

# Are health care payments in Albania catastrophic? Evidence from ALSMS 2002, 2005 and 2008

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**ARE HEALTH CARE PAYMENTS IN ALBANIA CATASTROPHIC?  
EVIDENCE FROM ALSMS 2002, 2005 AND 2008**

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## **Abstract**

The absent or poorly functioning risk pooling mechanisms and high amounts of out-of-pocket payments for health care expose households to financial risks associated with major illnesses or accidents. The aim of this paper is to analyse the extent to which out-of-pocket health spending impoverish the households in Albania. The study augments the existing evidence by analysing the dynamics of such payments over different years and the weight that informal payments have in the total out-of-pocket health spending.

The data used in this study come from Albania Living Standard Measurement Survey (ALSMS) for 2002, 2005 and 2008. We measure headcount catastrophic payments using different thresholds and the decomposition of indicators by expenditure quintiles to understand better their effects. We find that out-of-pocket and informal payments have increased in real value throughout the years. Even though their catastrophic effect has gone down (due also to declining trends in absolute poverty), the effect for the poorest expenditure quintiles remains high. Out-of-pocket payments deepen the poverty headcount and also enlarge the poverty gap and again the effect is larger for the poorest quintiles. Future policy interventions should provide better protection mechanisms for the poor by providing exemption criteria or subsidised transport and should seek to address the widespread informal payments in the country.

**Keywords:** catastrophic payments, out-of-pocket payments, impoverishment, Albania LSMS,

## Introduction

High levels of out-of-pocket payments for health care expose households to financial risks associated with major illness (World Bank, 1993, 1995a; WHO 2005). Expecting households to make some financial contribution for their health care is reasonable even in wealthy countries with sophisticated public and private health insurance, and particularly for frequently occurring conditions that are inexpensive to remedy. However, an over reliance on out-of-pocket payments for health care may endanger households' customary standards of living and disrupt household welfare (Berki, 1986; O'Donnell et al., 2005 & 2008; Gertler and Gruber, 2002; Xu et al., 2003), particularly for serious, less-frequently occurring conditions for which the costs of treatment can quickly mount. Households, especially in developing countries, may not be able to insure their basic needs (World Bank 1993, 1995a) and uninsured health care events can therefore increase the risks of loss of incomes from reduced labour supply or lower productivity. This can cause long-term consequences pushing them into a "trans-generational cycle" of poverty (Baeza and Packard, 2006). High out-of-pocket payments for health care can also prevent some people from seeking necessary health care creating thus barriers to access for the most poor (Xu et al., 2007).

In essence, health care costs can be considered catastrophic when they force individuals or households to significantly decrease their standard of living now or in the future (Stiglitz, 1988). A survey of 89 countries has showed that almost 150 million people globally suffer financial catastrophe because of high out-of-pocket health care expenditures (Xu et al., 2007). Giving that one of the main objectives of health care systems should be ensuring the equity among health care seekers, households should be protected against such catastrophic medical expenditures (WHO, 2000).

While cross country comparisons show that out-of-pocket payments are prevalent in most Western Balkans Countries, recent studies (Bredenkamp et al., 2010) show that catastrophic out-of-pocket payments (including informal payments) in Albania are higher than in most other countries. When this finding is examined alongside the much larger share of out-of-pocket spending in total financing of health in Albania relative to other similar countries (like Montenegro, Macedonia or Serbia) (Bredenkamp et al., 2010) and the much

higher incidence of informal payments, concern that these payments are further raising barriers to care and increasing the financial vulnerability of households grows.

This paper looks at the effect of out-of-pocket and informal payments on household expenditures by exploring the existing and the newly available ALSMS (Albania Living Standard Measurement Survey) data for 2002, 2005 and 2008. The paper focuses on two main aspects of out-of-pocket payments: (i) the incidence and intensity of ‘catastrophic’ health care expenditure, and (ii) the effect of out-of-pocket payments on poverty headcount and poverty gap measures. The main questions that this paper attempts to answer are: Does out-of-pocket health spending impoverish the households in Albania? And what weight do informal payments have in increasing the burden of out-of-pocket health spending? The paper uses the decomposition of out-of-pocket payments in health care by main expenditure quintiles to look at the particular burden for different categories. Further decomposition of such payments by main components and public/private sector aims to give a ‘panoramic’ picture of the main developments over the years.

