LIVING CONDITION AND INEQUALITY IN ALBANIA

Population and Housing Census 2001

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The production of social research publications presents an important moment in the professional lifespan of INSTAT.

The Population and Housing Census of 2001, as well as the Living Standard Measurement Survey (LSMS) of 2002, were used as the main data sources of analysis during the last decade. The information collected in these two surveys pertained to such issues as internal and external migration, the state of the labour market, the impact that these issues have on the lives of women and men in Albania, their living conditions, and how the inequalities are distributed in the basic sectors of everyday life. This data was also used in the population projections for 2001-2002.

These research publications represent a significant instrument for policy makers and other stakeholders. The information collected can be used in mainstreaming poverty reduction, minimizing inequalities, guiding investment funds towards services and infrastructure, and helping local authorities in designing specific strategies in favour of vulnerable groups.

These publications will contribute to completing information concerning the Millennium Development Goals (MDG) in Albania, and bringing in new elements to enable the continuous monitoring of the indicators.

Without the direct collaboration of Albanian and international experts, these publications would not have been accomplished. These research papers demonstrate the existence of a network composed of local researchers ranging from public administration agencies to Universities, that cooperate together in order to analysing social phenomena in the country. INSTAT take this opportunity to extend its thanks to Swiss Agency for Development and Cooperation and to Italian Cooperation, who have made great efforts to support and coordinate the initiative to finalize these research publications.

Milva Ekonomi
General Director

TABLES AND FIGURES

c h a p t e r

1

Describing Poverty in Albania

1.1 Defining Poverty – Definitions and Methodology

Poverty is a complex phenomenon involving multiple dimensions, of which the lack of goods and services is only one indicator or deprivation. Poverty is hunger; poverty is not having shelter, being sick and not being able to see the doctor; poverty is being unemployed and being uncertain about the future, poverty is being illiterate; having no access to sanitation and lacking many of the provisions and services in everyday life. It is difficult to give a final definition of the poverty, as it changes in time and from one place to the other.

This paper is based on data from the Living Standard and Measurement Survey conducted in Albania in 2002 and the Albanian Population Census of 2001. These surveys collected data on all aspects of poverty, from income and consumption to employment and transfers, from education and health status of the population to provisions for these services, from sheltering and quality of housing to the existence of basic utilities within households. LSMS is a powerful data collection tool with a multidimensional content. As such, we also follow a multidimensional approach to analyzing the concept of poverty and inequality. This report examines the inequalities in the standard of living of Albanians, not just its economic aspect, but also in the provision of services such as health and education, the provision of shelter as well as how all these factors affect the level of poverty and health status of the population.

The concept of 'who is poor' in Albania was developed based on the work carried out by the World Bank in the report 'Albania: Poverty during Growth' (2003) and the work of INSTAT in the LSMS 2002 survey. Different "poverty lines", defining who is poor in Albania are suggested in this work. Applied in the context of this report, the general poverty line calculated is based on per capita level of consumption. An individual is poor if his/her per capita level of consumption in the household is below this poverty line. Apart from this measurement of poverty and inequality, we have also created another measurement of inequality that is applied in this analysis i.e. A variable is calculated that compares the top 20 and bottom 20 percent of the population based on the total consumption aggregate.

1.2 Data Description - LSMS and Census

The work conducted in this report is based on two primary datasets; the Living Standard and Measurement Survey 2002 and the Population and Household Census 2001. Both data sets have been made available from the Institute of Statistics in Albania.

LSMS 2002 is a multidimensional survey conducted by World Bank in collaboration with INSTAT and DFID in 2002. It is a panel survey and this report makes use of the data from the first wave of a series of data collected. The primary aim of the survey is to capture a 'snapshot' of poverty and inequalities in the country. The idea of conducting a panel survey is to also monitor the changes in the poverty level and patterns in Albania. LSMS is conducted at the household level, and collects data on both household and individual levels. The information collected includes income, consumption, health status and utilization of health services, education level and utilization, demographic characteristics of the population, such as fertility, reproductive health and migration, employment and activity, and many other aspects of daily life.

A total of 3600 households and 16,521 individuals have been surveyed. The survey is a stratified with four main areas covering the northeast, central, southwest districts of the country and Tirana. The regions reflect the different levels of development in the country, the agro-ecological environment (World Bank and INSTAT, 2003), the urban-rural differences and the health and mortality gradient of the population (Gjonça A. and Bobak, B. 1997)

The second source of information is the population and household census of Albania conducted by INSTAT in 2001. The data from the census will be used to analyze the housing and dwelling conditions as well as education issues in the country.

1.3 Background of Poverty and Inequality in Albania: Prior to and Past 1990

Prior to the collapse of Communist regime, Albania was well known not only for its rigid government policy and isolationist approach from the outside world, but also for its pretence of an egalitarian society where equality was a main principle of government's policy. When the Communists came to power, the situation of poverty and socio-economic circumstances of the population were in a depressed state. Hunger was widespread, infectious diseases had killed approximately 140 infants, per thousands births, tuberculoses and malaria gripped the country, and a large proportion of the population was living in either uninhabited housing or did not have any at all. Thus, the challenges faced by the newly Communist government were both in solving the immediate situation and improving the long-term socio-economic situation of the population. This section looks at the achievements and setbacks of the Communist government in improving this situation and reducing the inequalities within the country.

Since 1990, Albania has undergone significant political and social change. Many important reforms have been implemented such as price and trade liberalization, privatization of state owned enterprises and privatization of strategic sectors, private sector development, and other reforms in different sectors such as education, health, social services etc. Apart from some progress achieved in the social agenda during transition, there is clear evidence that shows the existence of significant disparities in the living standards of different areas, especially in the rural areas. The unem-

ployment rate, in particular after the crisis situation increased dramatically such as in the year 1993 when it reached 29.0%. In 2001, 77.3% of the labor force was employed and 50.5% of the employed population was still working in the agriculture sector (INSTAT, 2003). The unemployment rate of 22.7% is one of the highest levels compared to other countries in the region and the situation is even worse in some districts (HDPC, 2002) where the unemployment rate reaches more than 40%. There is a high degree of poverty present in the country that is also accompanied by significant regional disparities. There are also other basic services that show large disparities in the living conditions of the populations in different regions of the country.

The disaggregated results of the Human Development Index (HDI) in Albania show substantial differences in the level of human development between the various regions of the country and between various districts within the same region (HDPC, 2002). The political instability and the insecurity among Albanians in the country have not improved reform of the social policy agenda. Most of the changes in the 1990s have been affected by this situation. While it is difficult from the existing data to test a causal relationship between the situation of political instability and insecurity that is present in the country, the results relating to social change and in particular the social inequality substantially reflect this situation.

1.31 Income Level and Inequality: Urban-Rural and Economic Sectors

Prior to the1960s, Albanian pay scales were similar to those in the rest of Communist Eastern Europe. The income differentials up to 4:1 were thought to have occurred (Schnytzer, A. 1982, p. 113). After the break with Soviet Union, attempts were made for equalization by reducing top salaries. The aim was the narrowing of the differences in the way of living between the urban and rural areas as well as between different social classes.

In April 1976, new legislation was passed making improvements to the pay system of working people and the further narrowing of the differences between town and country. This law stated, that "the reduction of high salaries and also made certain improvements in the system of wages and remuneration of the working people". It also, promoted "the reduction of main differences between urban and rural areas" (P.H. "8 Nentori", 1982, p. 328).

The reform of income equalization then progressed further, particularly in regard to the differences between rural and urban areas and northern and southern areas. As a result, the ratio between the average pay of the employees and the director of an enterprise was 1:1.7; the ratio of the average pay of the workers in general and the salary of a director of a ministry was 1:2, and the ratio between the lowest and the highest wages of the workers in a given sector, was about 1.5:1.65 (Bollano, P. 1984, p. 21).

Figure 1.31-1 and Table 1.31-1 (Gjonça, A. 2001), show that the total real income per capita increased during 1970-1975 by 14.5%, while for rural workers, it increased by 20.5% compared to only 8.7% for urban workers. This policy was clearly aimed at narrowing the income disparity between rural and urban ar-

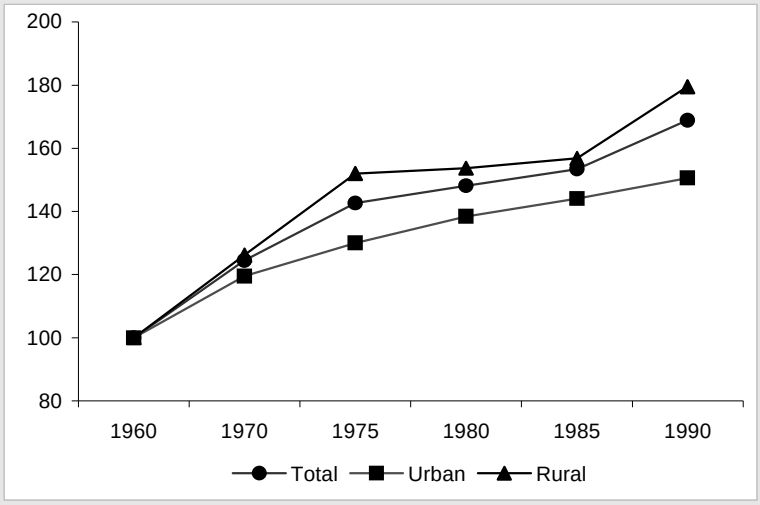
Table 1.31-1 Real Income per capita (*in Leks)*

Year	Total	in% (1960=100)	Urban	in% (1960=100)	Rural	in% (1960=100)
1960	2155	100	2840	100	1738	100
1970	2684	124.5	3395	119.5	2193	126.2
1975	3074	142.6	3691	130	2642	152
1980	3191	148.1	3932	138.4	2672	153.7
1985	3305	153.4	4090	144	2736	156.8
1990	3640	168.9	4277	150.6	3120	179.5

Note: 1960 is taken as the base year (100)

Source: Statistical Yearbook of Albania 1991, p. 131.

Figure 1.31-1 Change in percentage of real income per capita



eas, as well as between professions. Application of all these measures made Albania the country with the most equal income distribution. This, coupled with a number of other measures, had an impact on the health status of the population, especially in rural areas. The increase in living standards in the rural areas was very important for a country with 75% of the population living in rural settings, and additionally was emerging from a history of semi-feudalism. Despite the success of better equalizing the income differences between the rural-urban areas as well as those lowland-upland, the gap never actually disappeared.

1.32 Health Inequalities: Utilisation of health services; Health status of the population

The Albanian Communist Government made health a priority of its social agenda. From 1950-1990, the improvement of the health status of its population, "Health of the population (of the labor force) – is centre of the government policies" (P.H. 8 Nentori, 1982). When the Communists came to power in Albania in 1945, the state of population's health and the Albanian health system was in a poor state. Prior to 1940, the health system consisted only of 10 state hospitals and an Institute of Hygiene founded in Tirana in 1938. The number of doctors was very low - only 102 Albanian doctors and a very small number of foreign doctors. Thus, the number of physicians (doctors and dentists) per 10,000 of the population was only 1.17, while the number of beds for 1,000 of population was only 0.98 (Table 1.32-1). Outpatient clinics and medical offices were provided in all municipalities, while traveling medical officers visited villages examining schoolchildren. The share of health expenditure was only 1% of the state budget, which is today comparable with most developing countries.

