

Informal Patient Payments
in Central and Eastern European Countries

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INFORMAL PATIENT PAYMENTS
IN CENTRAL AND EASTERN EUROPEAN COUNTRIES

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CHAPTER 1.

GENERAL INTRODUCTION

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1.1. Scope of the dissertation

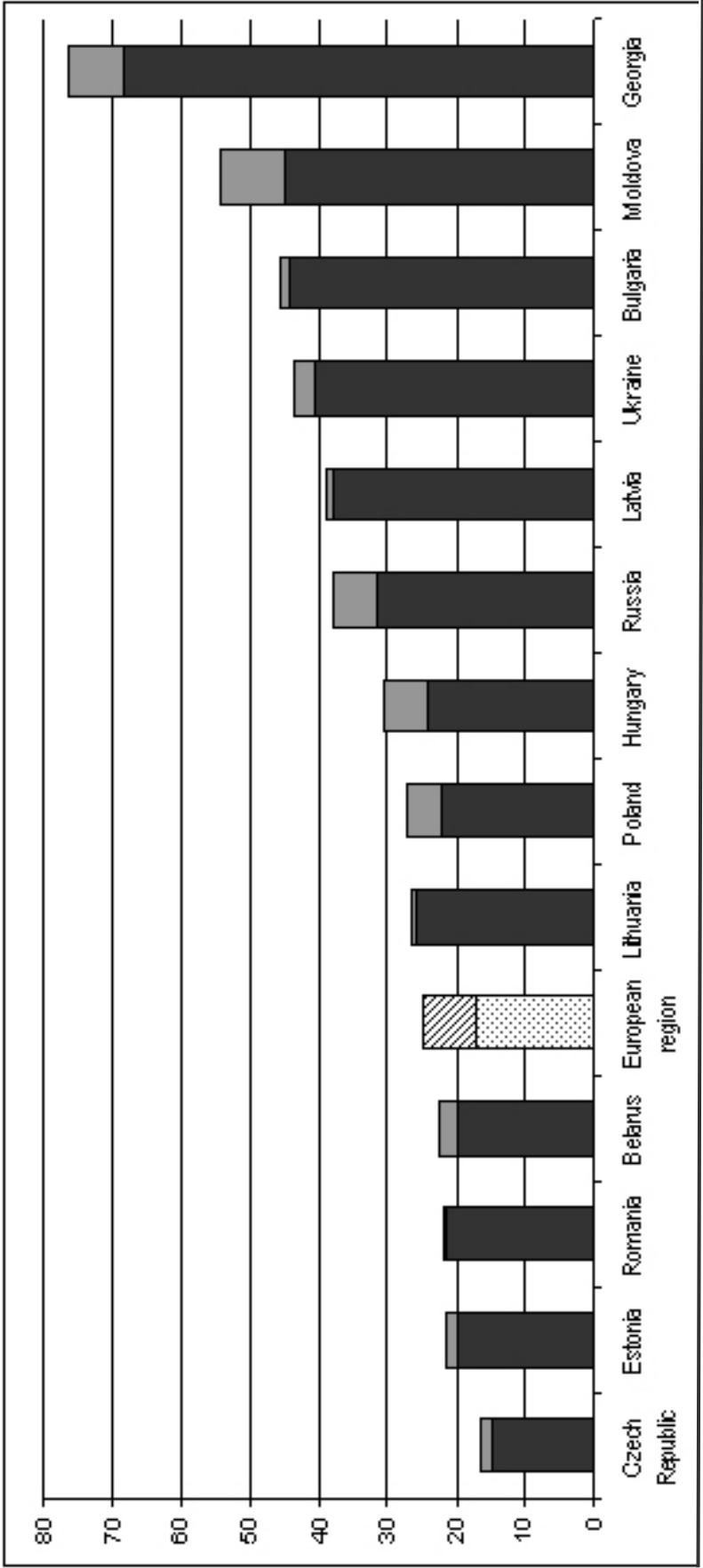
The funding of health care systems in Central and Eastern European (CEE) countries has changed considerably since the late 1980s. Major reforms in most of these countries have led to the introduction of social health insurance that replaced the tax-based system funding established during the communist period¹. Additionally, new patient payments policies and practices appeared which turned the out-of-pocket payments into a major source of health care funding in this region (Rechel & McKee, 2009). As shown in Figure 1.1, the share of out-of-pocket payments in total expenditure on health care (dark shadowed areas) varies from 16.3% in the Czech Republic to 76.4% in Georgia (WHO, 2012). In virtually all countries, this share is higher than the European average.

Out-of-pocket payments in CEE countries take different forms, namely formal, quasi-formal and informal payments. Formal payments refer to official patient charges for public and private health care services and are regulated by national legislation. Quasi-formal payments are also official but they are set by the health care provider in the absence of clear government regulations. Informal payments (also known as “under-the-table” or “envelope” payments) comprise all unofficial patient payments for publicly-funded health care services. They are unregistered and hidden, and are not always included in the estimates of private health care expenditure (like those shown in Figure 1.1). Still, analyses indicate that informal payments constitute about 1.5-4.6 % of total expenditure on health in Hungary (Gaal, 2006; Baji et al., 2011; Pavlova et al., 2012), about 0.3-0.5 % in Poland (Golinowska et al., 2008; Pavlova et al., 2012) and about 2% in Bulgaria (Atanasova et al., 2011; Pavlova et al., 2012).

Compared to formal and quasi-formal charges, informal patient payments claim more attention as ignoring these payments causes an underestimation of total health expenditure and their hidden nature imposes a great challenge to health care provision in terms of accessibility as well as accountability and transparency. These payments are a threat to public health since they jeopardize efficiency, quality and equity of health care provision (Bonilla-Chacin et al., 2005; Gaal, 2010; Gaal & McKee, 2005; Gelormino et al., 2011; Gordeev et al., 2011; Szende & Culyer, 2006). Most importantly, those who cannot afford to pay informally might receive inadequate care, or even delay seeking treatment (Balabanova et al., 2004;

¹ In this dissertation, the term “communism” is used to label the political ideology that governed the CEE countries before 1989/91, and the term “socialism” is used to label the economic arrangements that prevailed in these countries during that period. Thus, throughout the dissertation, the phrases “communist period”, “communist context”, “communist regime” and “communist past” reflect the political system, and “former-socialist countries” reflects the economic system in CEE countries before 1989/91.

Figure 1.1. Out-of-pocket and other private health care expenditures as a percentage of total expenditure on health care in CEE countries in 2010



Notes: Bars present the share of private expenditure in total expenditure on health. Dark shaded area is out-of-pocket expenditure and light shaded area is other private expenditure (e.g. private insurance). Informal payments are not always included. Source: WHO, 2012

Burak & Vian, 2007; Gaal & McKee, 2004; Tambor et al., 2010). This dissertation focuses on the phenomenon of informal patient payments and in particular on the cross-country comparison of the determinants, level and scope of these payments in the CEE region.

Informal patient payments in CEE countries are of a multi-dimensional nature. They include both cash and in-kind contributions given to publicly-funded health care providers by patients or patients' relatives before, during or after the service is provided. Such payments are observed in both out- and in-patient care. Although the existence of informal payments is publicly known, the specific informal transaction takes place in secret without divulging detailed information about the individuals involved (Cohen, 2012). Still, informal patient payments are not always perceived as illegal (Ensor, 2004; Gaal et al., 2006; Lewis, 2000) especially when the legislation and codes of ethics (even the moral codes) in the country fail to prescribe proper conduct and behavior. As a result, informal patient payments are typically not prosecuted in the CEE countries. Besides, the health care sector is not unique for such behavior. Informal payments are also present in other areas, e.g. in education, police, court and custom offices (Miller et al., 1998). Thus, general moral dispositions in society such as "everything that is not forbidden is allowed" may well predispose the existence of informal payments in the health care sector.

In fact, there are various explanations for the existence of informal patient payments in the CEE region (Balabanova & McKee, 2002; Gaal & McKee, 2005; Lewis, 2007; Thompson and Witter, 2000). The culture of giving gifts seems to be the most straightforward explanation that applies beyond the borders of a single country. However, in the context of inadequately funded public health care services, informal payments also provide a means for CEE patients to receive services with quicker access and better quality, as well as for health care providers to obtain a respectable reimbursement for services provided (Belli, 2002; Chawla et al., 1998; Cockroft et al., 2008; Tatar et al., 2007). Governments who are unable to adequately reform and fund their health care sector, often neglect and condone the existence of such payments (Lewis, 2006; Shahriari et al., 2001; Thompson & Witter, 2000). Therefore, informal payments are seen as an indicator of problematic areas in health care funding and organization. Hence, when the government fails to ensure the provision of adequate health care, patients and providers resort to informal payments (Cohen, 2012).

This dissertation studies informal patient payments in six CEE countries – Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. The countries present an interesting context for a cross-country comparison given the past similarities in their health care sectors (the Semashko type of health care systems) and in the general socio-political environment

during the communist period. All of these countries experienced radical economic and cultural changes in the era after the fall of the Berlin wall (Berend, 2007; Rechel & McKee, 2009). However, the pace of the reforms was different: faster in Central European countries (e.g. Hungary and Poland) and in Baltic countries (e.g. Lithuania), slower in Balkan countries (e.g. Bulgaria and Romania), and especially slow in former Soviet republics in Eastern Europe (e.g. Ukraine). This brought an analogous diversity not only in the economic and socio-political development of the CEE countries but also in their health care sectors (see Appendix A). Overall, the health care system performance in Eastern European countries is lagging behind that in Central European countries (Health Consumer Powerhouse, 2010). Nevertheless, informal patient payments remain a key characteristic of nearly all CEE health care sectors. A cross-country analysis of the determinants, level and scope of these payments in the CEE region, which is the main goal of this dissertation, enables a better understanding of the informal payment phenomenon in the context of different health care policies and systems.

1.2 Research on informal payments for health care services

Researchers' interest in informal patient payments has been increasing during the last decades (Cohen, 2012). Although cross-country comparisons are sparse, the scope and scale of informal patient payments in single countries, as well as the determinants of these payments, are widely studied. Also, theories from the field of economics, management and psychology are applied to explain why informal payments exist and how they affect health care provision (Burak & Vian, 2007; Gaal & McKee, 2004; McPake et al., 1999; Özgen et al., 2010).