## **Data and methodology**

Out-of-pocket expenditures for health care in Albania are assessed in this paper using ALSMS data for three different years, 2002, 2005 and 2008. The data are representative for Albania and are collected using a similar methodology. However they can only offer cross-section features and lack the longitudinal dimension. Longitudinal data would be ideally if we want to estimate the extent to which living standards are disrupted by the purchase of medical care in response to illness shocks (O’Donnell et al., 2008). This allows to see how household well-being is affected by certain health shocks (Gertler and Gruber, 2002; Wagstaff, 2007). However, as often only cross-section data are available, it has been proposed to define out-of-pocket payments as catastrophic if they exceed a critical share of households’ resources during one year (Berki, 1986; Russell, 2004; Wagstaff and van Doorslaer, 2003; Xu et al., 2003). In this paper we exploit the same definitions used in different ALSMS to compare the trends of out-of-pockets and their impoverishing effects over the years.

One of the debatable points in the literature is the choice of the comparators of out-of-pocket payments (O’Donnell et al., 2008). The two possibilities are to calculate out-of-pocket

as a share of household's income, consumption or expenditure. All measures have advantages and disadvantages. Income is often argued to be a better denominator as it is completely irresponsive of health care expenditures. However, this advantage is offset by the fact that an out-of-pocket-to-income ratio will not account the use of other resources available to some of the households and not available to others (e.g. the use of savings). Total expenditures on the other hand may be more responsive to health care. For example for the poor households resources tend be directed to items that are indispensable (i.e. food). Given this the poorest will always tend to spend more on such subsistence items leaving little to health care. One of the solutions mentioned in O'Donnell et al. (2008) is to consider catastrophic payments as the share of out-of-pocket payments to the non-necessity total expenditures (defined often as the expenditure on non-food items). Because of the non-indispensable nature, non-food expenditure may distinguish better between the poor and the rich. Given these reasons and also the fact that poverty measures in countries like Albania are based primarily on expenditures rather than income (World Bank, 2006) we present here the estimated catastrophic health payments based on non-health expenditure. To test for the consistency of the results when expenditures on non-food items are considered we have also estimated the tables for the catastrophic effect of out-of pocket payments on such expenditures (see also Table A1 in the appendix).

Health economists have not yet agreed on a uniformly accepted threshold of out-of-pocket spending that triggers alarm or that unambiguously motivates a policy response. Different researchers have used varying thresholds from 5 percent (Berki, 1986), 10 percent (Waters et al., 2004) and up to 40 percent when non-subsistence spending is used as a denominator (Xu et al., 2003; Wagstaff and van Doorslaer, 2003). In order to test the sensibility of our estimations we discuss here the results for different thresholds.

### **Out-of-pocket spending in Albania**

Previous work on Albania and other Western Balkan countries has shown that out-of-pocket payments remain high for most of these countries (Bredenkamp et al., 2010). Such spending has been reported to amount to more than 6 % of the per capita expenditures in Albania. However, the aggregate figures can only tell about the overall impact of these out-



of-pocket expenditures. The separate effects of private and public expenditures or formal and informal payments over the last years are less known.

Table 1 gives the average per capita expenditures on health and non-health items (indexed with 2002 prices). As it can be observed the gross per capita expenditures for households who have paid out-of-pocket payments have increased in real value during the years from 11092 Albanian Leks (ALL)<sup>1</sup> in 2002 to 11923 in 2008. This is consistent with the decrease in the headcount poverty indexed throughout the same years (INSTAT, 2009). On the other hand, this increase has been mostly dedicated to both out-of-pocket expenditures and other non-health expenditures. Spending on all out-of-pocket items was on average 808.30 ALL in 2002 and increased to 1125.65 in 2008. The same trend is almost true for all the items of spending (formal payments, informal payment, transport or expenditures on private health care providers and drugs purchased on own initiative). Formal payments and payments in the health sector are two categories with the largest increase over the years. Formal payments per capita have increased with almost 500ALL from 2002 to 2008 (from 767ALL to 1269ALL) while expenditures on private sector have increased with 175ALL over the same period (from 298ALL to 473ALL). The value of informal payments per capita has also increased substantially over the years from 220ALL in 2002 to 384ALL in 2008. The constant increase of such payments throughout the whole period demonstrates once more their prevailing incidence in the health sector (despite any measures taken).