If anything, the situation became worst during World War II. By 1947 aiming to improve the situation, the government introduced a wide-ranging social insurance and health scheme. Most medical treatments (thought not the medicines) were provided for free. Legislation was introduced to protect mothers and children, set up the pension scheme, other regulations on sanitary conditions and control, as well as for the treatment of infectious diseases. The most significant improvements were made during 1960-1970, through a rapid build-up of infrastructure and training programs. A number of endemic diseases were brought under control (Gjonça, A. Wilson, C., and Falkingham, J.C., 1997, Gjonça, A. 2001), including malaria, tuberculosis and syphilis.

By 1980 there were 6.5 hospital beds per one thousand citizens, compared with only 0.98 in 1938, and 4.4 in 1950. By 1990, this had fallen to an average of 5.9 beds per one thousand. This reduction was due to the start of the collapse of the health system in Albania. The proportion of physicians and dentists rose from 1.1 per ten thousand population in 1938 and 1950, to 16.8 and 17.1 respectively in 1980 and 1990. The significant increase in the number of nurses and midwives in 1980s reflected the priority given to primary health care by the Government - a cost-effective solution for a country with limited resources. The Gov-

Table 1.32-1. Health Indicators of Albania

	1938	1950	1960	1970	1980	1990
1. Physicians per 10,000 population	1.1	1.1	3	7.4	16.8	17.1
2. Beds per 1000 population	0.98	4.4	5.4	4.1	6.5	5.9
3. Health expenditure in % of Total Government Expenditures	1	4.9	5.9	5.3	5.3	6.6
4. GP consultations per 1000 of population		614	1220	2223	2970	3399
5. Life expectancy at birth (both sexes)		51.6	62	66.5	68	70.7
6. Infant Mortality Rate (as probability of dying during infancy – per 1000)		143.1	96.6	89.1	74.1	45.4

Note: 1950 Figure on health expenditure refers to 1952

Source: Albanian State Archive, Statistical Yearbook of Albania

ernment increased health expenditure from 1% in 1939 to 6.6% in 1990. In fact this is significantly high, considering that those expenditures were mainly made to primary health care. In fact we can say that the investment of the government in primary health care was a precondition for the improvements in mortality statistics in Albania. In 1980 there were approximately 800 medical institutions distributed across the country, with most urban centers having more than one hospital, while the number of general practitioner consultations per thousand of the population rose from 153 and 614 in 1938 and 1950, to 3399 in 1990.

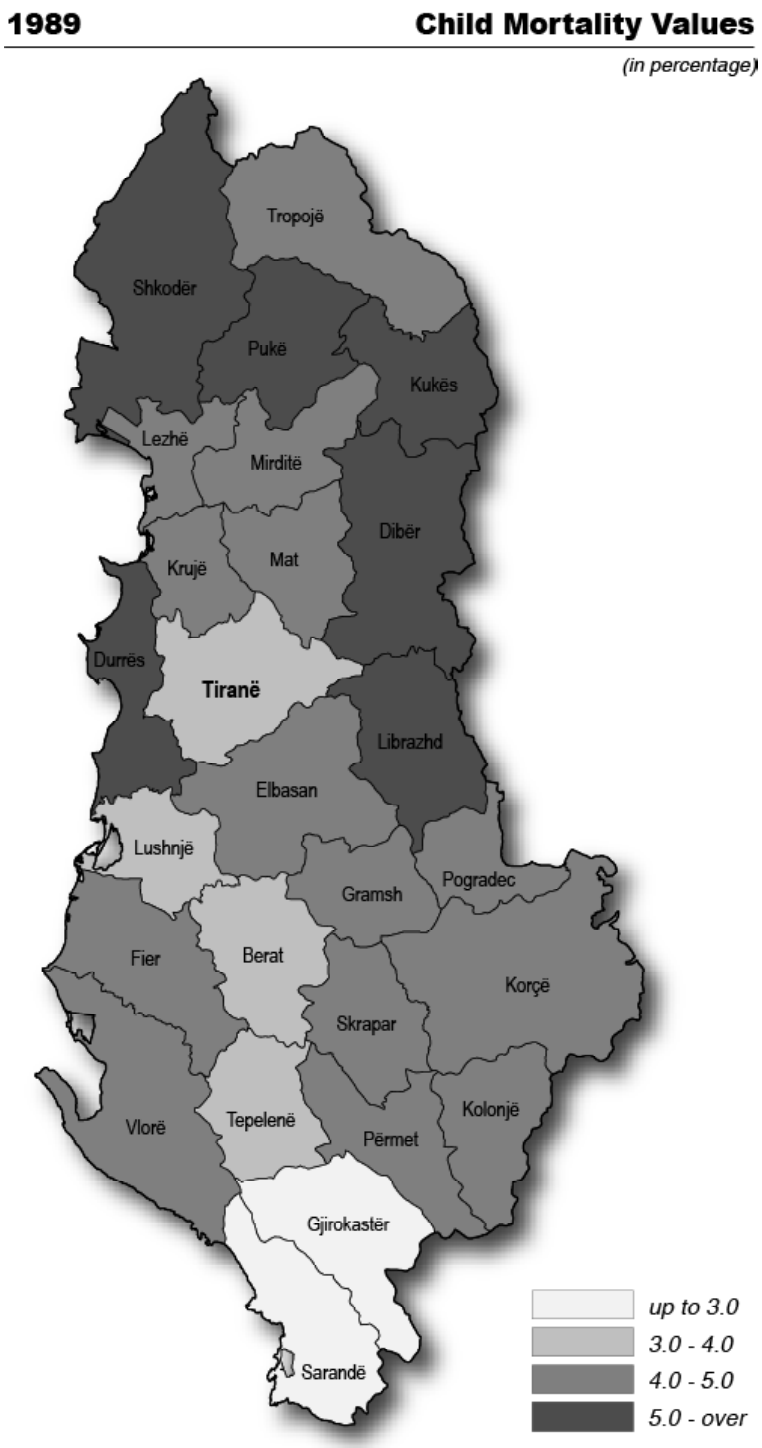
One of the most important government policies was to direct medical personnel to the country's more remote areas. By 1971, every village was said to have its own medical centre. More than 80% of health and medical institutions were located in villages. These measures were vital for a population that was 75% rural (Hall, D. 1994, p. 71).

The health of mothers and children was central to Communist policies during the entire period of rule. This was highly correlated to the high maternal and infant mortality rates in pre and post-war Albania. In 1950, the Infant mortality rate was 143.1. Health centres for mothers and babies were established in both urban and rural areas. Maternal health was monitored regularly before and after pregnancy. Subsidized day-care, nurseries and kindergartens were set up to make it easier for mothers to work, as well as to provide good care for their children (Cikuli, Z. 1982).

During the 1990s, the health care system has been characterized by poor standards in infrastructure and quality of care. Many buildings for provision of health services are in need for rehabilitation and equipment, while there are areas without direct access to health services, and people face difficulties to reach the nearest health centres because of poor infrastructure. There are many disparities in the distribution of health facilities among districts and there is a lack of qualified staff even in the existing ones. Most of these disparities are reflected in the results of the analyses of LSMS data presented in Section 2.

Despite all of the focus put on child mortality, and in particular, infant mortality during the Communist period the inequalities within the country still persisted. Thus, regional differences in mortality were clear between the poorer north-east region compared to the slightly better off south-west region. More than a reflection of the circumstances of poverty this regional mortality gradient was a reflection of disparities in education, in particular in the education of women in the country (Gjonça, A. 2001)

Figure 1.32-1 Regional differences in child mortality rate in Albania in 1960 and 1989.


1989
Child Mortality Values
(in percentage)
Tropojë
Shkodër
Pukë
Kukës
Lezhë
Mirditë
Dibër
Krujë
Mat
Durrës
Tiranë
Librazhd
Elbasan
Lushnjë
Gramsh
Pogradec
Fier
Berat
Korçë
Skrapar
Vlorë
Tepelenë
Kolonjë
Përmet
Gjirokastër
Sarandë
up to 3.0
3.0 - 4.0
4.0 - 5.0
5.0 - over

1.33 Inequalities in education: Urban-Rural differences and Regional differences

The Communist government inherited a challenging situation with respect to the education of the population when they came in power in 1945 as more then 80% of the population were illiterate. One of the first measures taken was in 1952, when education was made compulsory for children between the ages of 7-14 years. A further step against illiteracy was taken in 1949, when the government passed a law requiring all illiterate citizens between ages twelve and forty to learn to read and write (Keefe, E.K. et al., 1971, p. 86). The government proclaimed that between 1955-1956, illiteracy was effectively eliminated among all people under forty years old.

An eight year elementary and four year secondary school education structure was instituted and schools for training skilled workers were established. Night schools were also opened to give adults the opportunity to begin or to continue their education without leaving work (Skendi, S. 1956). The last education reform was passed in 1970. A uniform system of separate elementary and secondary school programs was introduced, and all secondary school curricula were standardized, to be comprised of 55% academic work, 27% production (applied work) and 18% military training and physical education (Hall, D. 1994, p. 75). When enrollments are considered, Albania had a broad-based education system, with almost 90% of pupils completing the compulsory basic eight year school and 74% continuing on to secondary school. Out of these, more than 40% went to the university.

At the end of 1972, according to official figures there were 700,000 schoolchildren and university students, meaning that every third citizen was enrolled in some form of educational institution (Kellezi, A. 1973, p. 39). The number of kindergartens in urban areas increased by 112% from 1970 to 1990 while in rural areas it increased by 150%. The number of primary schools in urban areas, for the same period of time, rose 31%, and by 24% in rural areas. The total number of secondary schools increased by 291%, and by 60% for high schools.

A similar trend can be seen with respect to the number of students that graduated. Thus the number of pupils that graduated from primary schools for the period between 1970-1990 increased by 74.8%, for the secondary school, the number rose 914.2%, and for university 147%. Education tuition was free of charge. Students whose families had low incomes were entitled to scholarships, which gave them free accommodation, food, etc. (Marmullaku, R. 1975, p. 79). Similar to the health status of the population, government policy on education was set again in order to reduce inequalities between different regions and between rural and urban areas. While the expansion of education and educational establishments was rapid, these national averages, however, conceal a regional variation of some magnitude. A regional division exists for trends and levels, between north-east and

Table 1.33-1. Number of schools and number of students graduated from schools, 1950-1990.

Number of Schools						
	Pre-school		Primary		Secondary	University
	Urban	Rural	Urban	Rural	Total	Total
1950	93	62	82	111	23	1
1960	230	204	132	425	69	6
1970	378	1045	187	1187	131	5
1980	666	2001	212	1347	280	8

Number of Students Graduated from Schools			
	Primary (000)	Secondary (000)	University
1950	4.3	0.5	-
1960	11.2	2.4	690
1970	34.6	3.5	1613
1980	60.4	28	2877
1990	60.5	35.5	3990

Source: Statistical Yearbook of Albania 1991.

south-west of the country. The southern districts of Kolonje, Permet, Tepelene, and Sarande, were above chapter one the national average, while the reverse holds for the northern districts of Puka, Mirdita, Gramshi, Kukesi and Dibra (Golemi, B., and Misja, V. 1987, p. 184; Sjoberg, O. 1991, p. 71). Regional differences in education have also been noted by Vejsiu in 1981. Some of the reasons why the northern mountainous areas lagged behind in educational level, could be the level of urbanization, tradition, religion, and age structure. The influence of this complex number of factors is also reflected in the differences in mortality rates.

While the enrolment performance and the elimination of illiteracy were impressive, this could not be said for the quality of education. The schools suffered from overcrowding and lack of facilities and teaching materials. The principle of "self- reliance" cut Albania out from the developments of the outside world. Specialized and relevant literature were lacking in most fields of education and censorship, restrictions and the lack of personal freedom only made the situation worse. The inequalities with regards to both urban-rural and north-east versus south-west were still present when Communism collapsed in 1990 (INSTAT, 2003). Nevertheless, the achievement of universal education must be judged one of the Communist regime's main achievements.

