

How do Patient Characteristics Influence Informal Payments for Inpatient and Outpatient Healthcare in Albania

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Abstract

Informal payments for health care are common in most former communist countries. Causes of such payments are mostly related to the former 'Shemasko' systems and inefficiencies in provision of health care. This paper explores the demand side aspects of informal payments in a transition country like Albania. By using data from Living Standard Measurement Survey 2005 we control for individual characteristics determinants of informal payments in inpatient and outpatient health care. Using multivariate methods (OLS and probit) we test three main hypotheses explaining informal payments in the country; cultural, economic and governance.

We find clear evidence suggesting that there are differences between determinants of informal payments in inpatient and outpatient care. Generally our results show that informal payments are dependent on certain characteristics of patients, including age, education and health status. However, they are not dependent on level of incomes, suggesting for homogeneity of payments across income categories. Results support governance and economic hypotheses compared to the cultural one.

I. Introduction

Informal payments to health service providers are a widespread phenomena not only in the former communist countries (Central and Eastern Europe and former Soviet Union) but also in other middle income and developing countries (Lewis, 2000; Mæstad and Mwisongo, 2007; Liaropoulos and Tragakes, 1998; Killingsworth et al., 1999; McPake et al., 1999; Gaal et al., 2006). These unregulated out-of-pocket payments are often labelled as ‘under the table payments’, ‘envelope payments’, ‘under-the-counter payments’, ‘gifts’, and even ‘black money’. They are usually defined as payments made to health care providers for services which are supposed to be provided at no charge to the patient (Lewis 2000).

Informal payments in health care can be conceptualised as strategies to cope with lack of resources and poor performance at both the demand and supply side (Lewis 2000; Viana et. al 2005). Patients pay informally to jump the queue, receive higher quality of services or more care (Lewis 2000, Viana et. al 2006, Liaropoulos 2008). For providers of medical care they are an instrument to cope with underfunding and low payments accept them.

This paper addresses informal payments in Albania by exploring the demand side of health care. We try to get more insight in the characteristics of health care seekers who have reported to have made informal payments. To this aim, we use the data from the Living Standards Measurement Survey (LSMS) of 2005. By controlling for the main characteristics of health care seekers we seek to identify who pays, for what, how much, and whether it was voluntary or expected. We investigate the informal payments in inpatient and outpatient services and also look at the interdependence between them. . We address three questions: (1) What are the main patients’ characteristics determining the probability and amount paid informally? (2) Are patients paying in outpatient also likely to pay for inpatient services? (3) Are there re other factors driving these payments?

II. The determinants of informal health care payments

Informal payments may take different forms, from cash payments to in-kind contributions and from gift giving to informal charging, (Gaal et. al, 2007). Their causes and origins have long been debated in all countries in which these phenomena are growing and affecting health care performance. Researchers have suggested many factors influencing informal payments linking them to: a) culture of gifts (Delcheva et al, 1997; (Balabanova and McKee, 2002; Vian et al, 2006); b) low income of staff (Ensor and Savelyeva, 1998; Ensor and Witter, 2001; Chawla et al, 1998; Lewis, 2002; Dubois and McKee, 2004; Vian et al, 2006); c) lack of resources and material supplies (Delcheva et al, 1997; Chawla et al, 1998; Ensor and Witter, 2001; Dubois and McKee, 2004); d) bargaining power of doctors (Miller et al, 2000; Thompson and Xavier, 2002); and e) lack of regulation and unresponsive government (Ensor and Witter, 2001; Lewis, 2002). Based on Gaal and McKee (2005) these factors can be grouped in three main models: (1) cultural model, (2) the economic model, and (3) the poor governance model.