**Table 1.** Average per capita expenditures on health and non-health items (in Albanian Leks)

Non-health expenditure quintiles	Per capita gross expenditure (health payment inc)	Per capita health expenditures on formal payments	Per capita informal payments in public health care	Per capita health expenditures on transport	Per capita total expenditures in private health sector	Overall per capita health expenditures	Per capita net expenditure (health payments exc)
<b>YEAR 2002</b>							
Lowest quintile	4296.69***	475.14***	121.17***	101.82***	144.49***	493.94***	3802.75***
2	6230.03***	659.04	165.96	188.14	183.04***	653.82**	5576.20***
3	7915.78***	591.48***	177.93*	128.94**	265.7	698.51*	7217.28***
4	10317.47***	777.19	229.42	248.82	236.42*	780.42	9537.05***
Highest quintile	18077.70***	1041.31***	318.72***	286.27*	471.78***	1071.82***	17005.89***
<b>Total</b>	<b>11092.29</b>	<b>767.10</b>	<b>220.98</b>	<b>193.93</b>	<b>298.44</b>	<b>808.30</b>	<b>10284.00</b>
<b>YEAR 2005</b>							
Lowest quintile	4394.93***	496.82***	152.64***	104.60**	157.97***	519.44***	3875.50***
2	6446.95***	639.36	278.78	128.55	179.59***	617.97	5828.98***
3	8698.88***	749.24	267.69	127.79	271.39	763.44	7935.44***

<sup>1</sup> All prices are deflated to 2002 prices. 100 ALL = 0.73 Euros in June 2002 (Bank of Albania, 2010)

4	11147.78**	753.25	252.24	141.84	264.33	708.37	10439.42**
Highest quintile	19054.34***	1041.77***	348.80**	202.30*	381.92***	902.40***	18151.94***
<b>Total</b>	<b>10801.00</b>	<b>748.55</b>	<b>256.89</b>	<b>136.39</b>	<b>267.80</b>	<b>723.05</b>	<b>10077.95</b>
<b>YEAR 2008</b>							
Lowest quintile	5438.88***	865.67*	777.96	182.29	203.18***	849.31	4589.57***
2	7655.03***	1039.79	208.58	150.78*	327.82	866.62	6788.40***
3	9520.95***	972.28*	230.17	186.8	307.83*	769.02**	8751.93***
4	12837.11**	1494.32	426.61	288.23	727.13	1463.46	11373.65**
Highest quintile	21422.69***	1797.93*	336.94	236.36	658.98*	1520.30*	19902.39***
<b>Total</b>	<b>11923.66</b>	<b>1269.22</b>	<b>384.54</b>	<b>208.19</b>	<b>473.96</b>	<b>1125.65</b>	<b>10798.01</b>

Note: Stars indicate if the mean for the particular group is significantly different from the mean of all other groups (\*\*\*) p<0.01, \*\* p<0.05, \* p<0.1).

Expenditures are given as averages for each of the categories only for those households which have actually spent for that particular category.

Per capita health expenditures on formal payments include out-of-pocket expenditures on medical fees, laboratory works and drugs purchased in public outpatient and inpatient care (expenditures incurred in hospitals outside from Albania are omitted in the table).

Informal payments include gifts paid to medical staff for public outpatient and inpatient care.

Health expenditures in private sector include out-of-pocket expenditures on medical fees, laboratory works, drugs purchased and gifts to medical staff for private care.

The dynamic of categories of payments over the years is also interesting. Payments for most of the categories, i.e. formal payments, transport or payments in private, seem to have decreased in real value from 2002 to 2005 while they have increased substantially in 2008. The increase of formal payments may be due to a more aggressive policy in enforcing the referral system or increasing the fees paid for both outpatient and inpatient care. On the other side, the increased share of the private sector is more evident in 2008 causing also a substantial increase in the money spent in this sector.

While the increase in total out-of-pocket payments in 2008 seems warring, another warring trend is the distribution of informal payments between quintiles of per capita expenditure. As it can be observed, the amount that the lowest quintiles pay informally have increased almost five times over the years (from 121 in 2002 to 777ALL in 2008) while this is accompanied by a more moderated increase in the amount paid informally by the other higher quintiles. The formal payments for the same quintile have almost doubled for the same period, demonstrating that the effects of any increase in fees are mostly transmitted to the lowest quintiles.