Figure 1.33-1 Regional differences in education in Albania in the 1970s

During the 1990s the situation started to deteriorate slightly as a result of the rapid political, economic and social change taking place in the country. At present, the Albanian education system is facing important challenges. Despite the positive efforts made by the Albanian Government to improve legislation, improve quality of teaching and teachers, and decrease the level of dropouts, the education system is facing many difficulties. There are many schools, especially in rural areas with very poor physical conditions and with shortages of heating, lighting and other facilities. In some cases there is a shortage of teachers with basic qualifications and there are increasing disparities in education conditions between the urban and rural areas. This particular situation will have consequences in the years to come.

1.34 Inequalities in dwellings and living conditions

The dwelling and housing conditions in Albania have always been at best inadequate. Public sector and basic infrastructure have always been insufficient. Before the Communists took over, the drainage system was scare and the water supply was limited to parts of the country and even there to only few households, based mainly on private wells and cisterns. Poor housing constructions, extremely bad sanitation and hygiene, not just in rural areas but also the few urban settlements, accompanied this situation. Such circumstances forced the Communist government to make it central of its post-war policies not just the reduction of socio-economic differences within the country, but also the improvement of housing conditions and facilities within the country.

Immediately after the Second World War, the government increased the efforts to re-build the 62,000 houses destroyed from the war, as well as build new flats and houses in order to face the continues growth of the population. Thus, by 1970 there were 185,000 new flats and houses built on a rate of 7,400 dwelling per year (Hall, 1994, p.95). Despite this effort, growth in the number of dwellings could not keep pace with the rapid growth rate of the population that was increasing during this period at more than 3% a year. After the 1970s, the declining population growth rate and the increased number of new dwellings constructed eased the stress on housing demands. Despite the new construction, repair of the old stock was never carried out. This created a situation of uninhabited dwellings in parts of the country at the end of the 1980s.

The situation regarding services and facilities was not much different. By the end of the 1980s half of the rural population did not have access to running water . With regards to heating, the situation was even more serious. Only solid fuel was used for heating, mainly in the form of firewood. There was no central heating for most of the houses and apartments. Exceptions were the areas close to sources of gas or oil. Even them, provision was inadequate. The only ‘success’ the Communist government took pride in was the provision of electricity across all the country by 1970s. By mid 1990s the main disparity in the availability of basic services was between the rural and urban areas, with the latest being in a better state.

The living conditions in rural areas were inadequate at best, particularly with regard to running water and existence of indoor toilet facilities. Despite the increased number of dwellings during the past years prior to 1990, overcrowding was very common across all of Albania. Most of the newly constructed flats were on average two rooms and a kitchen and they were overcrowded. More than two thirds of the dwellings can be considered overcrowded even by 2001 data. The situation appeared better in the main cities such as Tirana and Durres.

1.4 Levels and Patterns of Poverty and Inequality

The estimates on the poverty line of Albania was based on LSMS data was carried out by World Bank and INSTAT (2003). Based on the calculations on the aggregate consumption of the Albanian population, different poverty lines were calculated. Two of the most important studies that are used in this paper are the 'food poverty line' and the 'full poverty line'. The food poverty line is the level of income per capita per month necessary for an Albanian to meet a minimum caloric intake. This level is calculated at 3,047 leks. The second, important level of poverty is the full poverty line including the consumption of non -food products, is estimated at 4,891 leks per capita per month.

The results show that an estimated 25.4% of Albanians (or about 780,000 Albanians) live below the full poverty line. This figure, comprising one quarter of Albanian population, is high compared to other countries in South-East Europe, but is similar to countries of Central Asia. While the proportion of people living below the full poverty line is high in Albania, the percentage living below the food poverty line is relatively low with only 4.7% of Albanians living in extreme poverty (WB and INSTAT, 2003).

The rural areas of Albania continue to remain the poorest in the whole country. This is significant when one takes into account the fact that almost half of the Albanian population is still residing in rural locations and that agriculture is still one of the main sectors of economy. 29.6% of the rural population lives under the poverty line compared to 20.1 % of urban population and 17.8% of the population of Tirana. The picture between urban and rural areas is not much difference when food poverty line is considered with 5.2% of the rural population living under extreme poverty, while only 4.8% of urban population and 2.3% of Tirana population live under this extreme poverty line.

As previously mentioned, the LSMS divides Albania into north-east region, central Albania, south-east region and Tirana. From the results of the analyses it is clear that the mountainous districts of the north-east region of the country are the poorest with 46% of the poor residing in this region, while only 8% of the poor population residing in Tirana. Almost half of the population in north-east region live under the poverty line with more than 25% living under the extreme poverty line. Similar to the rural-urban differences the poverty (income one) level shows the same regional differences as in the past decades. This is important to emphasize that the policies to reduce the regional inequalities in economic development have, to date been Despite efforts during the past Communist regime to reduce these inequalities they are still present. They are even more significant today compared to the past, not just because of the lack of policies to narrow these inequalities, but also as a result of the migratory movements that have had an effect on the development of some regions.

1.5 Demographic Characteristics of the poor in Albania

Poverty at the start of the 21st Century in Albania has a young face, it is more prevalent in the rural population, in the large households with high number of children and it is prevalent among the least educated and the unemployed.

The poorest in Albania are the young people. More than 55% of the poor population is under the age of 25, while this age group comprises only 33% of overall population. This is contrary to the popular perception that the most affected by poverty in the country are the elderly. On the contrary only 10% of the poor population are of ages 60 and above. In contrast to the young population, which is either unemployed (see paper on unemployment) or dependent on the household, the retired population has at least a minimal income (a guaranteed pension from the state), which comes as a result of the full employment policy during the past Communist years for both genders. While these pensions are not very high, they are still in most of the cases above the full poverty level of 4,891 Leks per capita, per month. Another factor that might have helped in the low percentages of elderly people living under the poverty line could be the high rates of emigration and remittances. At least one in four Albanians has emigrated in the last 12 years, which is an average of one person per household (INSTAT, 2003). As in most of traditional societies, Albanians continue to contribute to the income of their families and relatives in Albania. In particular this is even a more significant factor for households where elderly people are left alone. The high transfer rate from emigration might have also contributed to the low level of poverty among the pensioners compared to other vulnerable groups.

The fact that the young population is poorer and most vulnerable in Albania, comes from the fact that these individuals are living in poor households and as the LSMS analyses show large families with a high number of children. Additionally, these young poor people are more likely to be found in rural areas than in urban regions or in Tirana. Most of the poor population lives in households with more than 7 or more persons. Thus, more than 40% of the poor live in households with 7 or more members. This is significant when one takes into account that this group of population represents only 17% of the population (World Bank and INSTAT, 2003).

The gender differences in poverty in Albania are not very significant. Thus, the percentage of female-headed households living in poverty is only 9.3%, while percentage of not living in poverty is only 13.1%.

1.6 Social characteristics of the poor in Albania

As one would expect, the lowest members on the income scale are the less educated in most societies. This relationship between education and income is a well established. The data on Albania shows a similar pattern found in other countries. Thus, the poor households are headed by less educated people compared to the non-poor. Thus, the average number of years in education for a head of household living in poor household is approximately 6.2 years, while the number of years for the head of household living in a non-poor household is approximately 7.9 years.

Despite this difference, one has to accept that the inequality in Albania is not large. This is a legacy of the past, when education has been universal and compulsory up to the primary

level. The disparity among the poor and non-poor is more evident in enrollment and drop out rates. People living in extreme poverty have the lowest enrollment rates for both primary and secondary education system compared to the rest of the population. Despite the small percentage of population attending private schooling, the poor, as one would expect, cannot afford to pay for private schooling. Thus, 99.4% of the poor population attends only public schooling. The poor population also reports a worse health status than the non-poor. When the difference between the top and bottom 20% of the population is considered, people in the bottom 20% of the consumption aggregate report their health as worse compared to the top 20%.

The disease pattern also reflects the level of poverty in different groups of the population. When chronic diseases are considered, the non-poor are affected mainly from the diseases of affluence (cardiovascular diseases), while the poor population are more likely affected by diseases of poverty (respiratory diseases). While almost half of Albanians find it difficult to afford health care (45.1%), the disparity between the poor and non-poor is evident when access to the health system is considered. The disparity is not reflected in attendance to public ambulances, but mainly when visiting a doctor.

Thus the percentage of the people in the top 20% visiting a private doctor is about 11.9%, while the same percentage for the bottom 20% of the population is only 4.9%. When unemployment is considered, the poor population has almost a double unemployment rate compared to the non-poor. Thus, the unemployment rate for the poor is at 14.2%, for the non-poor at 8.5% and the worse affected are people living in extreme poverty with a rate of 23.7% (World Bank and INSTAT, 2003).

Table 1.6.1. Self assessed health and the level of poverty.

Inequality (as poverty indicator) based on consumption	Self-assessed health					
	Very good	Good	Average	Poor	Very poor	Total
Poorest 20%	28.3	40.3	17.4	11.2	2.8	100
Richest 20%	38.4	41.9	13.5	5.5	0.7	100

chapter

2

Poverty and Inequalities in Health

With the collapse of Communist regime, similar to other East European countries, Albania experienced massive drops in revenues as a result of the economic stagnation of the early 1990s. This was reflected in the large cuts in government expenditures to health care provisions. Thus, health spending as a percentage of GDP went down from 3.36 % in 1992 to 1.91% in 2000 (Table 2-1). Although the sources allocated for the health service have increased in 2001 and 2002 accounting 2.0% and 2.7% of the GDP respectively, the sector continues to remain still far from a satisfactory level of funding.

The Government of Albania, similar to other East European ones, was in desperate need to gain funding for health care from additional funding such as payroll taxes, insurance and cost-sharing with patients (Falkingham, J.C. 2003). In most of the Eastern European countries where reform of the health system has started to be implemented, there is a fear that the informal and under- the-counter payments for health care are becoming increasingly large components of health care spending in these countries. This trend will have important policy implications for health care reform and if as feared, these payments are very large, than they will pose a threat to the health care reform in these countries (Ensor, T. et al., 2000). Albania is no exception from this trend.

Albania inherited from its Communist past, a health care system based on central government funding, designed to provide full geographical coverage (Gjonça, E. and Gjonça, A., 2000). By 1990 more than 85% of the funding came from the central government and the rest from the out-of-pocket payments (Reynolds, D., 2003). The system was mainly focused on the primary health care.

The system, as shown in the pervious analysis resulted in some success in improving the life expectancy of Albanians in general and infant and child mortality in particular. The liberalization of the market and the wide economic reforms brought the need for health system reforming in Albania. The health policy aimed at first preventing the deterioration of basic health services as well as maintaining a stable cost-effectiveness system. Secondly, it was important to ensure equity in the system and improve the quality at the same time.

Some of the main reforms initiated in early 1990s were the creation of the health insurance system and the Health Insurance Institute. Another measure taken was the introduction of a parallel private medical system (Gjonça, E. and Gjonça, A., 2000). While these measures helped to ease the provision for health care as well as its partial financing, it did not help to maintain the equity and the full

geographical coverage of medical care, inherited by the Communist past. The access to health services is reduced particularly in the rural and remote areas during the 1990s. Out of 630 health centers that currently operate in the country, 50 are considered to be non-functional. In addition, out of 2,000 outpatient clinics needed for a normal coverage of the population with health services throughout the country, about 1,300 of them are not functioning (GoA, National Strategy for Socio-Economic Development, 2003).