The cultural model considers informal payments to be ta particular type of behaviour of care seekers to express their gratitude in the form of gifts. This model is found in many countries, in particular inMediterranean, CEU and Former Soviet Union countries. This ‘culture of gifts’ rooted in values and traditions (Balabanova and McKee, 2002) can be conceptualised as institutionalized behaviour of patients. Seen as voluntary behaviour, it is sometimes argued that it does not put any particular burden on patients. The value of gifts is only modest and depends on the wealth of patients. Payments are supposed to improve the motivation of health care staff, ensure a personal relation, and provide incentives for physicians to feel appreciated (Gaal et al., 2006).

If this model is valid, we would expect a high incidence of mostly voluntary payments. Furthermore, the amount of money paid is expected to be relatively low. At the same time, the amount of informal payments would positively correlate with the patient’s income.

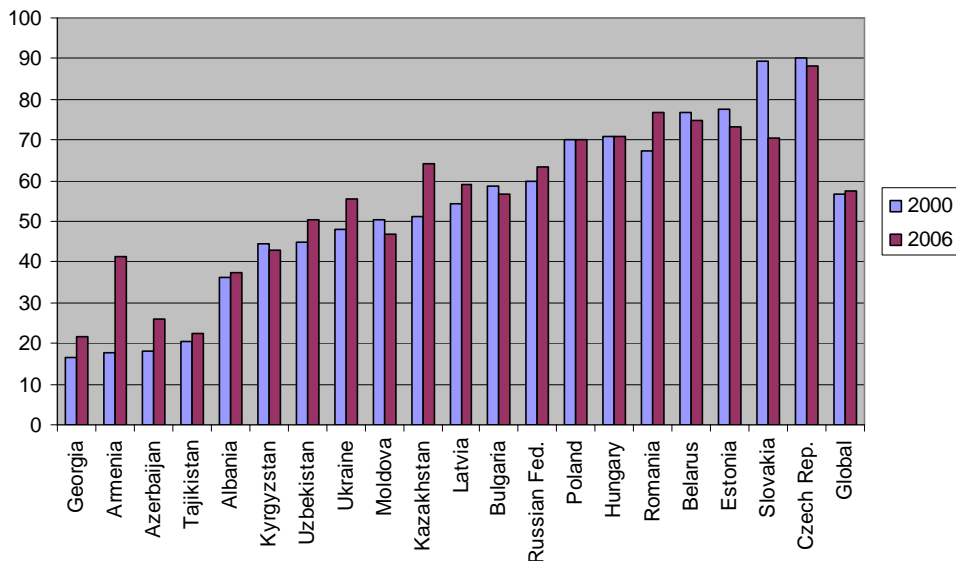
The economic model links informal payments to the scarcity of resources. After the Second World War the communism system established in CEE and FSU countries propagated free access to health care policy under the legacy of the 'Shemasko' health care system. Petchnig, (1983) argued that 'freeness' of access to health services with infinite demand leads to an artificial shortage. Kuti (1984) included the supply side of the problem and argued that under supply shortage "the socialist planned economy did not favour health care investments".

After the fall of communism regime, the governments of these countries faced three main challenges in their health care system. First, they were not financially capable to maintain an inefficient and universal health care system. In addition, they did not have enough incentives to further improve the system. With state revenues declining in many CEE and FSU countries in the early 1990s, health expenditures also fell but with little concomitant change in the number of staff or beds (Lewis 2002). The inevitable result was a large health system with underpaid and sometimes even unpaid staff. Graph 1 gives an overview of general government expenditure on health care as a percentage of total health expenditure in 2000 and 2006. We can observe that over the last years health care expenditures continued to represent a small share of total expenditures in health care. For countries like Georgia, Armenia, Azerbaijan, Tajikistan, Albania, Kyrgyzstan and Ukraine they represent less than 50 per cent of total expenditures on health care. Secondly, investments in health care favouring urban areas over rural areas created inequalities in health care provision. A rural-to-urban brain drain (Lerberghe et al., 2002) resulted in physicians' coping strategies, driving them from rural areas to the better conditions provided in urban areas. This created a physician shortage in rural areas and small towns (especially visible in inpatient health care). Finally, due to political sensibility, the privatisation of health sector progressed only very slowly. This further widened the gap between a rising demand and a non-responsive supply as the government share in health expenditures was declining (Ensor and Witter, 2001).