Similarly to the previous table, Table 2 above shows the distribution of health and non-health expenditures across each of the quintiles. The table shows that generally the most poor, i.e. the lowest quintile, spend much more in non-direct costs, i.e. transportation or

informal payments, compared to the other items. Moreover, the table shows that such figures have increased substantially over the years for this lowest quintile. Hence, in 2008 almost 30 per cent of all the amount of informal payments and 21 per cent of all transportation costs belonged to the lowest quintile (while these shares were 7 and 9 per cent respectively in 2002).

**Table 2.** Financing budget shares on health and non-health items

Non-health expenditure quintiles	Per capita expenditure gross of health payments	Per capita health expenditures on formal payments	Per capita informal payments in health care	Per capita health expenditures on transport	Per capita private expenditures in private sector	Overall per capita health expenditures	Per capita expenditure net of payments
<b>YEAR 2002</b>							
Lowest quintile	0.04	0.08	0.07	0.09	0.07	0.07	0.04
2	0.08	0.16	0.12	0.19	0.10	0.14	0.07
3	0.11	0.15	0.17	0.17	0.18	0.16	0.11
4	0.20	0.22	0.24	0.26	0.19	0.22	0.20
Highest quintile	0.57	0.39	0.40	0.29	0.47	0.41	0.57
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00
<b>YEAR 2005</b>							
Lowest quintile	0.06	0.11	0.10	0.15	0.07	0.10	0.06
2	0.11	0.17	0.23	0.21	0.12	0.16	0.11
3	0.15	0.20	0.20	0.21	0.19	0.20	0.15
4	0.23	0.21	0.16	0.21	0.22	0.21	0.23
Highest quintile	0.45	0.31	0.32	0.22	0.40	0.33	0.46
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00
<b>YEAR 2008</b>							
Lowest quintile	0.08	0.13	0.30	0.21	0.08	0.13	0.08
2	0.12	0.13	0.12	0.14	0.12	0.13	0.12
3	0.16	0.18	0.13	0.16	0.15	0.17	0.16
4	0.22	0.25	0.24	0.25	0.34	0.28	0.22
Highest quintile	0.42	0.31	0.20	0.24	0.30	0.30	0.43
Total	100.00	100.00	100.00	100.00	100.00	100.00	100.00

Note: Per capita health expenditures on formal payments include out-of-pocket expenditures on medical fees, laboratory works and drugs purchased in public outpatient and inpatient care (expenditures incurred in hospitals outside from Albania are omitted in the table).

Informal payments include gifts paid to medical staff for public outpatient and inpatient care.

Health expenditures in private sector include out-of-pocket expenditures on medical fees, laboratory works, drugs purchased and gifts to medical staff for private care.

The same could be said for other health expenditures like the formal payments or private costs which have increased to 13 per cent respectively for this quintile. Unfortunately, this increase in the relative shares of out-of-pocket payments has not been accompanied by a similar increase in the relative per capita non-health expenditure (which has only increased from 4 to 8 per cent for the poorest quintile). This shows again that policy measures through 2002 and 2008 have had a negative impact on the poorest quintiles. In 2008 the poorest households have on (average) relatively less budget than the rich if compared to 2002, but they face higher out-of-pocket payments. The dramatic increase in non-direct health care costs demonstrates that these people now face more barriers to health care than before.

## Catastrophic payments in health care in Albania

When total expenditure is used as the denominator the most common threshold employed in the literature to measure catastrophic spending is 10 percent – the threshold at which prior research has found households can be forced to sacrifice basic necessities (Pradhan and Prescott, 2002; Rason, 2002; Wagstaff and van Doorslaer, 2003). Table 3 presents alternative measures out-of-pocket payments for health care for each quintile of household non-health expenditure, over the three waves of the ALSMS. The headcount (incidence) in this table is the share of individuals for whom the proportion of out-of-pocket payments for health (shown as a percentage of total spending), exceeds a number of set thresholds, ranging from 5 per cent to 25 per cent. In 2002 22.6 per cent of the population paid health care out-of-pocket costs that exceeded 10 per cent of their total per capita budget. Encouragingly, this incidence declined to 17.6 per cent in 2005, and further to 13.3 in 2008. The largest drop occurred between 2005 and 2008 and may be related to the general fall in poverty during that period (INSTAT, 2009). However, as observed previously, households in the lowest quintile seemed to have suffered the most from catastrophic payments (according to this threshold) throughout the period of analysis. The share of individuals in the lowest quintiles paying more than 10 per cent of their total expenditures for out-of pocket health care was about 29-30 per cent in 2002 and 2005 and only decreased to 20 per cent in 2008.

