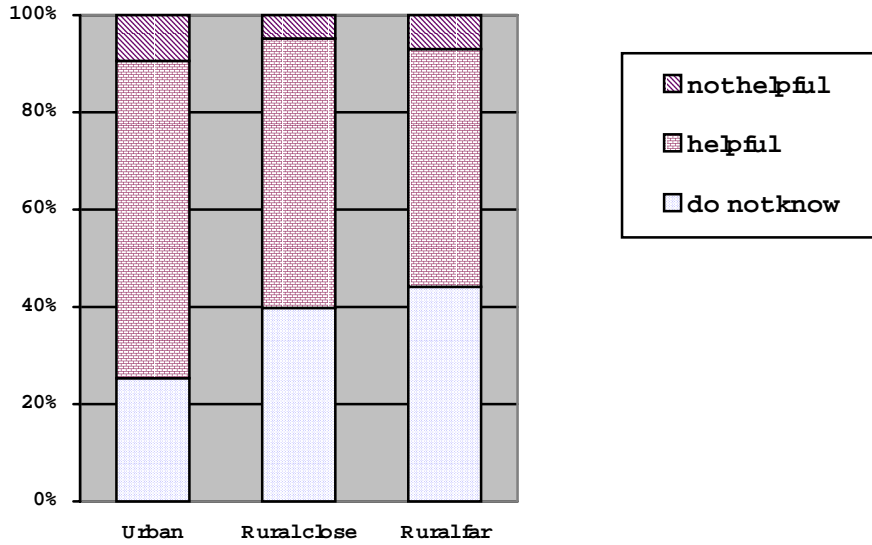
Graph 10

Opinion on paid care by score



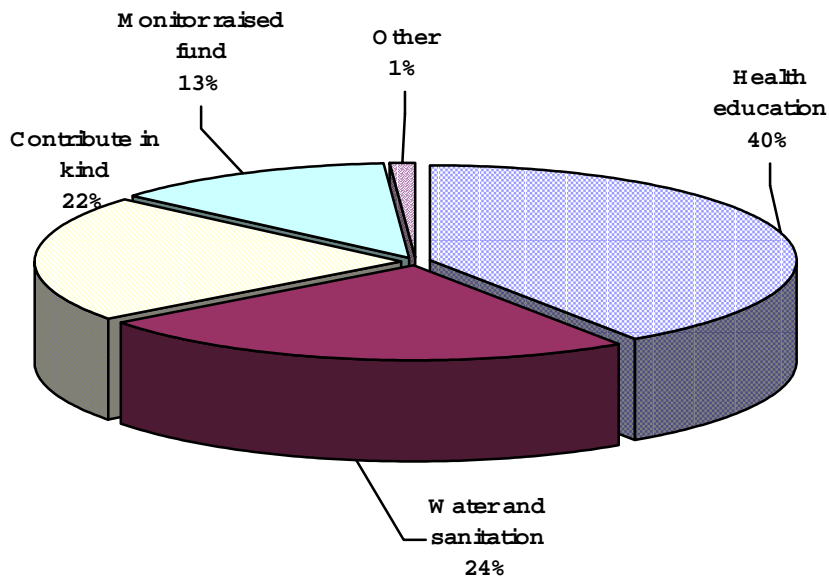
Graph 11

Opinion on health insurance by strata



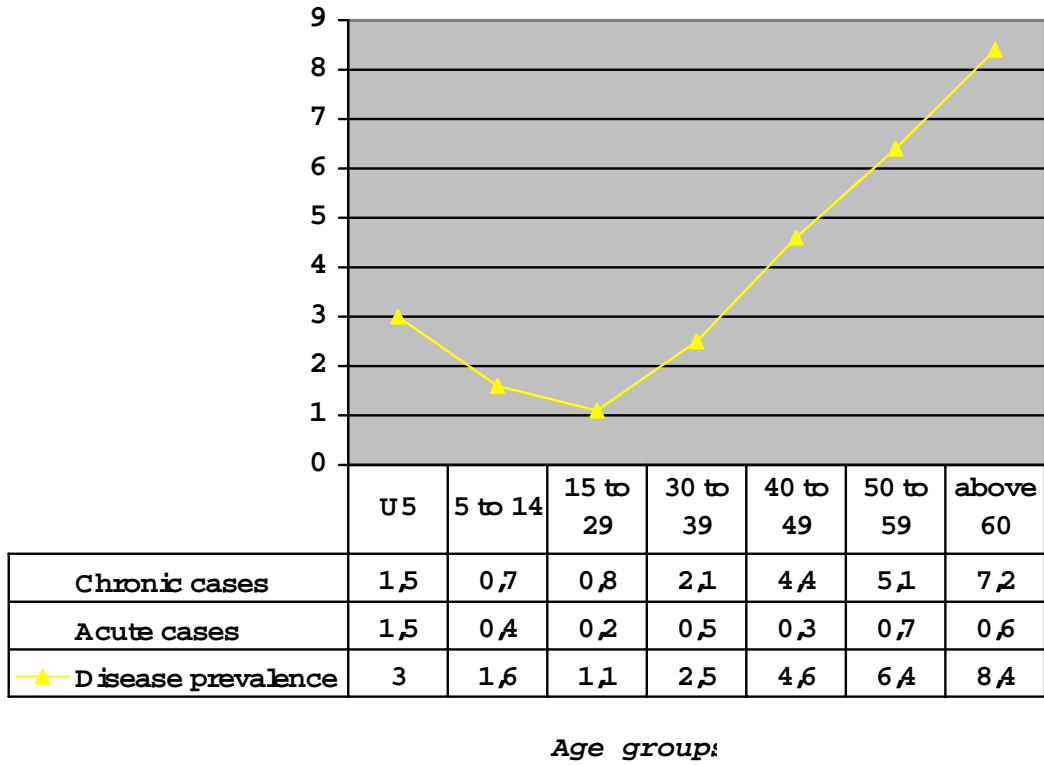
Graph 12

Community participation



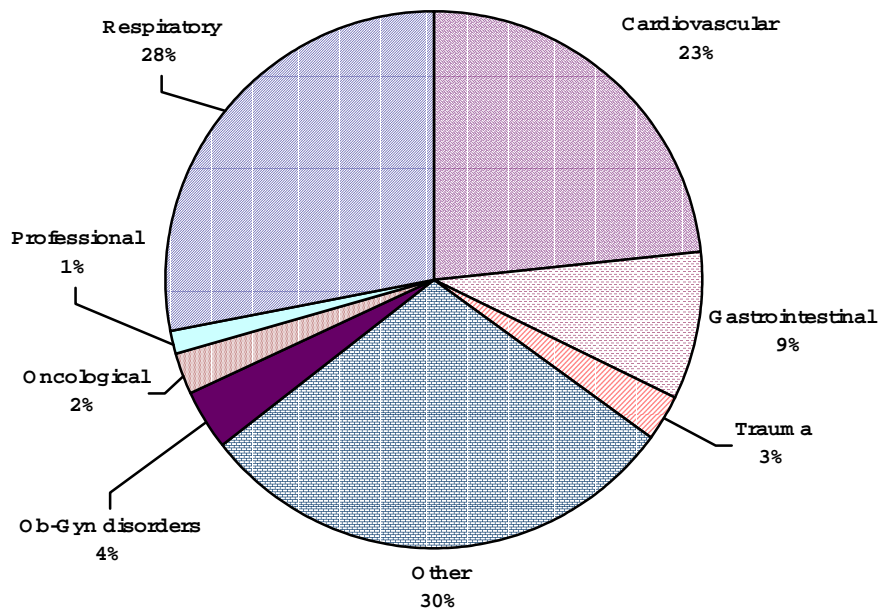
Graph 13

Disease prevalence



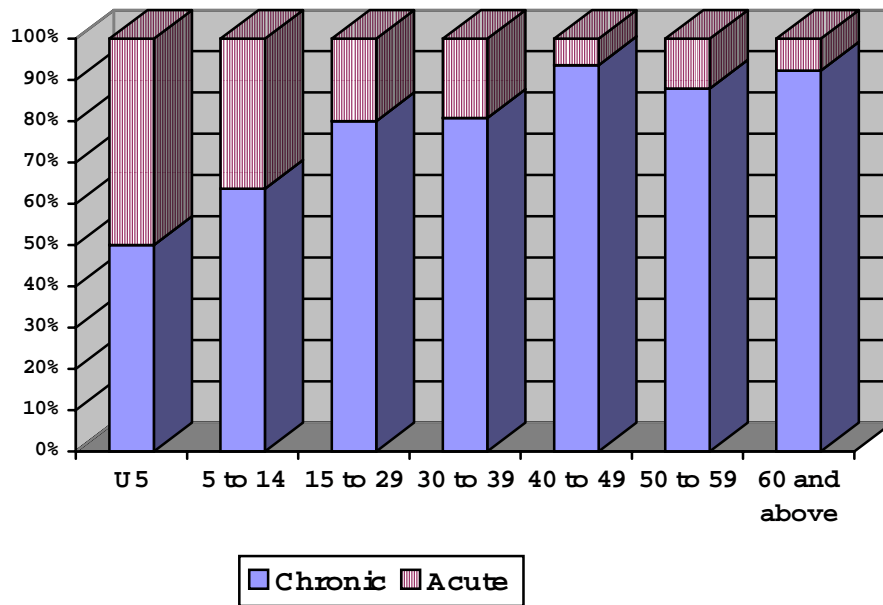