The non-responsive supply and the growing demand led to a situation where informal payments were considered as coping strategies of both patients and medical staff. Underpaid physicians (concentred mostly in urban areas) sought additional financial rewards, and patients asked for better or additional services which were not normally available. In turn, they promised to pay not only materially but also by means of in-kind payments or services exchanged. Ensor (2004) gives the example of a teacher who might tutor the children of a doctor in exchange for medical care.

If informal payments are driven by economic reasons we would expect unequal amounts paid for inpatient and outpatient health services. Payments would resemble more to a 'fee for service' model (as severity of illnesses cured in these two different services varies).

Graph 1. General government expenditure on health as % of total health expenditure



Source: WHO database

The poor governance model links informal payments to lack of control and accountability in the health sector (Gaal and McKee, 2005). The incapability to maintain the rule of law leads to non-ethical behaviour of the medical staff. Patients are not protected by public institutions and are consequently more exposed to the exploitation of doctors, despite their commitment not to exploit the vulnerability of their patients according to the model of medical professionalism (Wynia et al, 1999). Nevertheless, given the absence of regulatory or control mechanisms (Ensor and Witter, 2001; Lewis, 2002), they are tempted to use their bargaining power to increase their earnings (Miller et al, 2000; Thompson and Xavier, 2002).

If poor governance is to be the main reason for informal payments, we expect: (1) high incidence of explicitly requested payments for vulnerable groups (i.e. rural residents visiting hospitals in Tirana, non-insured, etc); (2) probability of paying informally to be dependent on level of education (lower educated and lower informed people have less negotiation power and are therefore easily exploited by medical staff).

In summary, these three models give a good basis for analyzing informal payments and their main causes. However, it should be noted that they are not meant to be exclusive. In countries where such payments are widespread, the policy options need also to account for the interdependence of these models.

III. Health care system in Albania and informal payments

Albania inherited a universal health care system from the former communist regime. This system had been designed to cover the entire country including every single village. It consisted of a net of hundreds of health posts and around 50 hospitals. After the fall of the communist regime the system faced immediate financial constraints (Nuri and Tragakes, 2002). Under current law inpatient services (including long-term treatment) are provided free of charge for the entire population, regardless of whether patients are being insured or not. Outpatient services involve patient co-payments, which are set at a low level and are publicized in principle.

The financing of the public health sector in Albania has remained highly centralized. The financial resources mainly come from general taxes and to a much lesser extent from health insurance contributions (the contribution rate for insured employers is only 3.4 per cent of gross wage). The Health Insurance Institute (HII), established after the fall of the communist regime, is supposed to cover primary health care visits, reimburse approved drugs and

cover the costs of secondary and tertiary care. In 2005 HII did not have a contract agreement with the provider organisations of secondary and tertiary care. The funding of these organisations came directly from the Ministry of Health budget.

Albania's limited public spending on health care sector (as compared to other Balkan or Eastern European countries) has resulted in an increased reliance on out-of-pocket payments for both inpatient and outpatient care (Nuri and Tragakes, 2002). In 2005 about 97 per cent of private health expenditures were out-of-pocket expenditures, while they account for 59.7 percent of total health expenditures in the country (WHO database). This is a high percentage relative to other countries in the region.

In Albania, informal payments are very common in inpatient and outpatient services. Health reports from the country show that 67 per cent of interviewed Albanians were likely to pay informally to medical staffs in hospitals when receiving health care services (Vian and Burak 2006). These payments are estimated to account for about 25 per cent of total out-of-pocket payments (Vian et al., 2006). Evidence from previous research suggests that informal payments are also widespread in outpatient care (Thompson and Xavier 2002), though the amounts paid be relatively lower than for inpatient services. Studies show that outpatient payments account for about 7 per cent of total out-of-pocket expenditures (Hotchkiss et al., 2005).