As a result of these measures, government spending dropped dramatically (Table 2-1) and was reflected in a decrease of large health provisions for the population. The number of physicians per 100,000 people has decreased from 171 to 139 in 2000, reversing the positive trend prior to 1990.

The number of nurses decreased as well. At a similar pace, the number of beds in hospitals also decreased from 590 in 1990 to 326 in 2000, as well as the number of hospitals per 100,000 people from 4.11 in 1992 to 1.61 in 2000 (Table 2-1). Unsurprisingly these changes in medical provision were expected to have short-term effects in the health of the population. The next two sections examine the state of health of the Albanian population by 2002 as measured by self-assessed measures and incidence of chronic and acute diseases.

Table 2-1. Indicators of heath care use in Albania

	1990 [1]	1992	1995	2000	2001	2002
Health spending as percentage of GDP		3.36	2.38	1.91	2.00	2.70
Physicians per 100,000 people	171.02	165.01	130.63	138.89		
Nurses per 100,000 people		499.20	435.09	390.94		
Beds per 100,000 people	590.01	401.34	319.22	326.33		
Hospitals per 100,000 people		4.11	1.57	1.61		

Source: WHO Regional Office for Europe, Health for All Database.

Note [1]*:* 1990 data are based on Statistical Yearbook of Albania.

2.1 Health status and inequalities (self assessed health)

In general, Albanians live a healthier life compared to other East and South-East Europeans (Gjonca, A. 2001). They live for a long time, with an average life expectancy of about 74.5 years for both genders in 2000 (INSTAT, 2003). They maintained this level of high life expectancy even during the 1990s. Other research has found that this has been mainly due to the improvements that occurred during the past 50 years in the Albanian health care system, improvements in nutrition as well as a healthy Mediterranean life style as compared to other Europeans (Gjonça, A. and Bobak, B., 1997). While these measures of mortality are based on aggregate data and indicate the level and pattern of mortality, they do indicate the level of morbidity in the population and how people perceive their health.

The LSMS is the first survey that has ever collected individual data on morbidity for the whole population of Albania. The data analyzed in this report are the self-assessed measurements of health status and the incidence of acute and chronic diseases for the individuals in the sampled population. Analyzing self-perceived health status data on the population, apart from reflecting the morbidity pattern in the country, has another important benefit for policy-makers, especially in a market orientated health care system, where patients choose what to 'consume' and pay for, it is important to tailor these services based on their needs.

These dada help researchers and policy-makers to design the health care needs of the population. Another benefit of analyzing this data is the ability to measure the health inequalities of the Albanian population, with regards to access to health care, user fees (who can afford and who not), to different social and economic status variables, such as income, education, etc.

Table 2.1-1 shows self-perceived health by age group of the respondents. As one would expect, the self assessment health measurement shows that as people get older they report their health as being poor or very poor. This is not just a reflection of their state of health, but it is also known that it might be an unsubstantiated data of elderly perceptions. While the respondents that reported their health as either 'very good' or 'good' were the younger cohorts usually ages 40 and younger. Thus, out all people reporting their health as being very good, 62% are between the ages of 10-39 years, while only 1.5% of people aged 60 and over reported their health as 'very good'. The picture is totally different for people that report their health as 'very poor'. The young people (aged 10-19) compose only 3.5% of these people and people over 60 years compose 57.9%.

Table 2.1-1. Self-assessed health by age of the respondent

Age groups	Very good	Good	Average	Poor	Very poor	Total
0-9	24.27	20.43	8.43	4.95	1.4	18.35
10-19	31.38	19.8	8.09	4.06	3.47	20.32
20-39	30.84	28.64	17.46	10.68	15.31	26.05
40-59	11.98	23.55	35.3	28.57	21.89	21.96
60+	1.53	7.59	30.71	51.75	57.92	13.33
Total	100	100	100	100	100	100

When rural-urban differences are considered it is clear that there is a tendency for a higher percentage of people rural areas to report poor health. Thus, the percentages of people reporting health as 'very good' is higher in urban areas (41.1%) compared to rural areas (26.6%). For people reporting very poor and poor health, percentages for rural and urban areas are, respectively 1.4% (urban) and 1.6% (rural) for very poor health, and 5.75% (urban) and 8.9% (rural for poor health reporting). This is an expected result because, as previously described, people in rural areas are generally poorer than in urban areas. This is also confirmed by the analysis on self-reported health by poverty level.

A very interesting pattern is also found when self-assessed health is analyzed by the regional distribution of the population. The areas with the highest percentages of people reporting good health are the more affluent areas of Tirana and south-west while the percentage of people in north-east of the country report their health as being very good is very small, 13.3%. One has to bear in mind that this area is regarded as a poorer area in the country. Tirana city, as the richest region of the country, stands out exhibiting the lowest percentage of people reporting their health as poor and very poor, respectively of 4.2% and 1.4%. It is also important to mention that the pattern of self-assessed health on a regional level reflects the pattern of urban rural differences with north-east presenting similar results to rural areas and Tirana having a similar pattern to urban areas. This regional difference is very important for not just trying to understand the health situation within the country but to also explain partially some of the trends and patterns of internal migration. It is known that poverty in real terms, as well as unemployment are the main factors responsible for the internal movements within the country during the 1990s. However, access to health care and other aspects of social agenda are also "pull" factors for the people living in areas where these services are lack-

Figure 2.1-1. Self-assessed health for urban and rural population (in percentage)

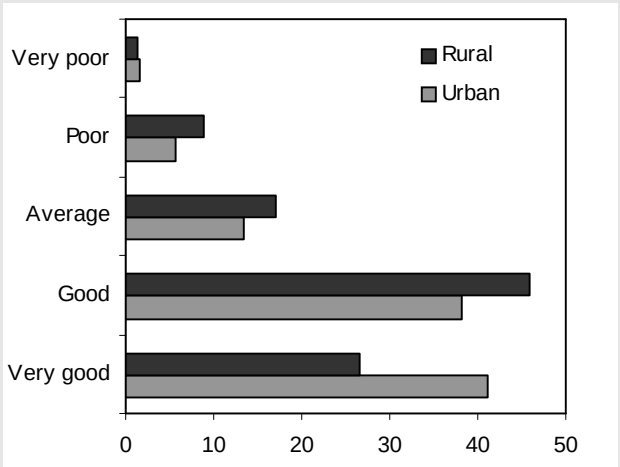
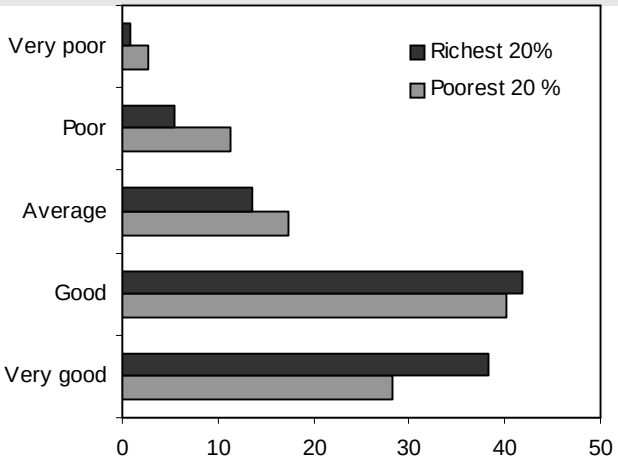


Table 2.1-2. Self-assessed health by the place of residence of the respondent (4 major strata of the LSMS survey)

Regions	Self-assessed health					
	Very good	Good	Average	Poor	Very poor	Total
South-West	38.2	37	15.3	8.1	1.5	100
Central	31.8	42.1	16.8	7.9	1.5	100
North-East	13.3	61.1	15.5	8.6	1.6	100
Tirana	41	41.5	11.9	4.2	1.4	100

Figure 2.1-2. Self-assessed health for the richest and the poorest population (in percentage)



ing to move to areas with better social services.

A familiar picture is portrayed when data is plotted in Figure 2.1-2 of the health self-assessment by the level of poverty rate as per the top and bottom 20% of the population consumption spending. As the data shows, being in the poorest 20% of the population with regards to levels of poverty is translated into a poor or very poor health status which is higher than being in the richest 20%. It is also interesting to note that the data, to a large extent also reflects the rural-urban distribution of self-assessed health, indicating once again that the rural-urban division of Albania is also a rich-poor division. However, it is important to mention that, in general even the rural population consider themselves to be healthy.

2.2. Disease patterns and inequality

The data on chronic diseases in the past three years shows an expected increased rate of illness with age for both genders. Children and youth between the ages of 0 and 15 years show the lowest percentage of chronic diseases with 3% and 2.6% for men and women respectively. While the elderly over 65 years old have the largest share with 54% and 58% for men and women respectively. The percentage of women of old age with both chronic and acute illnesses is higher compared to men, however this cannot be concluded in regards to visits for medical assistance. Males age 65 and older seek more medical assistance and are more regularly hospitalized then women. The percentage of men seeking medical assistance is approximately 77.6% compared to 41.5% of the women, while the rate of hospitalization is 9.6 % for men and 7.4% for women. Figure 2.2-1 shows the disease pattern as reported by the respondents of the LSMS.

The incidence of chronic diseases in the last three years shows the pattern of a country, which is in an advanced stage of epidemiological transition with respect primarily to cardiovascular diseases. This finding confirms other analyses carried out in the past showing that Albania has progressed to the final stage of epidemiological transition of man-made and degenerative diseases (Gjonca, A.2001). However, there is a large incidence of respiratory diseases that is not fully expected with the high level of life expectancy at birth of the country.

This is a reflection of the level of the poverty in the country, as respiratory diseases are mainly prevalent among the poor. It should be emphasized again that the self-reported morbidity in the country shows the same pattern as the cause-specific pattern.

Both the mortality pattern, with high life expectancy and relatively high infant mortality, and the self-reported morbidity, with high CVDs and relatively high respiratory diseases, reflect the paradoxical situation of Albania as a country that has achieved good health at a relatively low cost, but is still a poor with relatively high infant mortality and high incidence of respiratory diseases.

When morbidity pattern is analyzed by rural-urban difference and by regional variation, the same picture is revealed. Both rural-urban level and regional level reflect what one would expect, that the incidence of CVDs is higher in more affluent areas of the country such as Tirana or in urban areas. It is well recognized that the diseases of affluence, such as CVDs are more prevalent in urban areas, which are also more prosperous than rural areas. In contrast, the incidence of respiratory diseases is higher in less affluent regions, such as in north-east of the country, and generally in rural areas. Thus, the percentage of cardiovascular diseases in Tirana, the richest region in the country, is approximately 50% in north-east, the poorest area of the country is half of that, at about 23.2%. The opposite is true with respiratory diseases as the percentage is higher in north-east (11.8%) compared to Tirana (6.9%). When the morbidity pattern is analyzed by the level of poverty in the country (Figure 2.2-3), it is clear that the poor are more prone to respiratory diseases than to cardiovascular diseases and that the non-poor are more prone to cardiovascular diseases. This could be indicative that Albania is suffering from a 'double burden of disease'. However, one should emphasize that this is not as significant as it is in other transition economies.