**Table 3.** Incidence and intensity of catastrophic health payments defined with respect to total expenditure

CATASTROPHIC PAYMENTS MEASURES	THRESHOLD BUDGET SHARE			
	Thresh. 5%	Thresh. 10%	Thresh. 15%	Thresh. 25%
<b>YEAR 2002</b>				
Headcount (H)				
Lowest non-health expenditure quintile	45.2	29.9	20.6	12.2
2	41.1	26.7	18.2	8.9
3	37.2	24.1	15.1	8.6
4	33.8	20.6	13.4	6.5
Highest non-health expenditure quintile	25.3	11.7	7.3	4.1
<i>Total</i>	36.5	22.6	14.9	8.1
Overshoot (O)	5.4	4.0	3.1	2.0
Mean positive overshoot (MPO)	45.2	29.9	20.6	12.2
<b>YEAR 2005</b>				
Headcount (H)				
Lowest non-health expenditure quintile	42.9	28.7	20.6	13.2

2	39.1	22.3	14.4	5.8
3	33.6	18.5	12.8	6.4
4	25.6	11.8	6.7	2.8
Highest non-health expenditure quintile	17.2	6.8	3.5	1.7
<i>Total</i>	<i>31.6</i>	<i>17.6</i>	<i>11.6</i>	<i>6.0</i>
Overshoot (O)	3.9	2.7	2.0	1.2
Mean positive overshoot (MPO)	12.4	15.6	17.4	19.9
<b>YEAR 2008</b>				
Headcount (H)				
Lowest non-health expenditure quintile	28.9	20.0	13.8	10.0
2	25.0	14.8	10.7	6.3
3	22.4	12.0	7.9	4.5
4	20.1	11.3	7.9	3.5
Highest non-health expenditure quintile	15.9	8.4	5.0	2.9
<i>Total</i>	<i>22.5</i>	<i>13.3</i>	<i>9.1</i>	<i>5.4</i>
Overshoot (O)	5.0	4.1	3.5	2.8
Mean positive overshoot (MPO)	22.1	30.8	38.9	52.2

The second part of Table 3 gives also information on the measures of catastrophic overshoot for each of the years. This measure represents the average extent by which health care expenditure (as a proportion of total non-health expenditure) exceeds the respective threshold. In other words it measures the intensity of catastrophic out-of-pocket payments. This is important as it complements the headcount measure of catastrophic payments (the incidence). The table shows that the intensity of catastrophic payments drops as the threshold is raised from 5 to 25 per cent of total non-health expenditure throughout all years. The mean positive overshoot on the other hand gives an idea of the average spending on out-of-pocket for all those exceeding the threshold. Hence, we observe that households spending more than 10 per cent of their expenditures on out-of-pocket spend on average 39.9 per cent in out-of-pocket in 2002, 25.6 per cent in 2005 and 40.8 per cent in 2008.<sup>2</sup> As these numbers show the average out-of-pocket amount paid as a share of total non-health expenditure has increased sharply over the period 2005 and 2008. This reinforces our previous finding regarding the dramatic increase in certain categories of health care expenditure like the formal payments and the expenditures on private health care.

## **The impoverishing impact of out-of-pocket expenditures in Albania**

<sup>2</sup> The average out-of-pocket payment as a ratio of total expenditures for households exceeding a certain threshold is given as the sum of the threshold and MPO (Z+MPO). For example in 2002 for the 10 % threshold the average amount spent from those exceeding the threshold is 10% + 29.9%=39.9%.