The supply of health care is clearly deficient, forming a perfect ground for cultivating informal payments. Low health staff salaries and lack of private services are believed to be the main causes of such payments. Various studies (Viana et al, 2005) suggest that patients give informal payments, because they feel that the state does not reward health professionals well enough for their work (Viana et al got the same answer from interviewed health care providers).

The amount paid as informal payment also differs if we look at type of care. Informal payments are very dominant for inpatient care (see also World Bank, 2006). Varying on their position and medical profile, the official wages of hospital doctors may increase by a factor 3. Informal payments for outpatient doctors may amount to almost 50 per cent of their wages¹. The amount of informal payments for the auxiliary staff is pretty low (compared to their official wage level) both in inpatient and outpatient health care. This suggests an unequal distribution of these payments among health care staff.

If we consider the amount paid from every patient individually, it results that these payments have a big impact on the patient's welfare. The situation is particularly dramatic for people in the lowest quintile of income distribution, as they pay relatively four times more than people in the highest quintile (World Bank, 2006).

IV. Data

Our data were taken from Albania LSMS 2005. The survey contains data on 17302 individuals. They are collected both for individuals and households and concern demographic, social and economical characteristics. The data set includes detailed information on households' income and expenditures for housing, food consumption, education, and so on.

A set of questions of our interest refers to whether the individual has been seeking health care in the past period (4 weeks for the outpatient care, and 12 months for the inpatient care). Information on informal payments is collected on the total amount of gifts paid to medical staff. The persons interviewed are also asked whether they consider these payments as voluntary or requested. Out of the total sample, 1548 individuals reported to have re-

¹ These differences may be also due to the fact that outpatient patient pay less to these doctors and that their salaries are higher on average (since they have a contract with health insurance).

ceived outpatient and 671 inpatient services; 305 of them reported to have paid informally for outpatient services and 354 for inpatient services.

In fact, data collected by the LSMS include all informal payments under “gifts paid to medical staff”. Table A1 (appendix 1) gives a complete overview of the variables used in our models. In our analysis we will try to distinguish between gratuities and informal payments by controlling for their main drivers and estimating a separate model controlling for the voluntary aspects of them.

V. Models and Results

In order to investigate the determinants of informal payments in inpatient and outpatient care we estimate a couple of models that characterize the probability of payments (probit model) and the amount paid (OLS model). In addition, we run a probit model to test for motivations behind informal payments. For this, we use a binary variable reflecting whether these informal payments were explicitly requested or voluntary given. Our models are estimated separately for inpatient and outpatient health care (see also Table 2). For inpatient care we model informal payments for all visits in public hospitals over the past 12 months (average amount per day spent), while for outpatient informal payments for all visits (average amount per visit) in public ambulatories during the past 4 weeks².

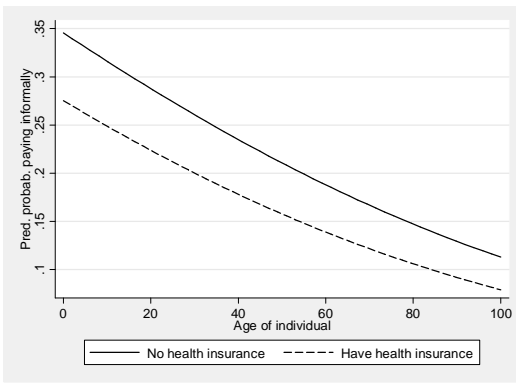
The results show that the determinants of informal payments for inpatient and outpatient services are different. The age of individuals for outpatient care is significant and negatively correlates with the occurrence of informal gifts in this service. Elderly patient are somehow ‘aware’ of their rights emanating from their health insurance status (they are entitled to full reimbursement of the costs of health visits and drugs prescribed). As a result, they seem less likely to pay doctors in an outpatient care setting for getting their monthly check or getting entitled prescriptions of reimbursed drugs. Results show that whenever they pay informally, they also pay lower amounts (especially for outpatient services). This may be due to the low income level of patients in this category.