1.2.1 How pervasive are informal patient payments?

Studies show that informal patient payments are not unique for CEE countries. They are a well-known phenomenon around the world. The practice of small gifts (flowers, chocolates, wine) given by the thankful patient to health care staff after service provision, exists in many countries (Abbasi & Gadit, 2008; Barr, 1996; Chiu et al., 2007; Lyckholm, 1998). Such gifts are not typically expected by providers. Although it is recognized that such gifts should be regulated and monitored, they are not seen as a problem in health care provision as long as patients, who do not give gifts, are not deprived from adequate health care services (Dodge, 1978; Greenberg, 1990; Orentlicher, 1994). Rubin (2012) even argues that such small gifts to

physicians should not be forbidden since gift refusal may hurt the tender affection of the patient. Therefore, in exceptional cases, medical professionals have asserted their right to accept small gifts from patients. However, when expensive in-kind gifts to physicians in exchange of better or quicker services, become a common practice and when informal cash payments appear, concerns about equity in access to adequate health care start to emerge (Allin et al., 2006; Barber et al., 2004; Ensor & San, 1996).

A huge variety in the nature and patterns of informal patient payments is reported across countries. Studies provide evidence on the variation of payment type (cash or in-kind gifts given by patients or their families), timing (before, after or during service provision), subject (out- or in-patient service), purpose (obtaining better quality or access), and motivation (physician's request or patient's initiative) (Balabanova & McKee, 2002; Belli et al., 2004; Cockcroft et al., 2008; Delcheva et al., 1997; Ensor, 2004; Falkingham et al., 2010; Gaal & McKee, 2005; Lewis, 2002; Shishkin et al., 2003; Tediosi et al., 2008; Thompson & Witter, 2000). By and large, informal payments are observed in all patient groups irrespective of socio-economic status (Belli, 2002; Falkingham et al., 2010; Tomini et al., 2011).

Ensor (2004) defines three main groups of informal patient payments, which can be linked to the key health care actors: (1) informal payments related to the inability of health policy-makers to reform the failing health care system (i.e. payments that cover the costs of medical supplies and personnel when health care budgets at the health care facilities are insufficient); (2) informal payments that result from the providers' misuse of market power (because of monopoly or principle-agent relations between providers and patients); (3) informal payments that result from the consumer's attempt to access better services or services that are not included in the benefit package (e.g. better hotel services, innovative treatment and procedures, for example laparoscopic in contrast to invasive). The differentiation between these groups of informal payments is essential because it can show the roots of the informal payment phenomenon (Ensor & Savelyeva, 1998; Gaal & McKee, 2005).

As empirical evidence suggests, developing and transition countries are more often affected by informal payments because the economic and socio-cultural environment is more conducive to "gifts" exchange as a means to maintain the underfunded health care system (Allin et al., 2006). Overall, the boundaries between informal payments and true gifts are not always easy to determine (Polese, 2008; Wanner, 2005). Still, in countries like France, Italy and Greece informal payments for health care services are also known (Bellanger & Mossé, 2000; Calltorp et al., 1994; Mossialos, 2002; Health Consumer Powerhouse, 2008). The level

and incidence of informal payments are difficult to compare across studies because of different methodological approaches used, as well as differences in the timing of data collection. However, previous research has shown that in countries, such as those in Central Asia, the size of informal payments is substantial in terms of both the share of GDP and the share of total health care expenditure (Baschieri & Falkingham, 2006; Lewis, 2002; Lewis, 2007; Gaal et al., 2006; Rechel & McKee, 2009). For example, about 84% of total expenditure on health care in Azerbaijan is reported to be informal (Lewis, 2000). In some instances, physicians are found to earn as much as a full additional salary from informal payments (Baji et al., 2011; Betliy et al., 2007; Ensor & Savelyeva, 1998; Falkingham, 2004; Kornai, 2000).

1.2.2 How do informal patient payments affect the health care system?

Empirical evidence suggests that informal patient payments affect the health care system in a complex and interrelated manner. Their impact on health care provision is revealed at the macro (system) level as they impede health care reforms, and at the micro (service) level by creating barriers to adequate care.

Informal patient payments present a problem for policy-making since they are unregistered and thus, they hinder the estimation of the actual size of private expenditures in a country (Chawla et al., 1998). Furthermore, informal patient payments can distort policies that aim to improve the efficiency of health care services. For example, the physician may be reluctant to provide detailed information about the diagnosis and treatment, or may avoid referring the patient to the most suitable specialist, or even ignore the patient if no informal payment is offered (Allin et al., 2006; Cohen, 2012; Ensor, 2001; Gaal et al., 2006; Lewis, 2002; Lewis, 2007; Pavlova et al., 2010). Consequently, informal payments may affect the physician's decision on what services to provide and to whom to provide them. Informal payments given by consumers are seen as incorporated incentives to a certain group of physicians. Parallel to the informal payment however, physicians or health care facilities also receive a formal reimbursement (public funds) for services provided. Thus, although at first sight both providers and informal payers benefit from the informal exchange, the allocation of public resources is also affected by the individual willingness to pay informally, not just the social value of the use of these resources. In addition to allocative efficiency, the cost-effectiveness of health care provision can be also undermined if there are patients willing to receive (and willing to pay informally for) less cost-effective services. In view of this,

informal patient payments can become a major impediment for health care delivery and reforms that aim at the efficient use of public health care resources.

Although informal payments may help individual patients to obtain services with better quality (Mæstad & Mwisongo, 2011; Thomson and Xavier, 2004), there is no evidence that these payments significantly contribute to the improvement of clinical quality in the health care sector in general (Gaal & McKee, 2005). Empirically tested (e.g. quasi-experimental) findings that support or refute the impact of informal payments on the attributes of services provided (including quality attributes) are lacking. It is recognized however that health care providers may artificially provide sub-standard care in order to extract informal payments for a return to the usual quality standards (Gaal & McKee, 2005). Also, health care providers are not interested in reinvesting the informal payments in the public health care system (e.g. purchasing new medical equipment) but are more likely to invest them in their own private practices or use them to supplement their income (Belli et al., 2004; Gaal et al., 2006; Kornai, 2000; Mæstad & Mwisongo, 2011). In the long-run, this may lead to better quality of services provided in the private sector (for those who can afford to pay the fees) than in the public sector, even if provided by the same physician. Thus, public health care provision remains under-funded and of low quality even when informal patient payments are widely spread (Ensor & Witter, 2001; Lewis 2000; Precker et al., 2002).

The most adverse effects of informal patient payments concern equity. When informal patient payments are established as a practice, patients who lack funds or social protections, and cannot afford to pay informally, either avoid or delay seeking treatment (Lewis, 2007). Frequently, they use personal savings, take out loans and sell assets to cover these payments. The ultimate effect is the same as referring patients to the private health care sector. In some instances, low-income patients are found to pay informally proportionally more in relation to their income than high-income groups. In fact, informal patient payments are highly regressive even when compared to formal co-payments (Baji, 2012; Mastilica & Božikov, 1999; Özgen et al., 2010; Thompson & Xavier, 20002). The idea that physicians (guided by a “Robin Hood” principle) charge rich patients informally and provide free-of-charge service to poor patients, is not supported by empirical findings (Szende & Culyer, 2006).

Given the above, informal payments are considered to be a key challenge to health policy-makers. A better understanding of the country-specific context and the roots of informal patient payments is essential for the design of adequate strategies for the elimination of these payments, as well as for the successful application of these strategies (Vian et al., 2006; Vian, 2008).

1.2.3 Why do informal patient payments exist?

The literature suggests a variety of interrelated factors which are associated with informal payment practices. Different authors (Gaal & McKee, 2005; Thompson & Witter, 2000; Tomini & Maarse, 2011) argue that the presence of informal patient payments can be explained by the tradition of giving gifts, as well as by other cultural, social and ethical factors that do not directly affect the health care system. However, solely cultural and moral factors can not fully explain the variety of informal payments. The term “multiple moralities” (Wanner, 2005, p.530) emerged during the transition period. The collapse of the restraints and the strong punishment system on the one hand and the political and economic changes in the former soviet countries (especially those related to public services provision, its accountability and transparency) on the other hand are seen as key factors of resorting to informal exchanges during the transition. The informal exchanges serve as a means for individuals to achieve at least individual welfare when the state fails to ensure social welfare (Wanner, 2005).

Under these cultural and moral conditions, it is important to take into account the double nature of informal patient payments since these explanations do not fully apply to informal payments requested by health care providers. In particular, payments requested by health care providers, do not necessarily reflect unethical provider’s behavior. Low salaries for health care staff seem to be a good excuse for these solicited payments (Miller et al., 2000; Balabanova & McKee, 2002), so they are more widespread in situations of chronic underfunding of the health care system (including lack of medical supplies, commodities, and sanitary aids). In other words, when certain goods or services (like health care) have to be accessed, it is not only morality or values inherited within primary socialization that rule human actions. Economic factors, such as low physician salaries and low health care funding, as well as managerial and legal aspects, and poor governance also matter (Ensor 2004; Gaal & McKee 2005; Tomini et al. 2012).

Overall, four basic dimensions mentioned in the literature (Gaal & McKee, 2005; Mossialos, 2002; Tambor et al., 2010; Tomini et al., 2011) – socio-cultural factors, economic and labor factors, political and regulatory factors, and health care systems in particular – can be used to classify the factors that shed a light on the causes of informal payments. Table 1.1 presents the key factors and possible indicators per dimension together with an explanation of their relation to the presence of informal patient payments.

It should be pointed out however that the dimensions (factors and their indicators) presented in Table 1.1, are rather interwoven jointly leading to the existence of a specific pattern of informal payments in a country. For example, the existence of informal payments is associated with insufficient health care system funding and low physicians' salaries (health care system dimension in Table 1.1). This offers an explanation of why health care providers request informal payments and emphasizes the providers' role in the informal payment chain. However, insufficient health care system funding is largely a result of poor economic circumstances (economic and labor dimension in Table 1.1). Low earnings in the country imply low general tax revenues and low social insurance contributions, which in turn limit the resources available for public health care provision. Thus, the two dimensions, the health care sector and the economic and labor environment, are interrelated and it might be difficult to distinguish their intertwined influence in practice.

Similarly, the socio-cultural factors (including indicators such as attitudes and perceptions in Table 1.1) indicate the role of society but also the role of the patient as a key element of the informal payment chain (health care system dimension in Table 1.1). Thus, even when the informal payment is requested, the patient makes the final decision to resort to an informal transaction with the provider or not. In other words, the patient is able to pour oil in the flame of the defective regulatory mechanisms and the economic climate that leads to informal payments. But it is also the patient who initiates informal payments as a means to obtain the desired services. Cohen (2012) describes this behavior as a 'do-it-yourself' approach - an adaptive strategy of an individual who is unsatisfied with government services and is willing to apply different (e.g. informal or 'extra-legal') approaches to fulfill health care needs. Therefore, theoretical discussions (Gaal & McKee, 2004) and empirically tested theories (Burak & Vian, 2007) offer a deeper look at individual's motives for informal payments.

Still, authors recognize that informal payments rarely dominate under well-designed regulations and good governance of the health care sector (Cohen, 2012; Gaal & McKee, 2004; Tomini & Packard, 2010). This indicates the role of health policy-making for the existence of informal payments (health care system dimension in Table 1.1). Thus, the "do-it-yourself" approach described by Cohen (2012) is applied when a clear health policy is lacking. Stated differently, it plays the role of "alternative politics" in the health care sector.