When sudden diseases in the past 4 weeks are considered, the conclusions are very similar in terms of inequalities to that described concerning chronic diseases. The incidence of sudden diseases in the last four weeks shows an interesting pattern with respiratory

Figure 2.2-1. Distribution of the incidence of chronic diseases in the past three years by the type of disease

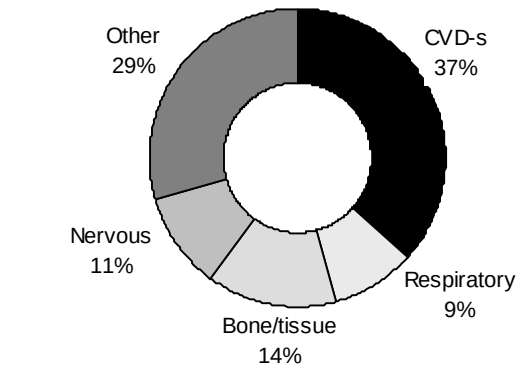


Figure 2.2-2. Rural-urban differences in the distribution of the incidence of chronic diseases in the past three years (in percentage)

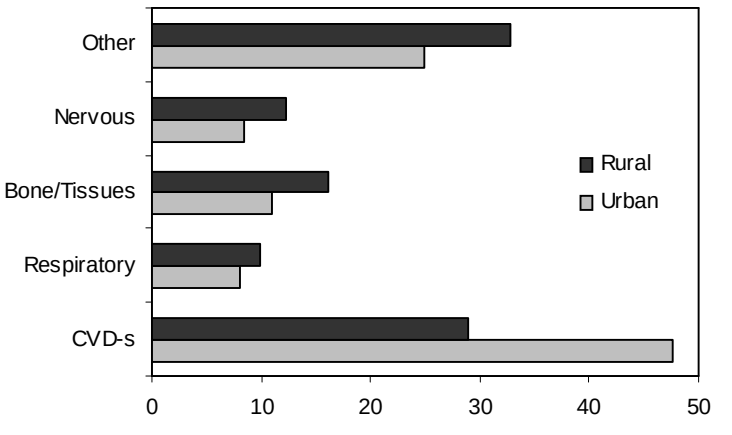


Table 2.2-1. Regional differences in the distribution of the incidence of chronic diseases in the past three years

Regions	Chronic diseases in the past 3 years					
	CVD-s	Respiratory	Bone/Tissues	Nervous	Other	Total
South-West	38.4	7.4	11.9	10.8	31.6	100
Central	35.8	10.4	14.7	11.4	27.7	100
North-East	23.2	11.8	22.3	11.7	31.1	100
Tirana	49.6	6.9	10	5.6	28	100
Total	36.8	9.1	14	10.7	29.5	100

Figure 2.2-3. The differences in the distribution of the incidence of chronic diseases and the poverty line in the past three years (in percentage)

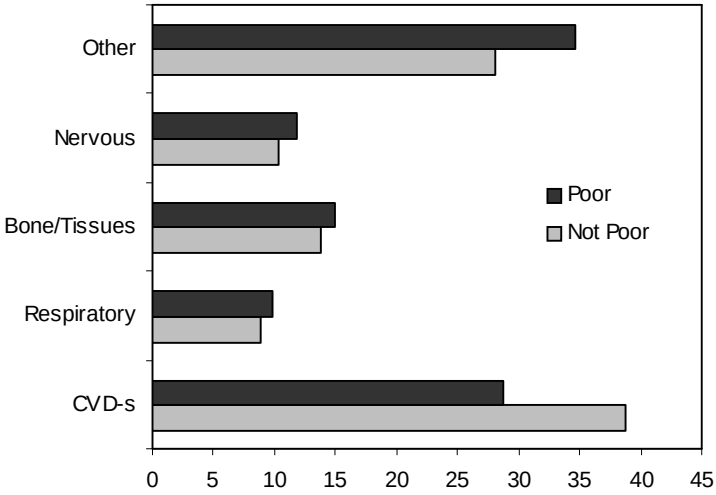
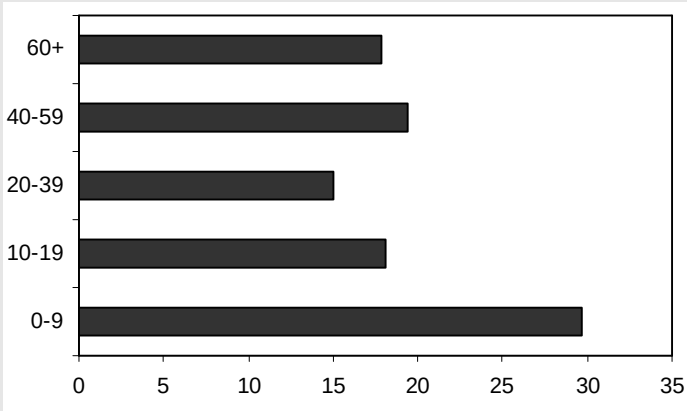


Figure 2.2-4. Age distribution of the incidence of cold and flu in the last four weeks prior to the survey (in percentage)



(cold and flu) diseases representing the major diseases or approximately 80.1% of all sudden diseases noted in the survey. The age comparison reflects the Albanian disease and mortality pattern. The incidence of cold and flu is higher among children, approximately 29.7%. If one takes into account the fact that Albania has a high infant mortality rate, approximately 23 deaths per one thousand live births, this is not a surprising result.

The incidence of cold and flu is higher in the north-east area of the country and also in rural as compared to urban areas. This does not come as a surprise because mortality in these areas is higher compared to the rest of the country, and in particular mortality from respiratory diseases. Tirana has only 3.7% of all cold and flu cases compared to north-east that has 47.8%. The urban-rural differences for sudden illnesses in the past four weeks is also telling of the poor performance of health system in health promotion and its ability to meet the needs of rural and most vulnerable groups.

2.3. Utilisation of health care and inequality

Albanian policy in reforming the health system consists of not just the reform of prevailing public health system, but also in the introduction of private health care. To maintain a balance between the systems is difficult in a transition economy where people cannot afford basic needs, and a quarter of the Albanian population lives under the poverty line.

Contrary to popular belief, most, Albanians, still, use the services within the public sector. When people have been ill from a chronic or a sudden disease most of them, approximately 76.8% have used the public ambulance service. It is interesting to note that only 7.5% of people in need of a medical visit see a private doctor, while 13.8% see the nurse and only 1.9% sick employ alternative medicine.

The distribution of visits to medical personnel does not vary for chronic or sudden diseases when analyzed separately. Thus, for both types of disease, Albanians still use public ambulances, 74% of them for sudden diseases and 77.4% of them for chronic diseases. There is a slight difference where people are suffering from sudden illness. The percentage visiting the nurse is high for sudden diseases (18.7%), as one would expect when a person has contracted either flu or cold.

Table 2.3-1. Percentage distribution of the visits to medical .
personnel while being ill

	Public Ambulance	Private Doctor	Nurse	Alternative	Total
Ill from either chronic or sudden diseases	76.8	7.5	13.8	1.9	100
Ill from chronic diseases	77.4	8.5	11.4	2.6	100
Ill from sudden diseases	74	5.7	18.7	1.6	100

Table 2.3-2. Mean number of visits to medical care providers in the past 4 weeks

	Mean number of visits to medical care providers			
	Public Ambulatory services	Private Doctor	Nurse	Alternative
Poorest 20%	1.6	1.7	4.5	1.7
Richest 20%	1.4	1.3	4.9	2.5
All population	1.5	1.4	4.6	1.7

Table 2.3-3. Hospital utilization and costs

	Mean number of times admitted to hospitals in the past 12 months	Mean length of stay in hospital (days)	Costs of hospitalization excluding gifts[1]	Gifts given to hospital personnel[2]
Poorest 20%	1.3	19.2	100	100
Richest 20%	1.4	19.3	179	151
All population	1.3	18	126	114

Note [1]: The cost of hospitalization does not include the amount of gifts, cost of medicines, transport and payments for tests. Poorest 20% category is taken as baseline and the other two are calculated as percentage towards poorest 20%.

Note [2]: Poorest 20% category is taken as baseline and the other two are calculated as percentage towards poorest 20%.

Table 2.3-2 shows the average number of visits made to medical outpatient centers by level of poverty as measured by level of consumption. It seems, as the utilization of health care is similar with both the poorest and the richest groups of the population having the same rates of utilization of the care centers, being private or public. The average number of visits to public outpatient clinics is 1.6 times per for the poorest 20 percent of the population compared to 1.4 times per for the richest 20 percent. Various scholars have found that the poorest people in a population tend to visit the public sector more than the richest segments of the population. However, this is difficult to quantify as the data is complex and one general rule to explain this trend is not available.

While this trend holds for visits to public ambulances, it is reversed when visits to private doctors are considered, with the poorest paying more visits to the private medical facilities than the richest people. Regardless of income level, people did pay visits to the nurse, paramedic or midwifes more than any other medical personnel. The average number of visits for the whole population in the last four weeks is approximately 4.6. This may be because the nurse, paramedic or midwifes are more accessible than the doctors, are a cheaper option as well as probably an tradition from the past, when this category of personnel was the first point of contact.

Table 2.3-3 looks at hospital utilization and costs in the last 12 months, for the whole population by level of poverty. The number of times people were admitted in the hospitals during the past 12 months did not vary to a significant extent with the economic status of the individual. As research has shown this is more related to the educational level than to the economic level of the individual. The figures are more a reflection of the need for hospitalization than being able to access and afford hospital services. On average, people were admitted to the hospital just over one time during the past year. The amount of days spent in hospital is similar.

However, with respect to the cost of hospitalization there is a large gap between the poorest and the richest segments of the population. The average hospitalization cost for the poorest 20 percent is more than one-half of the costs of the richest 20 percent, despite similar length of stay in the hospital. The higher costs of the richest might be as a result of agreeing to pay more expensive treatment (less likely in the case of Albania as the treatments are standardized within the system) or that they have requested better care

and amenities during their hospital stay. The mean value of gifts given by the richest is almost one and half times of that given by the poorest 20 percent of the population. Despite the richest paying more for the care in hospitals as they can afford more, the poorest still are carrying quite a large amount of the burden in terms of hospital costs.

2.31 Informal payments and inequalities

The difference between formal and informal payment is not a clear-cut distinction. The main confusion comes when the payment is considered informal due to the circumstances surrounding the payment, such as when it is paid before or after the treatment, if the payment is a gift, which may or may not be common for that community. The issue is complicated even further as the LSMS does make a difference between 'official' or 'unofficial' payments however it might have been rather difficult for the respondent to answer if the payment is official or unofficial as in practice it is difficult for the patient to make a difference, if it is a common practice in that community as it is in Albanian case. In general, the report does not focus on gifts given to medical personnel but rather examines if the payment is a burden to the population.

The decline in government spending in the health care sector has decreased the capacity of the system to provide accessible and universal and affordable health care , a service taken for granted in Albania due to the country's health care history. While the fall of revenues for the health system decreases rapidly, this creates a class of underpaid medical professional, lack of equipment, treatments, drugs and other medical supplies. In order to make up for low salaries and payments many health personnel have started charging informal payments in addition to other fees charged by the system itself (Lewis, M. 2000). While this began as a rare event early in the transition period, it is now a normal custom across most former Communist Eastern European countries to which Albania is no exception.

Table 2.31-1. The informal payments by the amount paid to medical personnel

Informal payments made to public health service in percentage	
No payments	71.18
100 – 1, 000 Leks	27.12
1, 000-10, 000 Leks	1.46
10,000 Leks +	0.24
Total	100

Table 2.31-1 shows the informal payments made to public health personnel. It is interesting to note that a large proportion of the population cannot afford these payments. This percentage of the population is about 71%. From the remaining 29% that pay (about 27% of the population) most of them pay between 100 and 1,000 leks, which is expected to be the norm. The general practice in the country is to pay an informal 200-500 leks payment for the visit to medical personnel.