Patients with health insurance are less likely to pay informally for inpatient and outpatients services. This may be due to their greater bargaining power in interacting with the medical staff. They know the rules of the game in hospitals and are better informed on what is covered. Figures 1.1 and 1.2 show the probability of paying informally for all age groups with or without health insurance. Younger subscribers are more likely to pay, while health insurance reduces the probability of out-of-pocket payments across all ages. However, we believe that the particular form of service contracting and financing in outpatient services “shapes” the curves differently.³ Older patients are less likely to pay informally for outpatient than for inpatient services. Having health insurance reduces this probability virtually to zero for outpatient services, while for inpatient services the probability remains still high. This suggests that health insurance protect the vulnerable groups much better for one type of service than for the other type of service.

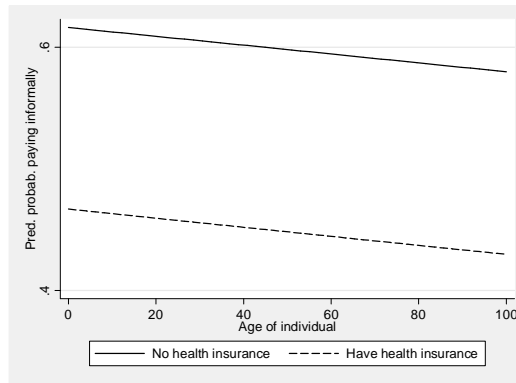
Figure 1. Predicted probability of paying informally by age group with and without health insurance

² Due to the low prevalence of informal payments in private doctors and dentist care we do not estimate models for these private services.

³ Outpatient services are contracted and financed directly from Health Insurance Institute, while inpatient services are financed by the state budget.



1.1 Outpatient services



1.2 Inpatient service

Families consisting of higher number of persons including children, grand parents and sometimes even other relatives are more likely to pay in inpatient care. These are mostly families with a higher number of children (family size is negatively correlated with age). At the same time these families pay lower amounts for inpatient care. This is because these families have lower income per capita. Furthermore, they mostly come from rural areas.

Patients with a lower health level (low health rate and chronic illness) are more likely to pay informally for inpatient care. At the same time they are paying lower amounts for inpatient and outpatient care. As they belong mostly to lower income categories (health is negatively correlated with income), they do not only pay informally for better service but sometimes even for access to services (Lewis 2000).

The numbers of visits for outpatient services or number of days in hospital have a significant influence on the amount paid. The amount paid negatively correlates with utilization. Moreover, estimates show that the higher the amount of ‘the gift’, the more likely it is to be ‘explicitly requested’.

People with higher education pay higher amounts for inpatient care. Based on Grossman’s theory of health care demand (Grossman, 1972), they are considered to be more efficient producers of health. When we test whether these payments are given voluntarily or requested, we see that patients with primary education are more frequently requested to pay informally. This suggests that educated people have more ‘bargaining power’ in interacting with doctors.

Testing for the location of the hospital, the results show that informal payments are higher in Tirana’s hospitals (capital of the country). This result is not very surprising. Hospitals in Tirana employ the elite of the medical staff and feature the most highly specialised treatments⁴. An additional explanation may be the absence of social relations between patient and physicians in a big city as Tirana.

People coming from rural areas are more likely to pay ‘requested’ gifts for outpatient and inpatient health care. Most of health centres in rural areas are non-functional or do not even offer the basic service. Consequently, most of the people living in these areas prefer the facilities in big urban areas. The effect is especially large and significant if both rural residence and location of hospital in Tirana is controlled for (interaction between “rural/urban” and “hospital in Tirana district”). This shows again that vulnerable groups are exploited in the absence of protection mechanisms and lack of social relations.