Additionally, the general political and regulatory environment (Mossialos, 2002; Pavlova et al., 2012) is also essential (political and regulatory dimension in Table 1.1). Indeed, the lack of transparency and accountability facilitates corruption in many areas, not

Table 1.1. Dimensions, factors and indicators that explain the presence of informal payments

Dimensions	Factors	Example indicators	Explanation
Health care system	Health care funding and policy	Total/government expenditure on health Level and structure of user charges Allocation and management of funds	Inadequate levels of health care funding, efficiency, and equity of service provision provides incentives to health care providers and patients to resort to informal payments in order to achieve their expectations for a reasonable income and service quality respectively. Low level of physician salaries and line-item budgets lack incentives to increase productivity and satisfy patient's needs.
	Health care organization and provision	Range and reach of services GP practice functioning Range of competing health facilities	
	Health care providers	Type of provider payment mechanism Providers' aspirations and expectations Moral standards of the medical profession	
	Patients	Willingness and ability to pay Patients' preferences	
Socio-cultural environment	Demographics	Age structure of the population Dependency ratio	Wide-spread informal payments can be associated with deeply rooted gift-giving culture and social acceptance of undeclared (informal) transactions. The abilities of individuals (and the society in general) to change their attitudes and perceptions may depend on education level and demographic factors (for example, age structure).
	Social factors	Level of education and literacy Civil society functioning	
	Social psychology and moral	Attitudes towards corruption Attitudes towards informal transactions Moral standards of citizens	
	Culture	Culture and cultural belief in gifts Perception of tipping and gratitude money	
Economic and labor environment	Labor	Employment opportunities Levels of unionization Level of capital mobility	Economic growth reduces the need of a grey economy and informal transactions. A well-functioning labor market gives alternatives to physicians who are not satisfied with work conditions and reimbursement.
	Economic circumstances	Rate of economic growth Size of the informal economy Income rates	
Political and regulatory environment	Politics	Appointment of new ministers New governments Joining to unions, e.g. to the EU	Good practices in politics and governance facilitate a bribe-free environment. Adequate regulations are reflected in proper performance (e.g. no informal payments). Lack of regulations in terms of ethics (e.g. Code of Ethics) can create atmosphere conducive for informal payments.
	Governance	Stability of political institutions Control, accountability, transparency Levels of corruption Political will to combat corruption	
	Ethics	Clear professional and ethics codes	

Source: Cohen, 2012; Ensor, 2004; Gaal et al., 2006; Gaal & McKee, 2005, 2006; Leichter, 1979; Lewis, 2007; McPake et al, 1999; Mossialos, 2002; Thompson & Witter, 2000; Tomini & Maarse, 2011; Walt, 1998.

only between patients and physicians but also in procurements, and in the administration-physician relation (Vian, 2008). Even further, the presence of informal practices and the depth of their roots also influence the pace and quality of the general reforms in the country (Thompson & Witter, 2000). The lack of consensus among policy-makers in following common political values, in the recognition of informal patient payments as a problem, and in the introduction of relevant measures to eradicate them, is often noticed (Allin et al., 2006; Balabanova & McKee, 2004; Cohen, 2011; Lewis, 2000).

Thus, the four dimensions presented in Table 1.1 jointly shed a light on the informal payment phenomenon. The monitoring of key indicators related to each dimension is essential when attempting to eradicate the practice of informal payments. In particular, policy interventions in this direction should be primarily focused on the most problematic dimensions. However, the rest of the dimensions should be also taken into account to assure the effectiveness of the intervention.

1.3. The escalation of the problem of informal patient payments in CEE countries

In CEE countries, informal patient payments have been observed to exist since the 1970s (Mossialos, 2002; Gaal, 2004). However, the phenomenon of informal payments emerged much earlier and existed also in Western European countries. It seems that in the past, patients in any country brought in-kind donations for family doctors on a regular basis in order to show thankfulness for their work (Adam 1985, 1986 in Gaal & McKee, 2005; Levene & Sireling, 1980). As Winslow (1946) has noticed over sixty years ago, “the tribute from one “g.p.” (the grateful patient) to another “g.p.” (the general practitioner) is a supplement to - not a substitute for - an assured income” (p.316). Most obvious, in Western European countries, informal payments diminished or even disappeared as a result of a drive towards more transparency, as well as accountability and control, and greater emphasis on professional norms and conduct (Bovi, 2003; Williams, 2005). Health care reforms, most notably the introduction of universal and generous health insurance systems which ensured physicians of a stable and adequate income have also contributed to elimination of informality in the patient-physician relation (except for small gifts given occasionally by some thankful patients). Gradually, a culture emerged in which informal payments were wiped out from the patient-physician relation (Bass & Wolfson, 1980; Greenberg, 1990; Orentlicher, 1994). At the same time, informal patient payments flourished in the CEE communist context.

Until the 1990s, market regulatory mechanisms such as prices and competition were not applied in CEE countries due to the existing socio-political arrangements. However, the low public health care funding in the CEE region (in the absence of private spending) led to insufficient health care resources and inequalities in access to public services and goods. Hence, a variety of informal strategies dominated in health care and other ‘non-productive’ sectors (Ensor, 2004). Indeed, ‘*blat*’ (the attainment of public goods through personal connections often anchored in long-term social relationships) became a ruling approach in social life and relations (Ledeneva, 1998; Patico, 2002; Rivkin-Fish, 2005; Salmi, 2003). Because of shortages in goods (rather than money) during the communist period, informal payments in the form of gifts like perfumes and alcohol, were especially appreciated in contrast to cash payments. The health care sector was no exception to the “ideologies of gift exchange” (Patico, 2002, p.346). Similarly to other sectors (Ledeneva, 2006), gifts and barter supported by reliable connections, dominated in health care provision. Patients relied on these strategies mainly to motivate the underpaid health care staff and to receive better medical attention.

In the late 1980s, the CEE societies started a transition process, which brought drastic changes in social values, social life, economic situation and in political arrangements (Berend, 2007). In particular, the collectivism with its link to wider social networks gave way to more individualistic approaches based on personal capital. Also, health care systems in CEE countries were faced with a dramatic decrease in public funding despite that the excessive health care infrastructure and large benefit packages established during the communist period, were preserved.

These changes affected informal patient payments in the health care sector as well. During the transition period, cash informal payments started to play an important role since they facilitated the maintenance of living standards of the health care staff who received them. Items that were valuable before, lost their importance because they became available at the market (Patico, 2002). During this period, the terms “under-the-table”, “envelop” payments but also “bribes” or “corruption” became common labels for “gratitude” money to physicians (Kornai, 2000; Rogers, 1997). Although informal patient payments are not exclusively seen as a transition feature, the prevalence of informal payments is thought to be higher in the post-communist period compared to the past (Gaal, 2004).

Currently, new trends in health care services provision (establishing social health insurance and emerging formal and quasi-formal patient charges) have resulted in new purposes for informal patient payments in the CEE region. For example, after the introduction

of official waiting lists, attempts of patients to avoid such lists or at least reduce waiting time through informal payments are noticed in some CEE countries (Gaal, 2004; Tymowska, 2001). Informal patient payments are also seen as a tool to obtain more specialized services, which provision is restricted by the health insurance system (Chawla et al., 1998; Shishkin et al., 2003). Although informal patient payments are most often reported for services included in the basic health care package, services outside the basic package are also affected. Hence, informal patient payments became widespread in the CEE region and their diverse patterns reflected the difficulties in accessing certain health services in the public sector.

1.4 Health care systems of the six CEE countries included in the study

The transition from a state-planned to a market economy has created a mix of contrasting political and social values, and a continuously changing socio-economic environment in the countries in the CEE region (Deppe & Oreskovic, 1996). Though, the CEE countries have a lot in common, they also show some diversity in terms of economic development, demographic patterns, and health indicators. Hence, the influence on consumers' perceptions and their spending decisions varies. The characteristic features of the six countries included in this study (Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine) are briefly described in this section.

Generally, a shortage of resources, a lack of good governance (e.g. lack of transparency and accountability) as well as other disadvantageous trends (poor health indicators, unemployment, low salaries of medical staff, lack of trust) are considered to be characteristics of all countries included in the study as shown in Appendix A (Kuszeowski & Gericke, 2005; Gaal, 2004; Lekhan et al., 2010). However, the extent of these problems differs between countries. In particular, the rates of political stability, government effectiveness, and per capita government expenditure on health are higher in Hungary, Poland and Lithuania than in Bulgaria, Romania and Ukraine. However, maternal mortality index in Hungary is quite high and comparable to that in Romania and Ukraine.

In order to compare the context of the six countries, we draw upon the SPACE-matrix analysis. The SPACE-matrix (Strategic Position and Action Evaluation Matrix) analysis is a management tool to determine the competitiveness of an organization at the market place. It uses a set of pre-selected indicators of four key dimensions of competitiveness, namely the organization's financial strength, the organization's competitive advantage, the stability of the external environmental and the general strength of the industry. The exact indicators per

dimension depend on the type of organization and its industry. Based on the value of the indicators for a given organization, an average score per dimension is calculated for that organization. The average scores are used to portray the organization's profile. The shape of the profile indicates the competitiveness of the organization and possible strategies for the improvement of its market position. Profiles of different organizations are used to compare the competitiveness of these organizations (for more details regarding the SPACE-matrix method see Swayne et al., 2008). Although the SPACE-matrix method is usually applied at an organizational level, applications of the method at country level are also reported (see e.g. U.S. Government Assistance to and Cooperative Activities with Eurasia, 2007). Country-level applications can help to highlight the position (strategic goals and barriers) of a given country compared to others.

We apply this tool to determine the conduciveness of the environment in the six countries to informal payments. We use the four dimensions of the presence of informal patient payments described in Table 1.1, namely economic and labor factors, socio-cultural factors, political and regulatory factors, and health care system factors. For each dimension, we select five key quantitative indicators whose values are readily available for all six countries from a single source though from different years (see Appendix A). This means that important indicators (such as average physicians' salary per country) are omitted because their values are either not available or are available but from different sources, which questions their comparability. The indicators and their values per country are presented in Table 1.2.

The values of the indicators are used to calculate standardized scores per indicator per country. In particular, for each indicator, we sum up the six country values and then for each country, we divide the country value by this sum. As a result, the country values are rescaled and the new values fall in the range from 0 to 1. High original values of an indicator indicate low conduciveness to informal payments (e.g. in case of GDP, health expenditure, etc.), but in the new rescaled values these are reversed. Thus, a high standardized score per country per indicator in Table 1.2 indicates a relatively high conduciveness to informal payments, i.e. a relatively problematic area in the country. The sum of all country standardized scores per indicator equals 1. Thus, the standardized scores allow comparison across countries and across indicators. An average standardized score per country per group of indicators (dimension) is also calculated, i.e. four average standardized scores per country.