While informal payments given were mainly on a voluntarily basis (59%), the percentage of medical staff requesting such payment is still high at 41%. One has to carefully interpret those results as while most people still pay the informal charges voluntarily, 41% of people visiting the public sector that were asked to pay the informal charge that drives the whole informal charges payment within the system, thus creating a trend of 'compulsory volunteering payments'. Informal payments were mainly paid by people living in rural areas (60.1%). As one would expect, it is clear that the non-poor can afford to give these informal payments more freely and that is there is a higher percentage of the non-poor who pay informal charges, approximately 80.7% of them.

These informal payments to health care workers in the public sector have created a third informal market for health care within the public system. This market exists outside controls and is not regulated, thus its activities are illegal and go unreported. The existence of these payments is a form of corruption and undermines the efforts to reform the health care system. (Lewis, M. 2000). There is also evidence from other countries that these payments decrease the consumption level of health care services by the whole population as a result of the higher costs. It also undermines the reform of the health system that is greatly needed in these countries.

User fees are also a barrier to inpatient care. They restrict the poor from obtaining the necessary services and drugs, and even those people with money have a difficult time finding funds for in-patient care. For those people who are unable to afford the high costs or user fees, their options are limited. Stories of self-provision of medical drugs and care within the system are limitless as are the stories that people who do not pay do not get any treatment at all. The reality is that the poor face health problems and that 'they do not get help; poor are left to die' (World Bank, 1997)

2.32 Affordability of health care

Apart from collecting information on the informal payments and user fees, the LSMS also collected information with respect to the affordability of the health care. When respondents were asked how they found the cost of health care, a large proportion, approximately 45.1% found it either difficult or very difficult to pay for it. This also reflects the reasons given for not seeking help, as almost 45% said that they could not afford it. The proportion of people finding it easier to pay for health care is similar again approximately 45.1%.

While the percentage of people finding it difficult or not to pay for health care is similar, there still is a high proportion of people who do not seek health care. Of those about 30% do not seek help as they believe that they will get better without the need for seeing the medical personnel. Almost 10% of the people surveyed gave as the distance from the health care center as a reason for not seeing medical care. This is an interesting feature of the Albanian system in the 1990s, as in the past, the government was proud of the easy access to medical services and complete coverage across the country. This is an indication that complete coverage is probably not a regular feature of health care in the country. The same situation appears when people were asked if they visit the hospital when ill. A large proportion could not afford it, approximately 63.35%. The distrust to medical personnel and the distance to hospital do not appear as significant reasons for not going to hospital.

Figure 2.3-1. Affordability of health care (in percentage)

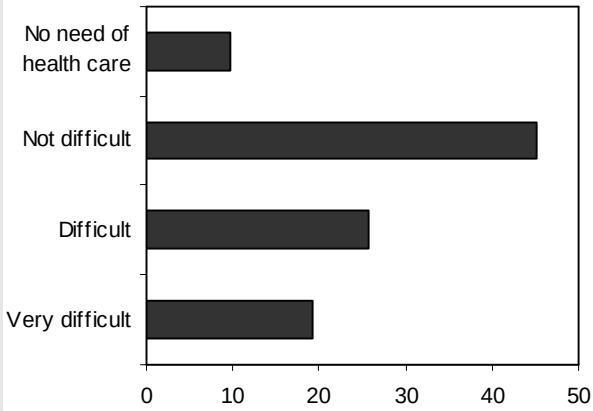


Table 2.3-1. Reasons for not seeking medical help and not visiting hospital

Reason for not seeking (going to)	Medical help	(in hospital)
Thought that they would get better without help	29.86	22.36
Thought they would get better using traditional medicine	6.94	
Thought they could get better using medicaments at home	9.03	
Put off getting help as could not afford	44.44	63.35
It was too far	9.03	3.21
(Unable to get to where services were available)		1.86
(Distrust to the health personnel)		3.21
Other	0.69	6.21
Total	100	

2.4 Concluding notes

Albanians, known for their high life expectancy at a 'very low cost' continue to have good health even after the collapse of Communism. Life expectancy has increased and they report a good overall health. What has recently changed is that this good health cannot be maintained in today's Albania at the same 'low cost'. In fact Albanians will have to pay quite a lot in order to maintain their good health.

One of the reasons is government expenditures on public health, as a percentage of GDP, have gone down dramatically since the collapse of Communism. There is a recent increase which is still not sufficient in meeting the needs of public health sector. This has affected almost all aspects of health care use, with the number of physicians and other medical personnel per 100,000 of population decreasing as well as the number of hospitals and outpatient clinics. However, the new private sector has started to emerge but still not totally compensating for this change.

Inequalities in health and mortality rates within the country are still present with north-east Albania reporting a higher incidence of different diseases, and in particular diseases related to poverty such as respiratory diseases. Inequalities are found also among the poor and non-poor population with the poorest reporting worse health and being more greatly affected by diseases of poverty. The 'Albanian health paradox' remains even in the beginning of the 21st Century, with the population having a low rate of diseases of affluence and a high rate of diseases of poverty, despite a very high life expectancy at birth.

Contrary to popular belief, most Albanians are still making use of the public health service. However, the introduction of the private sector and low salaries for medical personnel have increased the number of informal payments, which with 27% of the population making these types of payments. Despite reforms and an improved standard of living, the majority of the population (about 45.1%) still find it difficult to pay for their health care.

Finally, the analysis of health status and health care system in Albania supports the fact that it is the social inequalities that shape the inequitable health system in the country.

c h a p t e r

3

Poverty and inequalities in education

3.1 Illiteracy and the educational attainment

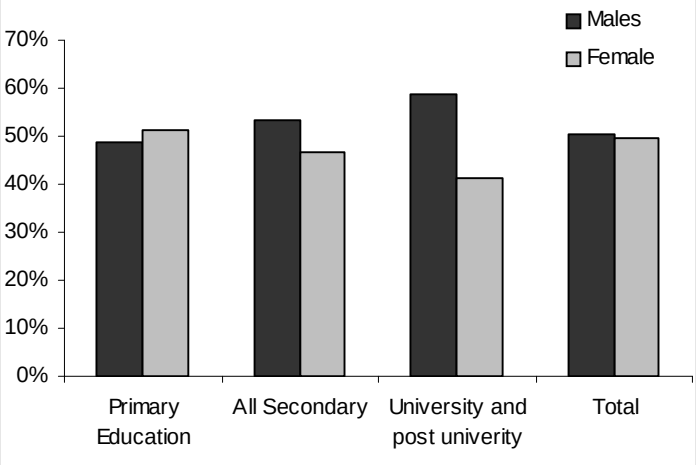
The results from the population and housing census show that the illiteracy rate is less than 2% of the population in Albania for ages 6 years and above. The data from the LSMS show that illiteracy rate is at 5.7% for people older than 14 years old. The difference from the two data sources might be as a result of an artefact of the data, as the first calculations include a large proportion of people from 6 to 15 years old, or may also be because of the two different definitions of illiteracy applied in census and LSMS. When the calculations were carried out for the population 6 years old and above (people that can read and write) the LSMS data, reflected a percentage of illiterate population at 4.6 %. Whatever the definition applied, rate of illiteracy in Albania is very low by contemporary developed societies standards. When gross enrollments are considered there is a clear change in the period from 1990 to 2000. Thus, the gross enrollment for primary education has decreased from 102% in 1990 to about 99.8% in 2002. While secondary enrollment has decreased from about 80% in 1990 to 44% in 2002, the university rate has increased by 5 %. The drop in enrollment for secondary schooling is very significant.

It is a well-established fact that Albania has a highly educated population with a high literacy rate compared to not just countries at the same level of economic development, but to also contemporary developed societies. This is confirmed from different data sources and publications that have focused on Albanian education (Gjonca et al., 1997, INSTAT, 2003, INSTAT-SRC, 2003).

There is not much difference in the illiteracy rates for males and females overall. This is an important aspect to examine as inequalities in education as in a traditional society, as the Albanian one remains today, the educational differences among males and females are good indicators of social equality achievement.

The LSMS data show an illiteracy rate for males at 2.8%, while for females at 6.2%. The census data shows an even smaller difference (1.2% and 1.9% respectively). This rate is likely affected by illiteracy in older age cohorts, as female illiteracy for over 60 years old is 34.8%, while for males is only 12.4%. When educational attainment is examined it is clear that male-female differences are very small overall (Figure 3.1-1). Thus, for primary education the number of female graduates is higher at 52% of all graduates. For secondary

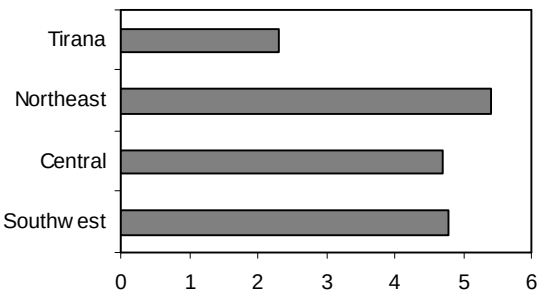
Figure 3.1-1. Educational attainment by level of education and gender (in percentage)



education female graduates is 47% of all graduates. The only level of educational attainment where there is a clear male advantage is the university level, where female graduates compose only 41% of all graduates. However, this pattern will change in the years to come as the number of new students registering in university in the last 10 years has increased for females and decreased for males. By 1999, 60% of students registered in university were females compared to 40% for males (INSTAT, 2000).

The disparities between urban and rural areas has been reduced in the last 50 years. The data from both the census and LSMS show a slight urban advantage in terms of a lower illiteracy rate compared to rural areas. Thus the illiteracy rate in urban areas calculated from LSMS data is at 3.5 % compared to 5.7% in rural areas. The number of graduates per person in urban and rural areas differs substantially compared to other indicators. Thus, the number of graduates per person for primary education is higher in rural areas as compared to urban areas, respectively at 59 per one hundred persons in rural areas and 39 per one hundred persons in urban areas. This pattern changes for secondary education and higher education, with rural areas accounting for only 11.9 secondary graduates per hundred people and 1.1 per one hundred university graduates,. While urban areas 29.7% are secondary graduates and 8.9 % are university graduates (census data). The gross enrollment for urban and rural areas also differs. For primary education, rural areas present a higher rate at 100.2% compared to 99.2% for urban areas (LSMS data). The main disadvantage in rural areas begin at the level of secondary education where gross enrollment is at 70.3% in urban areas as compared to 28.3% in rural regions.

Figure 3.1-2. Illiteracy rate for population 6 years and over by four major regions (in percentage)



Education by regional differences has been analyzed from different scholars in other publications. Thus, a report on the census results by INSTAT in 2003 found out that the previous existing gradient in illiteracy between the north-east and south-west of the country has diminished (Figure 3.1-2). One explanation could be the very low rates of illiteracy, which do not allow statisticians to capture the differences by districts. LSMS data allows an examination of larger regions, based on the four main strata that the data were collected, in the north-east, central, south-west and Tirana. The results are interesting.

There is a clear pattern in Tirana, the most urban area of the country having the lowest illiteracy rate at 2.3%. Most of the other regions are similar, with a slight exception of north-east having a higher rate of illiteracy at about 5.4%. It is not a coincidence that this area is also the poorest of the country, as the relationship between education and poverty has been established. Tirana also has the highest gross

enrollment rate for secondary schooling compared to the other regions with a rate of 81.5%. This regional difference becomes clear when census data is analyzed by region for secondary education. Thus, the north-east versus south-west gradient in secondary school attainment is evident with districts such as Diber, Bulqize, Has, Kukes, Librazhd and Devoll having the lowest number of upper secondary graduates per 100 persons compared to more developed south-eastern districts of Durres, Tirana, Fier, Vlore and Kucove.