⁴ This has created large inequalities between regions in the access to quality services (World Bank, 2006).

Table 2. Regression results

	Propensity of Informal Payments				Amount of Informal Payments				Voluntary / Requested Informal Payments			
	Outpatient Service		Inpatient Service		Outpatient Service		Inpatient Service		Outpatient Service		Inpatient Service	
_cons	-0.124	(0.622)	-0.137	(0.832)	8.015***	(0.653)	6.929***	(1.134)	-0.231	(1.524)	-0.882	(1.327)
Household size	-0.013	(0.021)	0.067**	(0.028)	-0.017	(0.021)	-0.071**	(0.035)	-0.112***	(0.042)	-0.038	(0.039)
Age of the individual	-0.008***	(0.002)	-0.001	(0.003)	-0.007***	(0.002)	0.003	(0.004)	-0.001	(0.005)	-0.007	(0.004)
Gender	0.070	(0.078)	0.077	(0.104)	0.086	(0.083)	0.019	(0.144)	-0.349**	(0.160)	-0.155	(0.157)
Urban/Rural	-0.069	(0.083)	-0.021	(0.138)	0.071	(0.086)	0.017	(0.192)	0.344**	(0.164)	0.185	(0.209)
Ln income/capita	-0.022	(0.051)	0.048	(0.065)	0.064	(0.056)	0.110	(0.087)	-0.162	(0.108)	-0.056	(0.098)
Health insurance	-0.200**	(0.084)	-0.380***	(0.115)	-0.483***	(0.085)	-0.071	(0.164)	-0.125	(0.171)	-0.004	(0.182)
Health rate (1 'v. poor' – 5 'v. good')	-0.025	(0.049)	-0.117*	(0.067)	-0.087	(0.057)	0.292***	(0.094)	0.148	(0.110)	-0.132	(0.103)
Chronic illness	0.072	(0.114)	-0.261*	(0.148)	0.275**	(0.125)	0.388*	(0.217)	0.574**	(0.245)	0.177	(0.238)
Education primary	0.045	(0.098)	0.048	(0.132)	-0.060	(0.107)	-0.092	(0.184)	0.027	(0.202)	0.363*	(0.195)
Education university	-0.264	(0.203)	0.181	(0.262)	0.076	(0.253)	1.026***	(0.357)	0.313	(0.471)	0.110	(0.390)
Hospital in Tirana district	-0.037	(0.150)	-	-	0.253	(0.214)	-	-	-0.219	(0.225)	-	-
Rural/Urban * Hospital in Tirana district	0.022	(0.219)	-	-	0.231	(0.313)	-	-	0.615*	(0.357)	-	-
Nr of times visit outpatient health service/Days stayed in hospital	0.015	(0.022)	-0.001	(0.003)	-0.093***	(0.018)	-0.033***	(0.004)	-0.018	(0.037)	0.003	(0.005)
ln informal amount paid	-	-	-	-	-	-	-	-	0.265**	(0.113)	0.299***	(0.061)
Number of obs (N)	1548		671		305		354		305		354	
R-squared					0.2191		0.3088					
Pseudo R2	0.0257		0.036						0.0001		0.0001	

Note: .01 - ***; .05 - **; .1 - *. Standard errors are in parenthesis

To understand better informal gifts, we also investigated the correlations between outcomes of the first two models (probability and amount paid for inpatient and outpatient care). For this, we look at the correlation of residuals from each of the models. This should tell us more on the mutual nature of informal payments if we consider people who utilised both inpatient and outpatient care. In other words we may answer questions like: Are people who pay for one type of service more likely to pay in the other type as well? Do the amounts paid for inpatient and outpatient care correlate with each other?