Table 1.2. Indicators of the four dimensions of the presence of informal patient payments applied in the SPACE-matrix analysis

Economic and Labor Factors		BG	HU	LT	PL	RO	UA	Socio-Cultural Factors		BG	HU	LT	PL	RO	UA
GDP [PPP per capita, US\$, billion]		13 563	18 738	12 323	19 752	11 860	6 656	Human development index [rank, lower value = higher level]		55	38	40	39	50	76
	Standardized score	0.15	0.11	0.16	0.10	0.17	0.30		Standardized score	0.18	0.13	0.13	0.13	0.17	0.26
		0.20%	1.20%	1.30%	3.80%	-1.30%	4.20%		Education index [score, higher value = higher level]	0.802	0.886	0.883	0.882	0.831	0.858
GNI [PPP per capita, US\$, billion]		11 412	16 581	16 234	17 451	11 046	6 175	Survival self-expression values [score, higher value = higher level]		0.16	0.17	0.17	0.17	0.16	0.17
	Standardized score	0.17	0.12	0.12	0.11	0.17	0.31		Standardized score	-1.52	-1.22	-1.00	-0.14	-1.60	-1.72
		4.741	4.6	0.044	0.919	1.536	4.310		Standardized score	0.21	0.17	0.14	0.02	0.22	0.24
Black market [US\$, billion]		4.741	4.6	0.044	0.919	1.536	4.310	Corruption perception index [rank, higher value = higher level]		73	50	46	41	69	134
	Standardized score	0.294	0.285	0.003	0.057	0.095	0.267		Standardized score	0.18	0.12	0.11	0.10	0.17	0.32
		0.17	0.14	0.08	0.07	0.30	0.23		Average standardized score	0.18	0.15	0.14	0.11	0.18	0.25
Health Care System Factors		BG	HU	LT	PL	RO	UA	Political and Regulatory Factors		BG	HU	LT	PL	RO	UA
Total expenditure on health [%GDP]		7.4%	8.2%	7.8%	7.1%	5.4%	7.0%	Political stability index [rank, higher value = higher level]		58	71	69	84	55	42
	Standardized score	0.16	0.14	0.15	0.16	0.22	0.17		Standardized score	0.17	0.14	0.15	0.12	0.18	0.24
		475	938	730	804	408	180		Government effectiveness index [rank, higher value = higher level]	55	72	74	84	55	42
Total expenditure on health [per capita, US\$]		0.15	0.08	0.10	0.09	0.18	0.40	Control of corruption index [rank higher value = higher level]		0.15	0.12	0.11	0.12	0.18	0.24
	Standardized score	0.15	0.08	0.10	0.09	0.18	0.40		Standardized score	0.15	0.12	0.11	0.12	0.18	0.24
		280	653	499	548	322	98		Average standardized score	0.18	0.15	0.14	0.11	0.18	0.25
Government expenditure on health [per capita, US\$]		0.16	0.07	0.09	0.08	0.14	0.46	Rule of law index [rank, higher value = higher level]		52	67	66	84	55	42
	Standardized score	0.16	0.07	0.09	0.08	0.14	0.46		Standardized score	0.14	0.11	0.11	0.12	0.18	0.24
		11	21	8	5	27	32		Average standardized score	0.16	0.13	0.13	0.16	0.22	0.17
Maternal mortality [deaths per 100 000 live births]		11	21	8	5	27	32	Democracy index [score, higher value = higher level]		53	73	72	84	55	42
	Standardized score	0.11	0.20	0.08	0.05	0.26	0.31		Standardized score	0.16	0.12	0.12	0.12	0.18	0.24
		3.73	3.03	3.61	2.16	2.27	3.25		Average standardized score	6.78	7.04	7.24	84	55	42
Physicians density [physicians per 10 000 population]		0.13	0.16	0.13	0.22	0.21	0.15	Standardized score		0.17	0.16	0.16	0.12	0.18	0.24
	Standardized score	0.13	0.16	0.13	0.22	0.21	0.15		Standardized score	0.17	0.16	0.16	0.12	0.18	0.24
		0.14	0.13	0.11	0.12	0.20	0.30		Average standardized score	0.16	0.13	0.13	0.16	0.22	0.17

Notes: BG= Bulgaria; HU= Hungary; LT= Lithuania; PL= Poland; RO= Romania; UA= Ukraine;

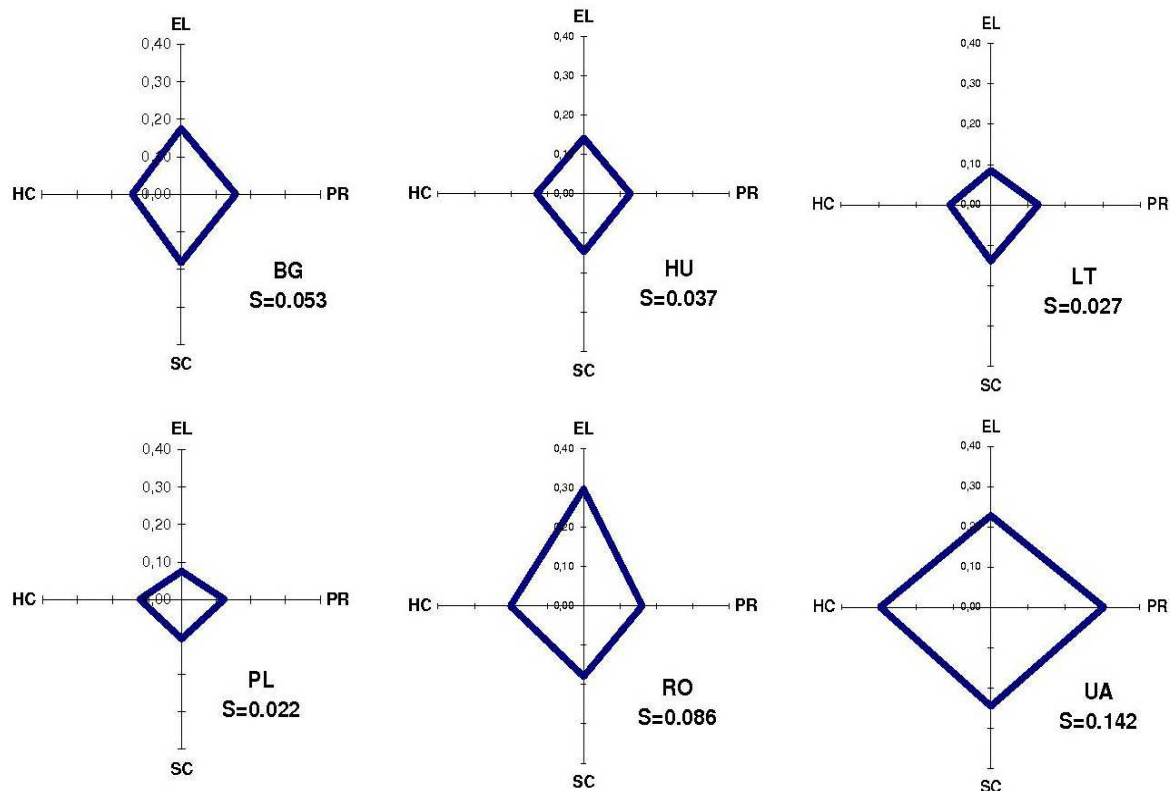
Standardized scores indicate the relative conduciveness to informal payments, the sum of the country standardized scores per indicator equals 1.

Source: World Bank, WHO, Global Health Observatory, UNDP, World Values Survey, Transparency international (different years, see Appendix A)

The average standardized scores (see Table 1.2) indicate a relatively similar economic, regulatory cultural and health care system environment in all countries except for Ukraine and in some occasions Romania. The scores for Ukraine are almost always the highest and for Poland are almost always the lowest. Based on the average standardized scores per country, the country graphic profile is drawn (see Figure 1.2). The area within the country profile indicates the conduciveness of the country environment to informal payments. A larger area indicates a relatively more conducive environment. Changes in the set of indicators do not change the relative order of the countries based on the conduciveness of their environment to informal payments.

Thus, Figure 1.2 shows that the environment in Ukraine and Romania is relatively most conducive to informal payments and that in Poland is relatively least conducive to informal payments. Bulgaria, Hungary and Lithuania present in-between cases. Therefore, the same cross-country pattern in informal patient payments can be expected. This expectation is studied in the dissertation.

Figure 1.2. Six CEE country profiles based on the average standardized scores from the SPACE-matrix analysis (see Table 2.1)



Notes: EL= economic-labor factors; SC= socio-cultural factors; PR= political-regulatory factors; HC= health care system; BG= Bulgaria; HU= Hungary; LT= Lithuania; PL= Poland; RO= Romania; UA= Ukraine; S= area size

The country profiles in Figure 1.2 lack some qualitative indicators. In particular, it is worth to underline important changes that occurred in most of the countries. Specifically, Hungary, Lithuania and Poland joined the EU in 2004 followed by Romania and Bulgaria in 2007. EU membership is considered to provide a frame and stimulus for the countries to improve regulations, to achieve better living standards, more transparency and accountability. It also requires the eradication of corruption. Since Romania and Bulgaria were late with the achievement of the EU requirements, especially with regard to the control of corruption, their EU membership was delayed. Ukraine is a non-EU member with doubtful chances to achieve this membership in the near future. Ukraine's disadvantaged situation is also visible in our SPACE-matrix analysis, the same for Romania and Bulgaria.

In addition to this, one or two decades ago, all countries except for Ukraine switched from the system of central planning and free-of-charge health care to a decentralized system with a health insurance fund. All six countries experienced numerous appointments of ministers of health during the last decade (e.g. 8 in Hungary and Lithuania, 10 in Ukraine and 13 in Poland with an average length of stay of 1–1.5 year), which partly explains the uneven character of their health care reforms. Nevertheless, achievements such as strengthening primary healthcare (GPs practice), reducing hospital capacity, improving quality and equity in health care provision as well as cost-effectiveness improvements, are observed in virtually all countries. The systems of patient payments for health care services are considered to be unclear in most of the countries except for Bulgaria where formal service charges were introduced in 2000. Also, most of the countries (except for Poland and partly Bulgaria) did not succeed to implement anti-informal payments actions. Though, informal patient payments were considered as subject of intensive policy debate in Hungary, Poland and Bulgaria (Atanasova et al., 2011; Gaal & McKee, 2005; Golinowska, 2010; Holt, 2010b). In the other countries, informal patient payments are not always recognized by policy-makers as essentially problematic.

Despite the absence of these qualitative aspects, the country profiles in Figure 1.2 highlight the strengths and weaknesses of the environment in each country with regard to informal patient payments. These profiles can be also used to elaborate a single-country strategy for an effective elimination of informal patient payments. This is considered in the general discussion of this dissertation.