When the data is analyzed at the level of poverty, as one would expect, the illiteracy rate is higher among the poor population at about 6.5%, while the rate is only 4.0% for the non-poor population.

3.2 Access and attendance to education

In most transition economies where the labor market is not stable, the rate of temporary and seasonal employment is relatively high. This type of employment requires available laborers as employment opportunities are generated. One way of meeting the needs for this type of employment as experienced in some East European countries has been employment of school age youth. This has especially been the case in societies with high levels of poverty. If the school age population is involved in this type of employment, school attendance will subsequently be affected. Albania has all the conditions to have employment of this kind as it has a high level of poverty and its labor market is not stable. In such circumstances it comes as a surprise to find out that the percentage of people not attending school is very low, approximately 1.94%. There are more males not attending school than females however the differences are small, and females at 1.72%.

Another surprising result is that the percentage of people not attending school is higher among the urban population, with urban areas having a dropout rate of 2.94% compared to rural areas with a rate of 0.81%. It is difficult to explain this pattern. However, it may be that opportunities for employment in general and temporary employment in particular in urban areas are higher than in rural areas.

One has to take into account that, other results at local level show a different pattern, where the dropout rate is mainly a rural phenomenon mainly affecting students of primary education. Most of the students dropping out school are male and the main reason given is economic (HDPC, 2003).

Most of the young people who do not attend school were primary school students about 82% of people dropping school being in primary education. Table 3.2-1 shows the dropout rates for different levels of education. It is clear that the dropout rates are higher for males than females in primary and secondary education. Thus, the rates for primary education are 2.02% for males and 1.75% for females. At the secondary level, the male-female gap increases with males having a rate of 2.85%, while the rate for females is 1.59%. This is not the case at university level. One reason that might explain the high dropout rate at university level for females might be the fact that for females the university age (between 18-22 years old) is also close to the mean age for first marriage. The increased rate of

Table 3.2-1. Dropout rates by the level of education

Level of education	Dropout rates by gender and level of education	
	Males	Female
Primary school	2.02	1.75
Secondary school (incl. vocational)	2.84	1.59
University	0	1.49
Total	2.08	1.72

Table 3.2-2. Reasons given for not enrolling (in percentage)

Reasons for not attending school	Urban	Rural	Male	Female	Primary	Second.	Univers.	Total
Too expensive	2.9	4.4	4	3.8	3.2	9.1	0	3.9
No interest	75	47.5	59.8	53.5	54.9	57.4	50.9	56.5
Agricultural work	0.5	21.5	15.1	14.3	17.7	6.2	0	14.7
Other work	8.4	7.6	10	6	6.4	10.8	36	7.9
School too far	0	7.5	3.3	6.7	6.8	0.4	0	5
Got married	5.2	6.6	2.5	9.4	5	10.5	7.6	6.1
Other	8	4.8	5.3	6.4	6	5.6	5.5	5.9
Total	100	100	100	100	100	100	100	100

marriages coupled with the rate of migration might also be an explanation of high female dropout rates at university level.

To explain why particular groups of population are either not attending, or dropping the school, the LSMS asked respondents questions about the reasons they did not attend or dropped out of school during the academic year. Table 3.2-2 shows the results when people were asked on the reasons why they did not attend the school this academic year.

More than half of people not attending school (56.5%) have lost interest in schooling. The second reason given for not attending school is work in either agriculture sector (14.7%) or other work (7.9%). This is clear when one looks at the reason given from people in rural areas where agricultural work composes 21.5% of all reasons for not attending school. The other important reason given for not attending school related to 'getting married' (6.1%). This response was more significant among female respondents (9.4%) and in the rural areas (6.6%). There was not much difference between categories with respect to the affordability of education. Of the respondents asked only, 3.9% did not attend school because of the expense. The variation for urban rural schooling is not high, with the exception of the university category. When the reasons given are considered by type of schooling, it is clear that the main difference comes from employment in agricultural work and other types of work affecting more people in primary and secondary education. Marriage is also important reason for both secondary and university levels and in specifically for female respondents. This might give some hints at the fact that dropout rates at university level are higher for females.

Table 3.2-3 gives the reasons for dropping out the school in the past year prior to 2002. From the data in this table it is clear that most of the people say that there have been different other reasons why they dropped the school. One thing stands out quite clear and that is work in rural community. The percentage for people dropping school because of work is high at 15.9% in the rural community. Second most important reason given is the poor facilities in rural schools.

Table 3.2-3. Reasons given for dropping out the school (in percentage)

Reasons for dropping out the school	Urban	Rural	Male	Female	Total
Work	0	15.9	3.2	9.4	6
Poor facilities	0	11.5	0	9.4	4.3
Got married	4	0	0	5.4	2.5
Other	96	72.6	96.8	75.8	87.2
Total	100	100	100	100	100

When the rates are analyzed by gender, the percentage of females that drop school for 'getting married' is higher compared to males (almost 0%) supporting evidence that marriage might be an explanation for female university students dropping the school. When people were asked if they intended to go back to school the percentage of people not intending to go back at school is very high at about 87.2%.

Table 3.3-1. School attendance in public and private schools by main regions of the country

Regions	Attendance in public and private schools		
	Public	Private - religious	Private - non-religious
South-West	26.85	17.39	12.91
Central	25.42	47.83	12.9
North-East	34.69	17.39	6.45
Tirana	13.04	17.39	67.74
Total	100	100	100

Table 3.3-2. School attendance in public and private schools by level of poverty

Poverty Line	Attendance in public and private schools			
	Public	Private - religious	Private - non-religious	Total
Not Poor	72.2	80.6	96.8	72.5
Poor	27.8	19.4	3.1	27.5
Total	100	100	100	100

3.3 Public versus private schooling comparison

Similar to the health care system, Albanians continue to make use of the public facilities, with 98.4% of them attending public schooling. Only 1.6% of them go to private school. Of those 0.7% attend private religious institutions and another 0.9% to private nonreligious institutions.

As one would expect, most private schools are located in urban centres (Table 3.3-1). Not unusually, Tirana, has most extensive private school system in place in comparison to the rest of the country. The private schools that do exist understandably operate in the most affluent areas of the country, such as Tirana and is reflected in the data for the poor and non-poor population. Table 3.3-2 clearly shows that similar to the health care system, the education system reflects the same pattern with regard to poverty i.e. the poor cannot afford the private schooling and only 3.1% of this population attend private, non-religious schools. The percentage of students in public schools that receive private tutoring is still very low at about 8%.

3.4 Affordability of education

It is well known that the level of income has a large impact on education in the national, but also at the level of the individual. The average cost of education per household per month in Albania in 2002 is 459.3 leks. This does not include extra costs associated with private tutoring and the cost of transport. On average this cost is not high in household budget of the families. The cost of education comprises only 1.3% of total income per household per month.

As mentioned above, it is clear that poverty and education are strongly related. Figure 3.4-1 clearly indicates that the number of poor households that pay more than 4400 leks per year for schooling is much smaller than the number of the non-poor that pay this amount. However, when smaller amounts are considered it is clear that the percentage of poor households that pay between 0 and 2000 leks per year is higher to the non poor households. This relationship is also reflected when the data is plotted for urban and rural population (Figure 3.4-2). In rural areas people can afford less and pay less for education. This is mainly because poverty is higher in rural areas. as found at the beginning of this paper. Regional data on the cost of education supports this finding that the citi-

Figure 3.4-1. Household distribution by the cost of education by the level of poverty (in percentage)

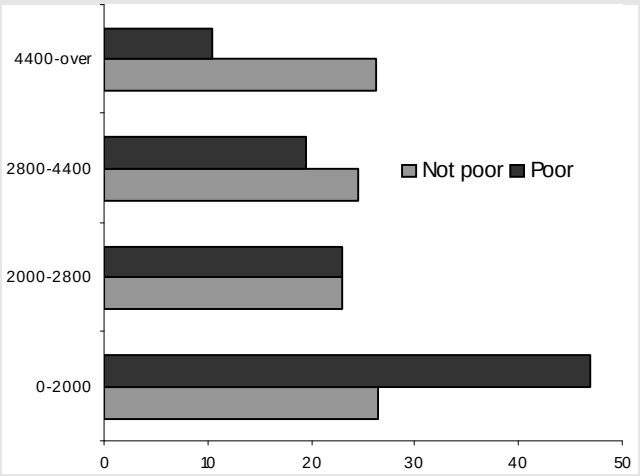


Figure 3.4-2. Household distribution by the cost of education by rural urban division (in percentage)

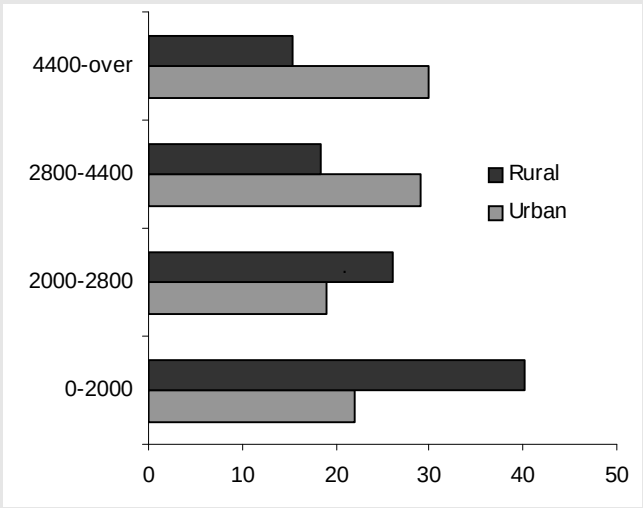


Table 3.4-1. The cost of education by region

Regions	Cost of education per household in percentage				
	0-2000	2000-2800	2800-4400	4400 over	Total
Southeast	26.5	28.5	28.6	16.4	100
Central	40	23.2	18.4	18.5	100
Northeast	34.3	23.2	19.4	23.1	100
Tirana	13.3	5.3	31	50.5	100
Total	32.1	22.9	23.1	21.9	100

zens of themore affluent regions of Tirana pay more for education than citizens in other regions. The percentage of households paying more than 4400 leks per year for schooling in Tirana is 50.5% compared to 16.4% in the south-west, 18.5% in central region and 23.1% in the north-east.

3.5 Concluding notes

The legacy of improved education and education system continues to progress in Albania. Albania in the 21st Century has one of the lowest illiteracy rates in the developed world. However, while illiteracy rates remain low, the same cannot be said for enrollment rates in the country. Enrollment rates have decreased at both the primary and secondary education levels. with the latter being more affected. This has been a consequence of political and economic changes during the 1990s that have made the labor market more flexible, but more insecure. This, among other things has affected the enrollment and dropout rates in the country. This supposition is supported by data that indicates people mainly dropout on the education system for reasons of employment.

While disparities among the different regions in the country have narrowed, there is still a slight inequality with people of urban areas obtaining more education (in particular Tirana and the south-east). Similar to the health care system, Albanians continue to make use of the public school system. The introduction of private schooling is in an early stage in the country with only 1.6% of schooling population attending private educational institutions. This is primarily an urban phenomenon, especially prevalent in Tirana.

c h a p t e r

4

Dwelling Condition and Inequality

It is difficult to judge about the standard of living of an individual or a population without looking at other aspects of poverty apart from the level of income and consumption. In previous chapters we looked at health and educational provisions of the population. Here we focus on another important aspect of standard of living in Albania, such as the state of housing and the basic services that come with it: sanitation, water supply, electricity and heating. These are basic services that in most of the developed societies are taken for granted. However, in Albania the history of the past decades shows that poverty in the infrastructure of provision of basic services is excessive.