Graph 14

Distribution of diagnosis



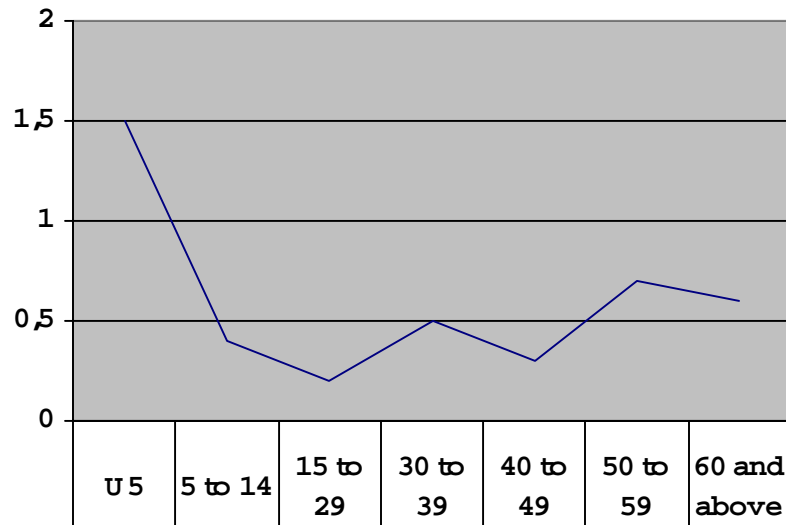
Graph 15

Acute /chronic cases by age



Graph 16

Acute cases by age



— Acute cases	1,5	0,4	0,2	0,5	0,3	0,7	0,6
Chronic cases	1,5	0,7	0,8	2,1	4,4	5,1	7,2
Disease prevalence	3	1,6	1,1	2,5	4,6	6,4	8,4

Age groups

Graph 18

Com position of expenditures