1.5. Aim and objectives of the dissertation

As outlined in this introductory chapter, informal patient payments present a policy problem in CEE countries. The problem has been growing for several decades despite the health care reforms in most of these countries during the transition period. Although empirical studies underline the need to eradicate informal patient payments, these studies mostly focus on a single country. Recent cross-country comparisons are lacking. The few cross-country studies on informal payments for health care services in CEE countries were conducted a decade ago although published quite recently (Belli, 2002; Cockcroft et al., 2008). Such cross-country studies are deemed to be important because they can help to identify country-level factors that influence the size of these payments and their causes (Allin et al., 2006; Gaal & McKee, 2006). This way, the mechanism of informal patient payments as well as good practices in the CEE region can be highlighted.

Therefore, the aim of this dissertation is *to study informal payments for health care services in CEE countries and to compare the level, scope and consumer's perceptions of informal patient payments in the region*. As mentioned at the outset, the focus is on six CEE countries at different stage of social and economic development:

- Economically advanced Central European countries (Hungary and Poland).
- Less advanced countries from Eastern Europe (Bulgaria and Romania).
- Economically advanced former Soviet republic in Europe (Lithuania).
- Less advanced former Soviet republic in Europe (Ukraine).

To achieve the aim of the dissertation, the following research objectives are defined:

Objective 1. To critically review previous empirical studies on informal patient payments

Since informal patient payments are a potentially sensitive issue and are characterized by a complex and diverse nature, the first objective of our study is to find the most suitable approach for studying informal patient payments. The focus is on the question “What are the most appropriate research designs available when informal patient payments are examined?” Moreover, a methodology review for the systematic development of a research instrument to study informal patient payments, has not yet been reported in the literature. In order to study difficulties in collecting data on informal patient payments, desk study is applied. Data

collection modes, research methods and instrument characteristics applied in published empirical studies are systematically reviewed and qualitatively analyzed in the light of scientific attainments in research methodology. The results provide a base for developing a research instrument for collecting data for this study.

Objective 2. To study perceptions and attitudes towards informal payments in CEE countries

Despite the methodological challenges, the level of and attitudes towards informal patient payments should be known to be able to design and implement strategies for dealing with informal patient payments. By and large, health care reforms especially those focused on the introduction of formal fees can be impeded if patients (and more generally, the society) accept informal payment practices. Therefore, we investigate public attitudes and opinions as well as individual beliefs and perceptions of informal patient payments in the six CEE countries. The analyses carried out for this objective are based on data from 1 000 effective face-to-face interviews conducted in each of the six countries in 2010. Data have been collected using a multi-stage sampling method (for more details see Appendix B-D). Taking into account the lack of multi-country and up-to-day studies, our results provide evidence on patients' inclination to make informal patient payments controlling for socio-demographic features and country context.

Objective 3. To study the scope and patterns of informal patient payments in CEE countries

The problematic areas in health care provision can be easily detected when the type and scale of informal patient payments is considered. Without this information, the use of official statistics on out-of-pocket expenditures (if there are any) can be misleading. Also, since a common methodological approach is not available, single-country studies cannot be used for a cross-country comparison. We provide data on the level of informal patient payments in the six CEE countries based on the analysis of the same dataset as that for objective 2 though it is supplemented by second-wave 2011 data on Bulgaria, Hungary and Ukraine. The informal patient payments in Bulgaria, Hungary and Ukraine are examined in detail with regards to the country and year of occurrence, type of service used, the purpose and initiator of the payment. We also consider countries' specificities in their health care system and general environment. In addition, as the literature suggests different explanations for informal payments for services and for supplies, we analyze them separately.

Objective 4. To study the case of informal payments for maternity care in CEE countries

Previous research has revealed higher informal payments for services of a surgeon, gynecologist, urologist and obstetrician compared to other services (Kornai, 2000; Vian et al., 2006). Since these services are not considered as routine procedures, more anxiety and fear of the patient and higher qualification of the provider usually explain the higher scope and scale of informal payment for these services. Given the peculiarities of obstetric services and taking into account the UN Millennium Development Goals, we take a deeper look at informal payments and behavioral patterns related to childbirth. Therefore, this dissertation provides quantitative results on maternity care (specifically for objective 3) from Bulgaria, Hungary and Ukraine combined with a qualitative study in the capital of Ukraine that explores the experience of consumers and providers with informal payment for childbirth. Insufficient data on maternity care provision in CEE countries (also in Ukraine) have attracted our attention to the qualitative aspects of the process of informal payments. Hence, our analysis of the bargaining process in maternity care in Ukraine as well as how patients, obstetricians and experts understand, apply and experience informal payments, discussed together with Ukraine's environmental peculiarities, allow a better understanding of the presence of certain patterns of informal patient payments for childbirth.

1.6. Dissertation outline

Overall, the design of the dissertation is not “traditional”, but a so-called “dissertation prepared to facilitate publishing”. Instead of separating methods, results and a discussion in different sections, the chapters of the dissertation can be read independently, each presenting a specific part of the study.

The dissertation includes seven chapters, the first of which is this general introduction. The next five chapters serve to study the specific objectives listed above. Chapter 2 focuses on objective 1, and contains the results of a systematic literature review focused on the research design when informal patient payments are examined. These findings were considered and applied for the methodology design in the next three chapters. In Chapter 3, we investigate public attitudes, perceptions and opinions on informal patient payments in six CEE countries illustrated with payment experience that corresponds with objective 2. Chapter 4 also focuses on objective 2, though patients' beliefs and perceptions of informal patient payments are analyzed. The scope, scale and patterns of informal payment for out- and in-

patient services are a focus of part of the study presented in Chapter 5 that relate to objective 3 and 4. Besides the two-waves multi-country survey that is the basis of analysis in three previous chapters, the results of a single country qualitative study is described in Chapter 6, focused on informal payments for childbirth in the capital of Ukraine. The dissertation concludes with Chapter 7 where key findings are summarized and discussed as well as concluding remarks are made.

CHAPTER 2.

EMPIRICAL STUDIES ON INFORMAL PATIENT PAYMENTS FOR HEALTH CARE SERVICES:

A SYSTEMATIC AND CRITICAL REVIEW OF RESEARCH METHODS AND INSTRUMENTS

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Abstract

Empirical evidence demonstrates that informal patient payments are an important feature of many health care systems. However, the study of these payments is a challenging task because of their potentially illegal and sensitive nature. The aim of this chapter is to provide a systematic review and analysis of key methodological difficulties in measuring informal patient payments. The systematic review was based on the following eligibility criteria: English language publications that reported on empirical studies measuring informal patient payments. There were no limitations with regard to the year of publication. The content of the publications was analyzed qualitatively and the results were organized in the form of tables. Data sources were Econlit, Econpapers, Medline, PubMed, ScienceDirect, SocINDEX. The results suggest that informal payments for health care services are most often investigated in studies involving patients or the general public, but providers and officials are also sample units in some studies. The majority of the studies apply a single mode of data collection that involves either face-to-face interviews or group discussions. One of the main methodological difficulties reported in the publication, concerns the inability of some respondents to distinguish between official and unofficial payments. Another complication is associated with the refusal of some respondents to answer questions on informal patient payments. We do not exclude the possibility that we have missed studies that were reported in non-English language journals as well as very recent studies that are not yet published. Given the recent evidence from research on survey methods, a self-administrated questionnaire during a face-to-face interview could be a suitable mode of collecting sensitive data, such as data on informal patient payments.

2.1. Introduction and background

In many countries around the world informal patient payments are seen as part and parcel of health care systems (Ensor, 2004; Thompson & Witter, 2000). As discussed in Chapter 1 (section 1.2.3), the persistence of this phenomenon can be explained by cultural perceptions, insufficient funding of the health care sector and lack of control and accountability in the health care system (e.g. Balabanova & McKee, 2002; Gaal & McKee, 2004; Thompson & Witter, 2000). However, despite the different explanations, informal patient payments are overall seen as a negative feature of health care provision. Informal patient payments can have adverse effects on equity and can hinder the determination of future funding requirements of the health care sector (Delcheva et al., 1997; Lewis, 2000; Lewis, 2007; Thompson & Witter, 2000). Empirical studies on informal patient payments provide evidence on the scope and scale of this phenomenon. Such information could compel and enable policy-makers to look for solutions to the problem of informal patient payments (World Health Organization, 1996). This is particularly relevant to countries where informal patient payments are condoned by the government mainly because they are filling gaps caused by insufficient health care budgets (Ferman & Berndt, 1981; Harding & Jenkin, 1989; Lewis, 2000).

Although the importance of data on informal patient payments is universally recognized, the collection of such data is a challenging task given their informal and potentially sensitive nature (Miller et al., 2000; Özgen et al., 2010; Vian et al., 2006). Moreover, Dabalen and Wane (2008) state that informal patient payments are a sensitive research topic due to their illegal character in some countries. This implies difficulties in estimating their real scope and magnitude, and above all difficulties in determining the frequency of their occurrence. Furthermore, verification and validation of the estimates on informal payments are usually difficult. To assure validity and reliability, empirical studies on informal patient payments need to pay special attention on the research design applied (Ensor & Savelyeva, 1998).

Methodological difficulties in collecting sensitive data (as well as data that indicate potentially illegal behavior) are an important topic in research on survey methods (e.g. Dillman, 2000; Holbrook et al., 2003; Roberts, 2007; Tourangeau & Smith, 1996). In this area of research, a sensitive topic is defined as a topic that “seems to be threatening in some way to those being studied” (Renzetti & Lee, 1993). Empirical research on a sensitive topic requires special attention to two main issues: the development of an adequate research instrument as

well as an adequate data collection process (e.g. Johnson & Clarke, 2003; Onsembe, 2002). To respond to these methodological challenges, the empirical studies on informal patient payments have employed a variety of solutions. Thus, the studies considerably differ with regard to the methodology used. These differences may well affect the results of these studies and this creates difficulties in comparing these outcomes (e.g. Szende & Culyer, 2006).

The aim of this chapter is to critically review the research designs applied to the investigation of informal patient payments following the method of a systematic literature review. Our review is expected to facilitate the development of future research designs for collecting valid and reliable data on informal patient payments. Such critical review has not yet been reported in the literature. To achieve our aim, we first define the term “informal patient payments”. Based on this definition, we identify keywords to search systematically for relevant publications. The following sections present our definition of informal patient payments and the methods of data collection, followed by the results and their discussion.

2.2. Definition of informal patient payments

Empirical studies on informal patient payments attribute different characteristics to this type of payments. As a result, informal patient payments do not have a universal definition although the definitions used by researchers partly overlap.