Most societies care if the households paying catastrophic out-of-pocket payments belong to the poorest quintiles rather than the richest ones. The concentration index  $C_E$  displayed in Table 4 can estimate such effect. A positive value of such concentration index shows that the better-off households have a greater tendency to fall into catastrophic payments and a negative value shows a greater tendency among the poorest. As we can see from the table in fact at every threshold we choose over the years, the poorest have a greater tendency to fall into catastrophic payments.

**Table 4.** Distribution-sensitive catastrophic payments measures – concentration index

CONCENTRATION INDEX, $C_E$	THRESHOLD BUDGET SHARE			
	Thresh. 5%	Thresh . 10%	Thresh . 15%	Thresh . 25%
Year 2002	-0.114	-0.161	-0.182	-0.201
Year 2005	-0.168	-0.257	-0.299	-0.364
Year 2008	-0.121	-0.178	-0.207	-0.278

Table 5 shows that out-of-pocket health expenditures have increased the percentage of the poor Albanian households. The poverty headcount has decreased from 2002 to 2008, but the post-payment poverty headcount are much higher if considering out-of-pocket expenditures for health care. Poverty increases by 6.49 percentage points in 2002, by 4.34 in 2005 and by 3.61 in 2008. The poverty gap after payments has consistently been higher than the pre-payment one during all analysed years. The percent point impact for the poverty gap has increased from 189.24 in 2002 to 185.93 in 2008 showing the significant increase in inequalities due to out-of-pocket payments.

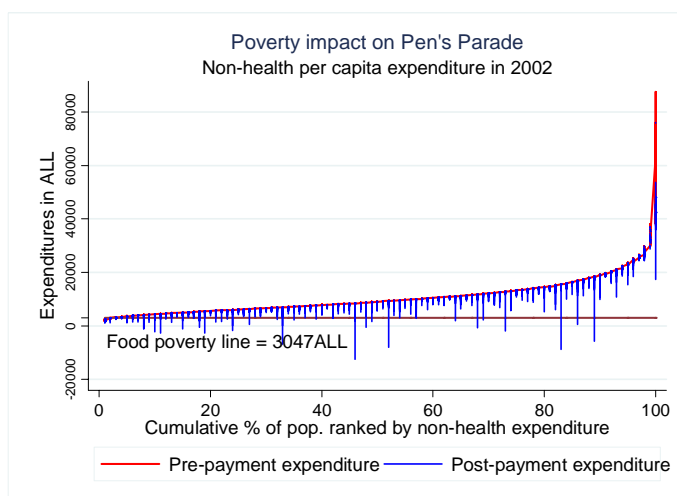
**Table 5.** Measures of poverty based on per capita expenditure gross and net of spending for health care.

	POVERTY HEADCOUNT	POVERTY GAP	NORMALISED POVERTY GAP	NORMALISED MEAN POSITIVE POVERTY GAP
<b>YEAR 2002</b>				
Pre-payment headcount	26.58	300.25	6.14	23.10
Post-payment headcount	33.07	489.49	10.01	30.26
Poverty impact- percentage point change	6.49	189.24	3.87	7.17
Percentage change	24.42	63.03	63.03	31.03
<b>YEAR 2005</b>				
Pre-payment headcount	19.45	215.71	4.41	22.68
Post-payment headcount	23.79	336.57	6.88	28.92
Poverty impact- percentage point change	4.34	120.86	2.47	6.25
Percentage change	22.33	56.03	56.03	27.54
<b>YEAR 2008</b>				
Pre-payment headcount	12.19	110.18	2.25	18.47
Post-payment headcount	15.80	296.11	6.05	38.31
Poverty impact- percentage	3.61	185.93	3.80	19.84

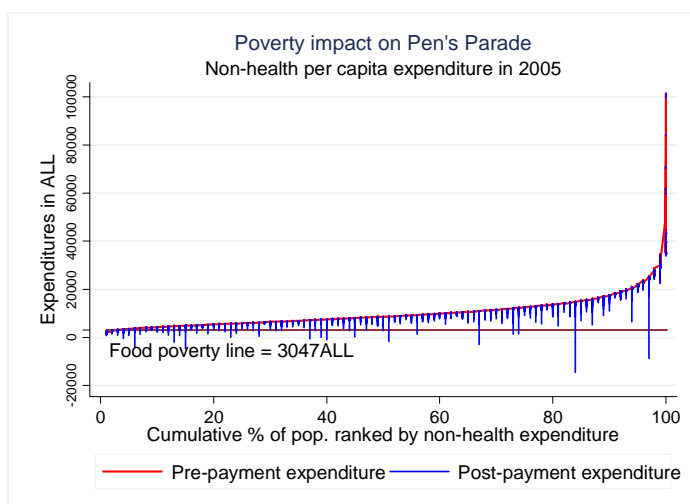
point change				
Percentage change	29.60	168.75	168.75	107.38