This section focuses on aspects of building and dwelling standards, main indicators of crowding as well as the provision of services such as water supply and electricity. The rapid re-urbanization of the country caused by massive internal migration and increased population density in the central and coastal areas (in particular Tirana) have increased the inequalities within the country and amongst different groups of the population

4.1 Conditions of buildings and dwellings in Albania

Analysis from LSMS data shows that the quality of building construction in Albania is relatively good. 93.2% of buildings are either constructed from brick and stones or from prefabricated materials, while 4.2% are still constructed with mud. However, the quality of housing is greatly varied; 11.1% of Albanians still live in inappropriate dwellings, while about 70% live in appropriate dwelling conditions.

Most of the dwellings in Albania are relatively new. Only 7.7% were constructed prior to WWII. During the 1990s there was a boom in construction with 24.5% of dwellings in the country constructed within this period. Also during the 1990s a trend can be seen that presents an increase in housing stock and, at the same time, a decreasing population. This is understandable taking into account the fact that conditions of housing in pre-1990 Albania were at the lowest level of all former Communist countries.

The average number of rooms per dwelling in Albania is at 2.4 rooms for the whole country based on analysis of the LSMS data, while the census data show a slightly lower national average of 2.2 rooms. The number of persons per room for the whole country is 1.9. This figure is high and suggests a relatively high crowding situation in Albania.

The percentage of dwellings with an area of less than 40 square meters is 13.6% (20.2% according to census data) with an area of 40-69 square meters it is 40.1% (40.3% census); 70-99 square meters is 10.2% (8.7% according to census data).

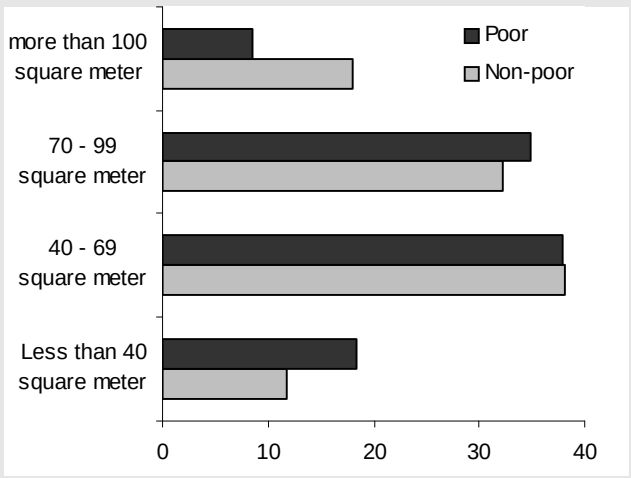
The sanitation situation in dwellings is a severe and significant problem in Albania. Only 63.9% of all dwellings had indoor toilet facilities. Additionally, only 35.9% of dwellings in the country had toilets located outside the dwelling.

Rural-urban and regional differences in housing

The poorer households in the country live in smaller dwellings with 18.5% of the poor population living in dwellings with less than 40 m^2, compared to 11.7% of the non-poorer population living in the same dwelling dimensions. In contrast, only 8.5% of the poor live in accommodation with more than 100 m^2, while 18% of the non-poor lives dwellings of similar dimensions.

It is interesting to note that citizens in regions that are more affluent such as Tirana live in dwellings, that are in better condition than in other regions of the country. 29.8% of people living in Tirana live in dwellings, which are considered in very good condition, compared to only 5.4% of people living in similar conditions in the northeast. The opposite is true for the other regions, where the conditions of dwellings are inappropriate for living. Thus, 23.2% of the population in the poor, northeast region live in dwellings with inappropriate conditions, compared to only 8.3% in Tirana and 9.2% in the central region. Inequalities in the standard of living are also reflected in the conditions of citizens living within rural and urban areas. 90.4% of citizens living in urban areas have toilets located inside the household compared to only 41.6% in rural areas. 44.3% of houses located in rural areas have an outside toilet without piping compared to only 2.8% in urban areas. The situation is more or less the same when the regional comparison is considered. Thus, in Tirana, similar to urban areas, 93.7% of dwellings having toilets inside dwellings, compared to only 46.9% of the poor northeast region. In Tirana, only 1.5% of dwellings have outside toilets without piping compared to 45.1% in the northeast region and 27% of the central region.

Figure 4.3-1. Household distribution by the level of poverty and the space of living area (in percentage)



4.2 Access to basic services and their supply

Analysis of the data on access to and supply of different services support evidence that while poverty can be measured by income is high in Albania, the poverty situation based on access to and supply of services is even more severe. Infrastructure related to the water and electricity supply as well as sanitation and heating, is at a critical state in Albania. Apart from citizens being unable to meet their income needs, a large proportion of Albanians are also deprived of basic services, which adds in the deepening of inequalities in the country.

While some regions of the country, such as urban areas and in particular Tirana have shown signs of improvement in these types of services and infrastructure, the inequality gap compared to the rest of the country has

increased. This inequality is also reflected among different groups of the population with again, the poorer suffering the most.

Water supply

Water supply has always been problematic in Albania, but the situation has become even more severe. This is as a result not only of increased demand for water consumption, but also because of a long-standing lack of investment in water supply infrastructure beginning during the Communist period and remaining to the present day. Only 53.1% of the Albanian population has indoor running water, and only 16% have running water outside of their dwelling. The percentage of the population having no running water outside the dwelling is still very high at 30%.

This lack of investment and the bad management of the existing resources have brought about a situation, where large areas of the country are experiencing major shortages of water supply. Only 47.3% of the population has continuous water supply during the day. The rest of the population has on average only 6 hours of water supply in a day.

It is the poor households that suffer the most from the lack of infrastructure and the lack of resources in the provision of these basic services. When the poor versus non-poor households are compared, it is clear that the majority of the non-poor population lives in households with running water inside the household (57.7%), compared to only 33.9% of the poor population. The percentage of the poor population who have no running water is very high at approximately 41.9%.

When the other aspects of poverty are considered, it comes as no surprise that rural-urban division reflects a division in the country with rural areas being less affluent than the urban zones. A very similar situation comes where the analyses are carried cent age of population with running water inside the household is only 23.6% compared to 88.4% in urban areas. What is more significant is the very high percentage of households with no running water supply in rural areas, approximately 52%. The same picture can be portrayed when regional comparison is considered. Thus, 92.3% of Tirana's households have running water inside the household, compared to only 33.9% in northeast region. 33.2% of households in north-east Albania have no running water at all within the dwelling.

Figure 4.5-1. Household distribution by the type of water supply and the level of poverty (in percentage)

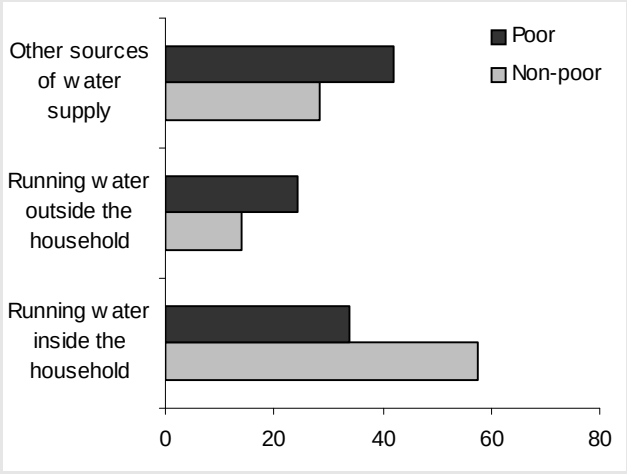
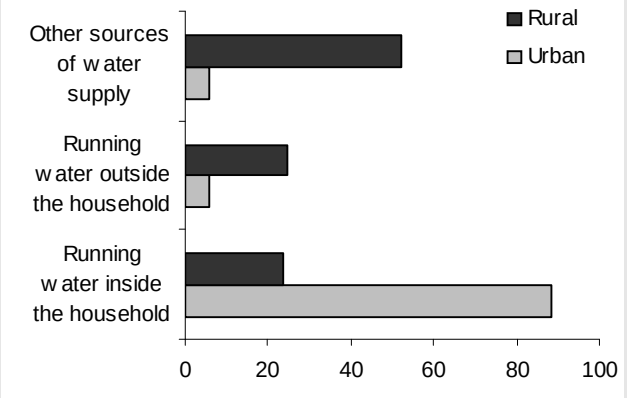


Figure 4.5-2. Household distribution by the type of water supply for rural and urban areas (in percentage)



Electricity and Heating

As previously mentioned, access to electricity in Albania has been universal for several decades now. However, problems with its supply date back to the 1980s, where the country could not meet even at that time its own needs for electricity supply and shortages of electricity were part of the life of Albanians. The analysis show that the present situation has not improved and even worsened.. This comes first as a result of an increased demand for electricity consumption within households. The improved living conditions during the 1990s meant that Albanians had more electric appliances at home compared to the past. Apart from that, the liberalization of the market brought about an increased number of small and medium businesses, which has also increased the demand for electricity quite rapidly. While the demand has increased, the resources to meet this increased need have not kept pace. Even the existing resources have not been managed properly during this period. This situation has made the supply of electricity as one of the most prominent and acute problems that Albanian society is facing at present.

Approximately, 85.7% of Albanian households have some form of power cut. Additionally, 71.5% of Albanian citizens experience power cuts on daily basis. The average daily shortage of electricity supply is approximately 8 hours per day.

The same situation is found with respect to heating issues in the country. Central heating is almost non-existent in Albania. This was the case before 1990 and it is still the case today. The situation of heating appears not to have improved in the country even after 1990. Approximately, 99.9% of Albanians have no central heating at all. The majority of Albanian population, about 58.1% of still use wood for heating, with gas as the second heating source (25.4%) and electricity the third source of heating (13.5%) across the country.

When poverty is considered it is clear that the poor population must choose the cheaper and most available source of heating. Thus, 75.1% of the poor population uses wood for heating compared to 54.1% of the non-poor population. The percentage of the non-poor households that use, either electricity, or gas is high at about 43.06% compared to poor households of approximately 21.3 %. The same situation is found when rural to urban comparison is considered. 81.3% of the rural households use wood as the main source of heating. While the main source of heating in urban areas is gas (39.3%) and electricity (25.4%).

4.3 Concluding notes

The analysis in this section shows that poverty and inequality in terms of infrastructure of provision of basic services is a grave and very serious problem in Albania in 2002. The high rates of internal migration and urbanization in the country have concentrated the population in the coastal area and in particular Tirana. This has increased the inequalities within the country and among different groups within the population.

A construction boom occurred during the 1990s, with approximately 25% of all buildings constructed during that time. However, the present situation shows that there is still a shortage of dwellings in the country. Crowding is a common phenomenon with a national rate of 1.9 people per room. People living in more affluent regions live in better housing conditions, especially in Tirana.

The sanitation situation is grave, with only one third of the households having a toilet outside the dwelling. The disparities within the regions and urban-rural are large with Tirana representing only 1.5% of the dwellings with outside toilets without piping, compared to 45.1% in the north-east of the country and 27% in the central region.

While poverty as defined by income level is high in Albania i.e. almost one quarter of Albanians living under the poverty line, the poverty situation with regards to physical infrastructure and service provision is even more severe and worsening over time.

Large areas of the country are experiencing major shortages of water supply, with less than half of households having running water, and the rest having, on average, only 6 hours a day of water supply. As expected it is the poorer households that suffer the most.

The situation of electricity supply has worsened since 1990, with 85.7% of households experiencing some form of electricity shortages. The average daily shortage of electricity supply is approximately 8 hours a day.

Heating remains a continuous problem in Albania with 99.9% of the population still having no central heating, and more than half continuing to use wood stock as the main source of their heating supply.

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