For example, Adam (1989) who reported on one of the first analyses on informal patient payments, uses the term “gratuity for doctors” referring to “a financial or other material benefit, given to the doctor voluntarily by a patient or his/her relatives after the treatment has been terminated”. More recent studies provide a broader definition of informal patient payments. Lewis (2000) defines these payments as “payments to individual and institutional providers, in kind or in cash, that are made outside official payment channels or are purchases meant to be covered by the health care system”. This definition includes “envelope payments to physicians” and “contributions to hospitals”, as well as payments for medical supplies and pharmaceuticals purchased by the patient privately but intended to be covered by the government-financed health care system. Thompson and Witter (2000) also provide a broad definition of informal patient payments but add other dimensions: “tips for health workers”, “bribes to obtain access to certain services or better quality care”, and “payments demanded by health workers or institutions”. They also refer to informal patient payments as payments that “are not sanctioned by the authorities”.

Other recent studies add the moment of payment to the definition of informal patient payments. According to Allin and colleagues (2006) “informal payments range from the ex ante cash payment to the ex post gift-in-kind”. The authors also outline some synonyms of the term “informal patient payments”, including “under-the-table payments” or “envelope payments”. Other synonyms used, include “unofficial out-of-pocket payments”, “under-the-counter payments” and “corruption in health care” (e.g. Chawla et al., 1998; Cockcroft et al., 2008; Delcheva et al., 1997; Falkingham, 2004). However, corruption in health care has a wider meaning and includes not only informal patient payments, but also informal (illegal) payments to physicians and/or officials initiated by pharmaceutical companies (or other actors) for own, mainly financial benefits. Allin et al (2006) as well as Balabanova and McKee (2002) define patient payments as direct payments by patients for services that should in principle be provided free-of-charge and usually within the public health care system.

Despite the difference in definitions, it is generally accepted that informal patient payments could take monetary and non-monetary forms, and could express patient’s gratitude but could also be requested by the health care provider. Overall, informal patient payments are accepted to be unofficial, i.e. they are not registered by the state and are made without an official receipt of payment, and remain outside the official payment channels. However, confusion arises when these payments are also defined as illegal. This is because informal payments are sometimes – but not always – illegal (Lewis, 2000). These payments are not illegal as long as the existing laws and regulations are not contravened. Moreover, if informal payments – like gifts and donations – are not directly related to treatment received they are usually legal and frequently even tax deductible. It is also possible to define quasi-official payments, which include those payments that are illegal but for some reason tolerated by the government (Ferman & Berndt, 1981; Harding & Jenkin, 1989; Lewis, 2000).

Based on the definitions of informal patient payments discussed above and reported in other publications (e.g. Gaal et al., 2006; Killingsworth, 1999), it is possible to define several key characteristics of informal patient payments, which can provide a base for a universal definition. These key characteristics include:

- Who initiates the informal payment? The patient who wishes to express gratitude, the provider (individual or institution) who requests the payment, or both?
- What is the nature of informal payment? In cash, in kind (e.g. candies, jewelry), or in a form of services (e.g. dinners, trips, and sponsorship)?

- What is the moment of informal payment? Before, during, or after the health care service, medical supplies or pharmaceuticals are provided to the patient?
- Who receives the informal payment? The health care institution (incl. quasi-official payments that are not official but where the patient receives a kind of receipt), medical staff (incl. physicians and nurses), or the administration of the health care institution?
- Who actually makes the informal payment? The patient or the relatives of the patient?
- What is the purpose of the informal payment? Expression-of-gratitude, fee-for-service, fee-for-commodity, fee-for-access, fee-for-quicker-access, or fee-for-better-quality?
- What is the amount of the informal payment? The monetary value of the informal patient payment is usually compared to the household's income.
- How is the informal payment perceived? Normal behavior, corruption, illegal behavior, or tradition (due to cultural perceptions)?
- What is the attitude toward the informal payment? Negative (especially, if requested) or positive (if an expression of gratuity), usually depending on the moment of payment?

The characteristics of informal patient payments presented above, cannot be analyzed separately because they may correlate among each other or one characteristic may even be a cause of another characteristic. For example, when the payment is requested, it is usually observed as a cash payment to medical staff in a surgical department, and the amount of the payment can be higher than the monthly income of the patient. At the same time, a gratuity payment that is in kind has a value that corresponds to the patient's income. Despite the possibility of such correlations, to be able to understand the phenomenon of informal patient payments, all characteristics listed above should be taken into account.

We take these characteristics as a definition of informal patient payments for our analysis. However, we focus solely on informal patient payments for health care services excluding informal patient payments for medical supplies and pharmaceuticals.

2.3. Methods

In order to identify the research techniques used in the study on informal patient payments for health care services, we conducted a systematic literature review using the method of desk research. The combinations of keywords used for the search of relevant literature, consisted of two components. The first component contained the term “informal patient payments” or one of its synonyms (see previous section), namely “unofficial out-of-pocket payments”, “under-

the-counter payments”, “under-the-table payments”, “envelop payments”, and “corruption in health care”. The second component consisted of the term “empirical research” or one of its synonyms, namely “survey” and “study”.

Using all possible combinations of keywords in each of the two components, the following databases were searched: Econlit, Econpapers, Medline, PubMed, ScienceDirect, SocINDEX. Only English language publications were selected for further analysis. There were no limitations with regard to the year of publication or publication status. Each publication identified in the systematic search for literature, was checked for its relevance with regard to our research questions. Only publications that reported on empirical studies were included in the list of relevant publications. If it was obvious that the same empirical study was reported in more than one publication, only one publication was included in the final list but all publications that reported the study were taken into account to identify details related to the study design. We also reviewed the reference lists of the publications that we identified for other relevant studies.

The content of the publications was analyzed qualitatively and the results were organized in the form of tables. The main objective of the analysis was to outline the research designs reported in these publications. The focus was to extract information on the data collection process (i.e. sample characteristics and data collection mode) and the research instrument (i.e. groups of questions, pilot and pre-test, cross-national specificity and recall period). The research results reported in the studies were also summarized (using the definition outlined in the previous section) to indicate the type and incidence of informal payments for health care services reported in the literature. The results reported in the tables, were assessed in view of findings reported in the literature on research methods.

2.4. Results

In total, 31 publications were identified as relevant in the systematic literature review. The publications are presented in Appendix E according to the year of their publication starting with the most recent ones. This section presents the general study description, data collection process, research instruments, as well as types and incidents of informal patient payments reported in these publications.

2.4.1 General description of the publication

The general description of the studies included in our review is presented in Table 2.1. As indicated in Table 2.1, we identified 24 articles and 7 reports/books relevant to our analysis. Most of the field work reported in these publications had taken place over the period 1990 – 2005, while the publications date from 1995 to the present. None of the papers contains an analysis of data collected before 1990. We observed that the number of publications was continuously growing: specifically, 7 publications appeared in the period 1995 – 2000 and a twice higher number appeared after 2005.

Research on informal payments for health care services was conducted in virtually all continents. This includes countries with low-, lower-middle-, upper-middle- and high-income economies (country classification by the World Bank, 2009). Moreover, we observed that the

Table 2.1. General description of publications included in the analysis (31 publications)¹

Classification category	Sub-categories	N	Reference index in Appendix E
Type of publication	Journal articles	24	1,2,3,4,5,7,8,10,11,12,13,14,15,16,17,18, 20,25,26,27,28,29, 30,31
	Reports, books	7	6,9,19,21,22,23,24
Year of publication	After 2005	13	1,2,3,4,5,6,7,8,9,10,11,12,13
	2001-2005	11	14,15,16,17,18,19,20,21,22,23,24
	1995-2000	7	25,26,27,28,29,30,31
Year of data collection	After 2005	1	6
	2001-2005	12	1,2,5,8,9,10,11,13,15,16,17,24
	1996-2000	9	12,14,18,19,20,21,22,25,26
	1990-1995	4	27,29,30,31
	Not clear	5	3,4,7,23,28
Origin of the study (type of country by World Bank)	Low-income countries	8	5,6,9,11,16,18,26,28
	Lower-middle-income countries	10	7,8,9,13,14,15,16,17,22,25
	Upper-middle-income countries	12	1,2,10,16,19,20,21,23,25,27,29,30
	High-income countries	9	2,3,4,12,16,21,24,25,31
Number of countries included in the study	Single country	26	1,3,4,5,6,7,8,10,11,12,13,14,15,17,18,19, 20,22,23,24,26,27, 28,29,30,31
	Several countries	5	2,9,16,21,25
Objective of the study	Descriptive	15	8,10,11,13,15,19,20,21,22,23,24,25,27, 28,31
	Analytical	18	1,3,4,5,12,13,14,15,16,17,18,19,20,23,24, 26,29,30
	Predictive	3	7,13,19
	Not stated explicitly	3	2,6,9

¹ One publication can be associated with more than one sub-category.

phenomenon was reported mostly in former-socialist countries but also in some countries that had not been socialist (e.g. Peru, Uganda, and Turkey). From all 31 publications, only 5 publications reported cross-national studies. The rest of the studies reported results from a single country. One third of the studies had a descriptive aim and half of the studies had an analytical aim. Only in three cases, the research objectives could be described as predictive. None of the studies (even earlier studies) could be classified as having an exploratory aim.

2.4.2 Specificity of the data collection process

The specificities of the data collection process reported in the publications that we reviewed, are presented in Table 2.2. We found that the topic of informal payments for health care services was analyzed from the perspective of members of households and patients, as well as from the perspective of health care providers and officials. The combination of several sampling units was also reported. The sampling area varied greatly: from a city and district to a single country and even several countries. Most studies reported probabilistic sample designs (e.g. random, stratified or stratified random sample), although studies operated also with snowball and convenience samples. In total, 9 out of 31 publications had a sample size of less than thousand respondents and 12 out of 31 publications reported thousand to three thousands respondents.

Of all studies included in our review, 18 publications reported one type of data collection mode. In the case of consumers, the most frequently used mode of data collection was face-to-face interview. In the case of providers, face-to-face interviews were also widely used, but besides them, focus-groups interviews and self-administrated questionnaires were also used to gather data. Focus-group discussions and questionnaires were applied to consumers as well. Overall, self-administrated questionnaires were seldom used as a research instrument. Few publications reported a mixing mode of data collection combining interviews and group discussions. Respondents were not the only source of data. For example, one article provided content-analysis of printed media.