Table 3. Correlation of residuals from the probability and amount models

	Probit of paying in Inpatient service	Amount paid in Inpatient service
Probit of paying in Outpatient services	0,5610*** (166)	n.a.
Amount paid in Outpatient service	n.a.	0,114 (33)

Note: .01 - ***; .05 - **; .1 - *. Numbers of observations are in parenthesis

The high and significant correlations in the left upper corner suggest that patients who pay for one type of service are also very likely to pay for the other type. This shows that certain characteristics of patients highly influence the probability of payment for these services. Based on the results of probit models, we can single out health insurance as the most evident variable (negative and significant for both models): people without insurance are more likely to be exploited in both services.

The uncorrelated error terms of the ‘amount models’ suggest that the amounts that people pay in inpatient is statistically different from the amount paid in inpatient. In fact, our data show that on average the amount paid for inpatient care is ten times higher than amount paid for outpatient care (see also Table A1). These differences suggest that the amount paid is based more on the specific treatment (considering the informal payment as a “fee for service” payment).

VI. Discussion

In this paper we have used information on informal payments from LSMS 2005 to check for the main determinants of probability of payment and the amount paid in both inpatient and outpatient health care services. We show that informal payments are dependent on certain characteristics of patients. Outpatient payments are more dependent on age, health insurance and chronic illness, whereas inpatient payments depend primarily on household size, health insurance, health rate, chronic illness, education, location of hospital in Tirana, and the number of days hospitalized.

By using the results for both services we aim to explain whether the causes of informal payments could be better explained using any of the three models: cultural, economic, and governance.

Considering that Albania is a Mediterranean country, initially we expected the cultural model to be a strong model for explaining informal payments. However, our data and results do not confirm this expectation. The higher incidence of payments for inpatient care (where the mean of amount paid is higher than in outpatient) and the high proportion of requested payments for both services (Table A1) are not in accordance with the cultural model. The weak role of income in exploring outpatient and inpatient payments suggests a dispersion of payments across income categories. From this perspective, the payment is seen more as a 'fee for service' rather than as a gratitude towards medical staff.

The economic model favours mostly a 'fee for service' description of informal payments, where payments fill up the gaps due to lack of resources. The unequal amounts paid for inpatient and outpatient care (Table A1), the low correlation of amounts paid in both services (Table 3) and higher amount paid in hospitals located in Tirana support the economic model. Better trained doctors (concentrated in such hospitals) seem to seek more financial rewards than their colleagues.

The higher probabilities of being requested an informal payment to the most vulnerable groups of patients (rural residents and chronically ill in outpatient and lower educated and rural residents treated in Tirana's hospitals) shows a lack of accountability in both services and can be used as evidence for the governance model. The high dependence of such payments on health insurance shows again that the most vulnerable are also more likely to be exploited. Lack of governmental support and lower negotiating power of these groups make them more vulnerable to informal payments.

Results show that governance and economic models dominate over cultural model. It is difficult to have a clear cut between governance and economic models. To some extent they can be seen as a consequence of each-other. From a purely economic perspective, informal payments for health care are a way to allocate scarce resources where the market prevails over rationing systems thought up by the government. Low level of investments and budget allocated to health care, inequalities between rural and urban areas, and unmotivated health care staff are main consequences of informal payments. They can be considered as governance failures in health care. On the other hand, lack of support for vulnerable groups and low levels of information enhance further negative effects for these particular groups.

Although our study sheds more light on important causes of informal payments it has some limitations because of our dataset. Our data does not allow us to distinguish between payments made to physicians or other staff, nor does it capture the payments made in kind or through favours rendered. Furthermore, we are not able to determine whether social connections (like knowing the doctor beforehand) influence informal payments.

We are mostly concentrated on the demand side of the problem. The data gives less information on the supply side. Information on the hierarchical position of the doctors or their particular professional background would allow to get more insights on who is requesting and who get what.

VII. Conclusion

In this paper we tested three models on the causes of informal payments. We particularly focused on the demand side of health care in order to investigate the main determinants of these payments. Based on our analysis we conclude that the empirical evidence for the cultural model is poor. The economic and governance model provide a better explanation for informal payments.