The catastrophic impact that out-of-pocket expenditures have on households can be seen visually in Figure 1. The graphs are based on Jan Pen’s parade of “dwarfs and a few giants” (see also Cowell, 1995; O’Donnell et al., 2008) and give the impact of health care expenditures by plotting household expenditures gross and net of total out-of-pocket payments. The x-axis represents the cumulative proportion of households ranked by their total expenditures and y-axis gives the level of total expenditures and out-of-pocket payments in Albanian Leks. The two moments are represented by the pre and post expenditure per capita and are compared against the food poverty line (the horizontal line) that amounts to 3047ALL per capita. The drops in the expenditure levels are given by the vertical bars (which represent the exact amount of health care expenditures per capita). All graphs show that there are many households whose expenditures fall below the extreme poverty line if we assume that they forego other consumption for health care. Such effects are not only observed for the lowest quintiles but also for all the others. Out-of-pocket health expenditures tend to be higher for the higher quintiles (see Table 1) and when they are not insured they may drive also such quintiles in poverty. Graph (c) in Figure 1 shows that for 2008 catastrophic health care expenditures tend to be more severe for certain households. This is due to the increase in private health care expenditures and also the rise of formal payments. Such increases can be problematic even for the highest quintiles and show that can be problematic in the long-run if no forms of insurance are taken against them.

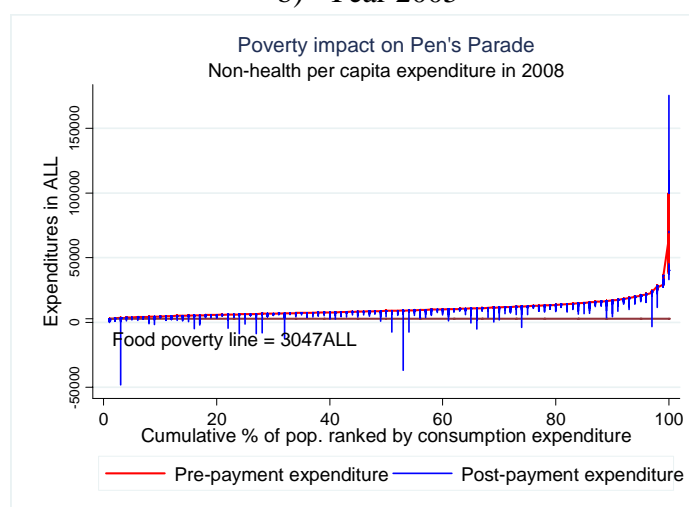
**Figure 1.** Poverty impact of health expenditure on the distribution of non-health expenditure



a) Year 2002



b) Year 2005



c) Year 2008

## Discussion and conclusions

The weak role of national health insurance in Albania, especially for inpatient care exposes households to the financial risks associated with accidents and sickness. A large share of the health services have to be paid for out-of-pocket, sometimes up front at the point of service. Such payments include formal and informal payments to medical staff. Health insurance in Albania should cover most of the formal costs of primary health care and all the costs of hospital care. Patients are formally required to pay small, fixed co-payments per visit in PHC or for specialised treatments in hospital care. However, evidence from ALSMSs show that until 2008 the amounts reported as formal out-of-pocket payments remained high.



This leads to believe that a large share of such payments is very likely to be defined as informal payments if a broader definition is employed.<sup>3</sup>

The analysis of the trends of out-of-pocket payments over the different years in Albania has shown that they have increased in real value from 2002 to 2008. The increase has not been the same for all the categories and expenditure quintiles. Formal/informal payments and expenditure in the private sector have increased significantly from 2002 to 2008 while expenditure on transport has remained more or less stable. The data show that the poorest households remain the most financially vulnerable to the cost of health care. Generally the poorest people (in households in the lowest expenditure quintile) spend much more in non-direct health costs, i.e. transportation or informal payments, when compared with other items. This category of spending has also increased substantially over the years for households in the lowest quintile. The catastrophic headcounts for all thresholds show that out-of-pocket spending may lead to catastrophic health care expenditures in Albania. Considering a 10 percent threshold of total per capita expenditures these numbers are 22.6 per cent in 2002, 17.6 in 2005 and 13.3 in 2008. But even though catastrophic payments have declined substantially over the years, the decline for the poorest quintiles has not been in the same range remaining to 20.0 per cent in 2008.