Additional analysis suggested that the collection of data on informal patient payments had changed over the years. At the beginning, only the general public and providers were involved in the studies, while later, patients and official were also included as sampling units. The number of sampling areas and sample selection techniques applied in the studies increased over the years. Thus, researchers included not only probabilistic sample designs but also purposive, snowball and convenience samples in the recent years, as well as larger

Table 2.2. Specificities of data collection (31 publications) ¹

Classification	Sub-categories	N	Reference index in Appendix E
Sampling unit	General public: households	13	1,2,3,4,9,10,11,15,18,21,22,29,30
	General public: individuals	10	7,12,13,14,16,20,21,24,25,27
	Patients	5	5,17,23,26,28
	Providers	10	2,6,13,17,19,20,23,25,28,31
	Officials	3	2,19,24
	Other (newspapers)	1	8
Sampling area	Cities	9	1,7,10,14,21,22,23,27,30
	Districts	7	5,13,15,17,19,26,28
	Single country non-representative	7	3,4,8,24,25,29,31
	Single country representative	7	2,6,11,12,16,18,20
	Multiple country non-representative	4	2,9,21,25
	Multiple country representative	1	16
Sample selection	Random sample	8	4,12,13,15,20,21,27,30
	Stratified random sample	9	2,3,10,16,22,25,26,29,31
	Stratified sample	5	1,5,6,14,24
	Purposive sample	1	8
	Convenience sample	3	7,13,17
	Snowball sample	2	17,23
	Not presented	5	9,11,18,19,28
Sample size (units)	Higher than 10000	3	2,9,16
	2000 – 3000	5	11,14,18,24,29
	1000 – 2000	9	3,4,5,6,12,20,26,30,31
	Less than 1000	12	1,7,8,10,13,17,19,22,23,26,27,28
	Not presented	2	15,21
Number of data collection modes applied in the study	One type	18	1,3,5,6,7,8,10,11,12,16,19,21,22,24,26,27,30,31
	Two types	3	13,17,23
	Three types	3	2,20,25
	More than three types	1	28
	Not clear	6	4,9,14,15,18,29
Data collection mode applied for general public and patients	Self-administrated questionnaire	3	7,11,24
	Face-to-face structured interview	13	1,2,5,10,12,16,20,22,25,26,27,28,30
	Telephone interview	3	3,4,21
	Semi-structured/in-depth interview	5	13,17,20,23,25
	Focus-group discussion	6	2,13,17,23,25,28
	Not clear (interview/questionnaire)	5	9,14,15,18,29
Data collection mode applied for providers and officials	Self-administrated questionnaire	2	24,31
	Interview	8	6,13,17,19,20,23,25,28
	Focus-group discussion	5	2,13,23,26,28
	Stakeholder workshop	1	2
	Diary	1	28

¹ One publication can be associated with more than one sub-category.

sampling areas. The samples in some recent studies were very large (more than 10000 units) compared to earlier studies. The data collection had also become more varied with the years including more types of data collection modes. An interesting example is the stakeholder workshop applied in one recent study.

We also considered the response rate reported in the publications but we found that only 9 out of 31 publications indicated this feature of the data collection. When reported, the response rate was quite high ranging from 70% to higher than 90%. Only one study based on telephone interviews reported a response rate lower than 20%. Nevertheless, the limited number of publications that report the response rate precludes a meaningful comparison in this direction.

2.4.3 Specificity of the research instrument

Table 2.3 presents the specificity of the research instrument applied in the 31 studies that we reviewed. We divided the questions on informal payments for health care services described in the publications into questions to consumers (i.e. the general public and patients) and questions to the providers and officials. Thereby, in 19 studies, consumers were asked to estimate the size of informal payments for health care services. In 20 publications they recalled incidents of such payments. Moreover, the type of informal payments, beneficiary of these payments, reasons for making informal payments, perceived effects of payments and attitudes toward the presence of informal payments were also investigated. With regard to the officials and providers, other types of questions besides those for consumers were included, namely: reasons for receiving informal payments, mechanisms of collecting informal payments from patients, and methods of reducing the unofficial payments.

Although, we could identify groups of questions on informal payments for health care services included in the studies, the content of the research instrument was rarely described in detail. The recall period and piloting/pre-testing were also not mentioned in any of the publications. With regard to the recall period, researchers frequently appealed to the memory of respondents when the experience with paying informally was the objective of the survey. There were only two options of the recall period applied to the providers and officials: last week and two years ago. However, we found a variety of recall periods applied in studies among consumers. Respondents were asked to remember making payments during a year or more, as well as during one to five months. Next visit and last visit were also used as reference points in the studies.

Table 2.3. Specificities of research instruments (31 publications) ¹

Classification	Sub-categories	N	Reference index in Appendix E
Groups of questions on informal patient payments for general public and patients	Incidence of informal payments	20	1,2,3,7,9,10,12,15,16,17,18,20,21,22,23,24,26,27,29,30
	Types of informal payments	14	1,2,3,10,11,15,17,18,20,21,23,24,26,27
	Beneficiary of informal payments	16	1,2,3,10,11,12,15,17,18,20,21,23,24,26,29,30
	Moment of informal payments	4	2,10,17,20
	Magnitude of informal payments	19	1,2,3,4,5,9,10,12,14,15,16,18,20,21,22,23,24,29,30
	Reasons for informal payments	10	2,3,10,13,17,20,21,23,24,28
	Perceived effect of informal payments	3	2,13,20
	Attitudes towards informal payments	7	2,7,10,20,21,22,23
Groups of questions on informal patient payments for providers and officials	Incidence of informal payments	2	24,25
	Types of informal payments	4	20,24,25,31
	Moment of informal payments	1	20
	Frequency of informal payments	1	31
	Magnitude of informal payments	2	6,31
	Reasons for informal payments	6	13,19,20,23,24,25
	Attitudes toward informal payments	6	17,19,20,23,24,25
	Perceived effect of informal payments	1	13
	Mechanism of informal payments	3	17,19,24
Pilot and pre-tests of the research instrument	Reduction of informal payments	1	13
	Pilot study	10	1,7,13,16,20,21,25,26,28,30
	Pre-test	2	7,17
Cross-national specificity of the research instrument	Not presented	19	2,3,4,5,6,9,10,11,12,14,15,18,19,22,23,24,27,29,31
	Backward translation	3	2,16,25
	Country specific part	2	2,16
Recall period of the experience or the general public and the patients	Not presented	2	9,21
	Less than 1 month	1	18
	1-5 months	9	1,2,5,7,9,11,14,15,17
	6-11 months	5	15,18,20,26,27
	12 months and more	11	3,4,5,9,11,12,16,18,22,29,30
	Other (last visit, 3 last visits)	3	2,7,24
	No recall period (next visit)	2	7,20
Recall period of the experience for providers and officials	Not clear	6	10,13,21,23,25,28
	Previous week	1	31
	2 years	1	25
	Not clear or not applicable	9	6,13,17,19,20,23,24,26,28

¹ One publication can be associated with more than one sub-category.

Two publications stated that the questionnaire was pre-tested and 10 publications provided information that the questionnaire was piloted. In cross-national studies, a backward translation was usually applied to ensure the proper wording of the questions. The introduction of country specific questions was also used in these studies.

2.4.4 Description of the main findings

Tables 2.4 and 2.5 contain the key empirical findings presented in the publication with regard to the type and incidence of informal payments for health care services. The findings are presented systematically in the tables based on our definition of informal patient payments outlined at the outset of this chapter. Both patients and providers were reported as the ones that initiate the informal payments for health care services. Informal payments in cash and in kind were equally reported. However, some early publications also reported informal patient payments in the form of service, e.g. car repairs, plumbing, sponsorship for conference participation. Informal patient payments that were in cash, were mainly paid before or during the treatment and gifts were mainly presented after the service was provided.

Researchers reported a variety of beneficiaries of informal payments for health care services, e.g. general practitioners, medical specialists, other medical staff, and administration. Overall, respondents reported higher informal payments for services of medical specialists (notably surgeon and dentist) than for services of general practitioners although we observed that researchers appealed more often to informal payments to general practitioners. Expression of gratitude was identified as a motivation for informal patient payments in about a quarter of the studies while more than a quarter of the studies reported improved service provision (better quality and quicker access) as the main reason for such payments.

The magnitude of informal patient payments was rarely reported (only in 5 publications). Nevertheless, this characteristic of informal patient payments was hardly comparable since researchers were using different measurement units: monthly household income, or monthly household expenditure, or health expenditures.

The few studies that investigated the perception and attitude of respondents towards informal patient payments, reported quite contrasting results. Informal patient payments were perceived by respondents as tradition and gratuity in 3 studies, and in the other 3 studies they were perceived as illegal behavior and corruption.

Table 2.4. Types of informal payments reported (31 publications) ¹

Classification category	Sub-categories	N	Reference index in Appendix E
Who initiates the informal payment?	Patients (expression of gratitude)	9	11,15,17,20,21,22,23,24,25
	Provider (demanded by a provider)	9	3,11,17,20,21,22,23,24,25
What is the nature of informal payment?	Payments in cash	20	1,2,3,5,10,11,15,16,17,18,20,21,22,23,24,25,27,29,30,31
	Payments in kind (gifts)	18	1,2,3,5,10,11,15,16,17,18,20,21,23,24,25,27,29,31
	Payments in a form of services	4	17,20,24,31
What is the moment of informal payment?	Before/during treatment (mostly in cash)	5	2,10,17,20,23
	After treatment (mostly gifts)	3	2,20,23
Who receives the informal payment?	General practitioner	10	2,5,11,12,17,21,23,24,27,30
	Medical specialist	6	2,3,6,12,21,24
	e.g. Surgeons	7	1,10,11,19,20,21,23
	e.g. Dentists	4	21,24,29,30
	e.g. Obstetrics-gynaecologist	4	11,19,20,23
	Other medical staff	3	3,11,30
	e.g. Nurses	6	3,6,17,21,25,30
	e.g. Emergency staff	1	24
	Health care institution ²	3	10,25,29
What is the purpose of the informal payment?	Expression-of-gratitude	10	1,2,8,13,17,20,21,22,24,25
	Fee-for-service	6	13,20,21,22,23,27
	Fee-for-commodity	4	17,21,23,27
	Fee-for-access	4	8,13,17,27
	Fee-for-quick-access	6	2,3,13,17,23,24
	Fee-for-better-quality	10	1,2,10,13,17,20,21,22,23,24
	Fee-for-psychological-comfort	4	3,13,20,28
What is the amount of informal payment? (% of monthly income)	Less than 30%	3	2,20,30
	More than 80 %	2	17,30
How is the informal payment perceived?	Tradition/gratitude	4	3,17,20,23
	Illegal behavior	1	22
	Corruption	3	2,20,22
What is the attitude of the respondent toward the informal payment?	Negative (requested)	6	7,10,19,20,21,23
	Positive (gratuity)	5	7,19,20,21,23

¹ One publication can be associated with more than one sub-category.² Health care institution (Incl. quasi-official payments when the patient receives a kind of receipt)

The incidence of informal patient payments reported in the publications that we reviewed (see Table 2.5), differed significantly. Although the studies offered the percentage of respondents that had made informal payments for health care services, this percentage was estimated in different manners: percentage of all respondents, percentage of health care consumers, or percentage of patients who paid for the treatments. This precludes the possibilities for further conclusions based on Table 2.5.