We can conclude that informal payments are generally widespread in Albania. Patients and physicians are using them as coping strategies to ease problems brought by lack of resources and poor governance. We show that the burden of these payments is mostly hold by the most vulnerable groups of society. From a demand perspective, the most effective policy measure would be to include inpatient care in the benefits package of health insurance scheme. Channelling resources through health insurance mechanisms and direct contracting of inpatient services by insurers may increase efficiency in health care provision. Extending health insurance to inpatient care must be combined with policy measures to protect the most vulnerable people (i.e. old aged and chronically ill). The experience with outpatient care looks encouraging in this regard. It goes without saying that an effective demand approach also requires an effective supply approach by increasing investments in Albania's health care system and taking measures to improve the quality and efficiency of health care provision.

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Appendix 1.

Table A1. Descriptive statistics (100 Lek = 0,84 Euro)

Variables	The amount paid informally				The incidence of paying informally			
	Outpatients services		Inpatients services		Outpatients services		Inpatients services	
Amount paid informally (in Lek) *	332,847	(327,033)	1298,988	(2499,494)				
Household size	4,649	(2,009)	5,248	(2,060)	4,505	(1,971)	5,028	(1,934)
Age of the individual	40,714	(25,701)	39,039	(23,210)	47,628	(24,565)	40,698	(22,817)
Gender (female=1)	0,622	(0,485)	0,598	(0,490)	0,596	(0,490)	0,576	(0,494)
Urban/Rural (rural=1)	0,452	(0,498)	0,590	(0,492)	0,423	(0,494)	0,557	(0,497)
Income/capita	8599,528	(6683,334)	7900,646	(6211,548)	9250,511	(7144,004)	8016,400	(6121,248)
Health Insurance (without health insurance=1)	0,570	(0,495)	0,403	(0,491)	0,657	(0,474)	0,485	(0,500)
Health rate (1 'v. poor' – 5 'v. good')	3,052	(1,005)	3,189	(1,151)	2,933	(0,995)	3,150	(1,148)
Chronic illness (chronic illness=1)	0,570	(0,495)	0,420	(0,494)	0,655	(0,475)	0,472	(0,499)
Without education (without education=1)	0,022	(0,149)	0,002	(0,053)	0,012	(0,112)	0,004	(0,066)
Education 8-years (education 8-years=1)	0,524	(0,500)	0,587	(0,492)	0,511	(0,500)	0,581	(0,493)
Secondary education (secondary education=1)	0,177	(0,382)	0,186	(0,390)	0,212	(0,409)	0,204	(0,403)
University education (university education=1)	0,029	(0,169)	0,045	(0,208)	0,056	(0,231)	0,044	(0,206)
Hospitals in Tirana (visiting in Tirana hospital=1)	-	-	0,302	(0,459)	-	-	0,323	(0,468)
Hospital in the same district (visiting in the same hospital district=1)	-	-	0,598	(0,490)	-	-	0,527	(0,499)
Hospital in different district (visiting in the different hospital=1)	-	-	0,096	(0,295)	-	-	0,123	(0,329)
Hospital in foreign country (visiting in foreign country hospital=1)	-	-	0,002	(0,053)	-	-	0,025	(0,157)
Rural/Urban * Hospital in Tirana district (rural patient visit in Tirana hospital=1)	-	-	0,124	(0,330)	-	-	0,128	(0,334)
Days stayed in Hospital /Nr of times visit outpatients care	1,957	(2,220)	15,477	(17,743)	1,648	(1,710)	16,171	(20,153)
The incidence of paying informally (paying informally=1)	0,186	(0,389)	0,527	(0,499)	-	-	-	-
The incidence of voluntary/requested payments (requested payments=1)	0,550	(0,498)	0,686	(0,464)	-	-	-	-
Nr. Of Observations	305		354		1548		671	

Note: *) In inpatient care the amount paid informally is the average per day in hospital.

In outpatient care the amount paid informally is the average per visit.

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