Moreover, out-of-pocket health expenditures can contribute to poverty among Albanian households. Both poverty rates and poverty gaps after the occurrence of out-of-pocket expenditure for health become higher. This demonstrates for an increase risk of falling in poverty or extreme poverty among health care seekers. Such issues may also be more serious as we expect an underestimation of the figures presented here for the lower end of the income distribution. Generally these people face higher obstacles and financial constraints when seeking health care and therefore are more likely to not seek it at all.

Overall, the results show that Albanian authority should consider more seriously the reduction of out-of-pocket payments through ensuring the effectiveness of prepaying mechanisms for health care. The impoverishing effects of such payments call for more attention from the policy makers. One of the possible interventions recommended would be revising the structure of user fees so that it reflects the income distribution (as the poor seem

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<sup>3</sup> Payments for health care or medicals that otherwise should have been provided free are also consider informal payments.

more likely to suffer the effects). This would include reinforcing fee exemptions for vulnerable groups (e.g. unemployed, recipients of social assistance, pregnant women, the disabled, people suffering severe illnesses, etc). Another potential policy measures are also price subsidies which have proven effective in reducing catastrophic payments in other countries (Pradhan and Prescott, 2002). Given that particular items like informal payments or transportation costs have a significant contribution in overall out-of-pocket expenditures, the government should also have clear policies in addressing them. While informal payments are more difficult to address (as they require integrated measures dealing with governance, accountability and availability of resources), transportation costs may be cut down more easily through measures like subsidised transportation for the poor or simply a better distribution of health care centres.

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## Appendix

**Table A1.** Incidence and intensity of catastrophic health payments defined with respect to total non-food expenditure

CATASTROPHIC PAYMENTS MEASURES	THRESHOLD BUDGET SHARE				
	Thresh. 5%	Thresh. 10%	Thresh. 15%	Thresh. 25%	Thresh. 40%
<b>YEAR 2002</b>					
Headcount (H)					
Lowest non-health expenditure quintile	45.2	29.9	20.6	12.2	5.5
2	41.1	26.7	18.2	8.9	4.4
3	37.2	24.1	15.1	8.6	3.4
4	33.8	20.6	13.4	6.5	3.8
Highest non-health expenditure quintile	25.3	11.7	7.3	4.1	1.4
<i>Total</i>	36.5	22.6	14.9	8.1	3.7
Overshoot (O)	5.4	4.0	3.1	2.0	1.2
Mean positive overshoot (MPO)	14.9	17.6	20.6	24.7	31.4
<b>YEAR 2005</b>					
Headcount (H)					
Lowest non-health expenditure quintile	60.8	49.1	43.9	31.6	22.1
2	54.7	43.7	36.1	28.3	15.8
3	48.5	38.7	31.3	20.9	12.1
4	44.6	30.4	22.3	13.6	6.0
Highest non-health expenditure quintile	33.0	21.6	14.7	8.0	4.5
<i>Total</i>	48.3	36.7	29.6	20.5	12.1
Overshoot (O)	17.2	15.1	13.4	11.0	8.6
Mean positive overshoot (MPO)	35.6	41.1	45.3	53.5	70.7
<b>YEAR 2008</b>					
Headcount (H)					
Lowest non-health expenditure quintile	42.9	33.0	29.3	21.3	16.8
2	41.1	31.5	24.7	17.6	13.0
3	34.0	27.4	22.2	15.2	8.9
4	35.4	25.8	19.7	13.2	7.1
Highest non-health expenditure quintile	26.1	19.3	14.4	8.8	5.2
<i>Total</i>	35.9	27.4	22.0	15.2	10.2
Overshoot (O)	17.0	15.5	14.3	12.5	10.6
Mean positive overshoot (MPO)	47.5	56.5	64.8	81.9	103.8

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