Table 2.5. Incidence of informal payments reported (31 publications)¹

% respondents	Informal payments in general	Gifts or gratuities only	Cash payments or extra fee only	Reference index in Appendix E
	N	N	N	
1-10%	3	1	3	2,9,11,21,24,26,27
11-20%	4	2	1	2,3,9,12,18,20,21,27
21-30%	2	3	2	1,10,15,18,20,24
31-40%	4	-	-	3,7,10,16,
41-50%	1	1	2	18,24,29,30
51-60%	2	-	-	12,24
61-70%	2	-	1	1,7,15
More than 71%	1	2	-	7,20

¹ One publication can be associated with more than one sub-category.

2.4.5 Methodological difficulties and limitations reported in publications

The publications included in our review, reported and discussed methodological difficulties and limitations. One of the main research problems concerns the respondents' understanding of the concept informal payments. In particular, respondents were often not able to distinguish between official and unofficial payments, which made the estimation of the magnitude of informal patient payments very approximate (Cockcroft et al., 2008; Dabalen & Wane, 2008; Vian et al., 2006).

Another problem related to data validity, was the refusal of some respondents to answer questions on informal patient payments when filling in a questionnaire or asked by interviewer (Anderson, 2000). Nevertheless, Belli, Gotsadze and Shahriari (2004) provide evidence that users' and providers' answers were frank and open, and Barr (1996) observed that providers did not look confused while filling in the questionnaires. Some researchers (e.g. Szende & Culyer, 2006) indicated possible uncertainty about the accuracy of responses to

questions on informal patient payments when an interviewer was present. Methodological limitations such as sample design, units of analysis applied, memory recall bias, and under- or over-estimation of the informal payments were also stated by the authors.

2.5. Discussion and conclusions

Informal patient payments are a multi-face phenomenon with different features even within a single country (i.e. in the frame of the same health care system, regulations and traditions). Therefore, a universal definition is not available. The key characteristics described at the outset of this chapter provide a more appropriate base for studying this phenomenon than pursuing an all-inclusive definition. Still, country-specific features should be taken into account to make sure that the unit used to measure informal payments is meaningful to the population being sampled.

The results of our review suggest that the study of informal patient payments for health care services is rather new, though the phenomenon has been in existence for a number of decades (Ádám, 1989). Most of the studies that we identified were conducted between 1990 and 2005 mostly in former-socialist countries. It is likely that during the communist period, it was not possible to collect and report data on informal patient payments in these countries. Ideology also made it difficult to discuss the issue openly. Moreover, these types of payments might have been perceived as illegal. With the end of the communist period, the socio-political changes resulted in more public attention for social problems, such as informal payments for health care services, which motivated their investigation. In addition, data collected since 2005 might still be in the stage of data analysis and therefore, not yet published. Overall, the dynamics of publications on informal payments indicates the growing research interest in this topic including new research techniques and larger sampling areas.

Our findings confirm that informal payments exist in countries of all levels of economic development, and in different parts of the world. However, we did not find studies reporting informal patient payments in high-income countries in North-West Europe, North America and Australia. The phenomenon is most often observed in former-socialist countries and developing countries (in Africa, South America and Asia), although it also exists in some high-income European countries that were not former-socialist countries (Italy, Greece, and Turkey) (Health Consumer Powerhouse, 2008; Liaropoulos et al., 2008). As mentioned at the outset of this chapter, the literature offers various explanations why informal patient payments exist in these countries. This includes under-funding of the health care system, the specific

organization and governance of the health care sector, but also culture and social perceptions (Belli et al., 2004). Still, these are only hypothesis and they need to be tested to explain the existence of informal patient payments in some parts of the world and their absence in others.

When we look at the study designs that we reviewed, we can outline several discussion points relevant to research. The first discussion point refers to the study objectives. We differentiated between exploratory, descriptive, analytical and predictive aims. However, we did not find studies with an explicit exploratory aim even among the earlier studies. We expected that an exploratory aim would be typical for the early studies when scant information was available because then, the research interest would be concentrated on exploring the phenomenon. Although some earlier studies had an explicit descriptive aim, other earlier studies had an analytical aim. Descriptive and analytical objectives allow finding determinants of informal patient payments and their correlation.

The second discussion point refers to the sample design. The sample design is part of the entire research design and it may minimize some biases in case of a well-developed sample. To estimate the level of informal patient payments, a probabilistic sample strategy is commonly implemented as it gives equal chances of being included in the study. Moreover, triangulation of the data is feasible when all parties participate (e.g. consumers, providers, officials) in the research. For instance, Cockroft and colleagues (2008) present quantitative data collected from households, where the main findings are discussed with physicians and nurses, as well as with stakeholders, to define the policy implications of the results. However, in the studies that we reviewed, the sample is not always constructed to avoid biases and to get valid data for the analysis. More pragmatic reasons, such as available research funds, are also reported (Cartwright, 1983; De Leeuw, 2005). In view of this, it is not surprising that some recent studies on informal patient payments applied purposive, snowball and convenience samples.

Another discussion point is the data collection mode. The mode of data collection can be especially problematic when sensitive data are studied. This is because each single mode of data collection has its own pros and cons when sensitive questions are asked. The mode of data collection might even be a determinant of the value of indicators estimated based on sensitive data (e.g. Holbrook et al., 2003; Tourangeau & Smith, 1996). According to our results, the response rate (when reported) was highest in face-to-face interviews with both consumers and providers. Face-to-face interviews are considered the most adequate approach in gaining understanding of what respondents mean when answering questions (De Bruin et

al., 1996). However, face-to-face interviews might not be very effective in assuring the validity of the data when such a sensitive topic as informal patient payments, is addressed. Respondents might be less willing to reply truthfully to questions on illegal expenditures if asked by an interviewer since the level of confidentiality is lower. In contrast, self-completion methods are usually preferred when the subject matter is sensitive (Cartwright, 1983; Saris & Gallhofer, 2007) even though some questions might be left unanswered by the respondents. The issue of confidentiality plays a key role. Respondents may be unwilling to describe their informal payments in front of an interviewer, and may feel more comfortable to express such behavior when the pen in hand is the only “eyewitness”. To overcome this difficulty, mixing modes of data collection could be used. De Leeuw (2005) gives an example of U.S. National Survey on Drug Use and Health where respondents use a computer for answering sensitive questions while several non-sensitive questions are asked by an interviewer. This could also increase the response rate (Dillman et al., 2009). Evidence from research on survey methods confirms the importance of combining various modes of data collection in surveys where potentially sensitive issues are investigated. The objective should be to help respondents to exert the necessary cognitive efforts and to answer the questions carefully. At the same time, the objective should be to make the respondents comfortable enough to answer openly and honestly the questions that might be of a sensitive nature (Roberts, 2007). Thus, using mixing modes of data collection, specifically the introduction of a self-administrated part during a face-to-face interview could be suitable for collecting valid data on informal patient payments. To the best of our knowledge, such a mixing mode of data collection has not been used in studies on informal patient payments.

Virtually all publications that we reviewed are based on retrospective research, thus another relevant discussion point is the recall period. The human memory can be a source of bias in research (De Bruin et al., 1996). Consumers might not remember the exact number of visits to health care providers/facilities if the recall period is long (e.g. one or two years). This holds all the more so for the amount of payments they have made. Overall, respondents remember the event for a longer period of time if it is important to them (Cartwright, 1983). Thus, the experiences of utilization of health care services can be different in case of less severe health complications (e.g. out-patient visits) and more severe health problems (e.g. in-patient services). Therefore, we recommend introducing different recall periods for questions on out-patient and in-patient services could enable the respondents to make less cognitive efforts. In particular, Baschieri and Falkingham (2006) apply a 30 days recall period for utilization of health care services and expenditures associated with visits to physicians and

one year period for hospitalizations. There is a possibility to avoid the use of a recall period. For example, the researcher's choice may lay on the introduction of diaries, which could allow collecting all household expenditures on health care at the time of payment. The choice of an adequate recall period is especially important for the valid measurement of informal patient payments.

Our findings on the response rate were surprising to a certain extent. The response rate reported in the publications that we reviewed, was rather high. This could suggest that people are willing to talk about informal patient payments despite their informal and potentially illegal nature. However, it should be recognized that only few publications presented this characteristic. It might be that the response rate was presented in these publications because it was favorable for the study and indicated the representativeness of the data.

To enrich the methodological approaches to the investigation of informal patient payments, researchers can appeal to methods for measuring corruption in society. Although informal patients are not always illegal, our review suggests that they are sometimes perceived by respondents as corruption and illegal behavior. The literature on measuring corruption suggests that corruption can be studied through the measurement of perceived corruption, as well as perceived willingness to pay bribes and bribe payments (Jones et al., 2006). Specifically, studies that focus on corruption include questions on the respondents' perception about level of corruption in a country, as well as hypothetical questions about the amount of money that a respondent would be willing to pay as a bribe in a given context. The latter technique could be useful to study respondents' attitude toward corruption. The measurement of both perceived corruption and the willingness to pay bribes and bribe payments could be especially appealing for the investigation on informal patient payments to gain a better understanding on why informal patient payments exist.

The key results on the type of informal patient payments indicate that informal patient payments are a multifaceted phenomenon. All characteristics of informal patient payments included in our definition, appeared relevant for describing the pattern and magnitude of informal payments for health care services. Overall, the results indicate a great variety in the types of informal patient payments reported. This needs to be considered when designing a research instrument for the investigation of these payments. In particular, the researcher needs to clarify in advance what types of informal patient payments should be studied and thus, what type of questions to be included. It is also important to decide how to measure the incidence of informal patient payments since various measurement units are possible.

Our attempt to compare the empirical results presented a significant challenge. This is mainly due to the great variety of research methods applied. However, the overall findings indicate that informal patient payments are a substantial phenomenon in terms of both scope and scale, and cannot be neglected. Moreover, results of household surveys would be more meaningful if considered against the background of macro-level data at a national level (whenever available). For example, the National Health Accounts could be a useful source of macro-level data since they report total health expenditures as well as formal transactions in the health care sector (e.g. expenditures by various institutions, external financing and out-of-pocket spending). Moreover, little is known on why informal patient payments exist and how the specific patient-providers relationship determines them. This indicates the need to combine quantitative and qualitative research methods when studying this type of payments. The need of deeper understanding of the informal patient payments has already captured the attention of researchers who are trying to provide theoretical explanations to the existing empirical findings (Burak & Vian, 2007; Gaal & McKee, 2004).

We searched systematically for relevant publications. However, we can not exclude the possibility that we have missed some studies reported in non-English language journals as well as very recent studies that are still not reported. Despite this shortcoming, our results and discussion are relevant to future research on informal patient payments. As mentioned above, the investigation of the phenomenon is interwoven with methodological complexities related primarily to the data collection and research instruments. We have outlined and discussed most of these complexities. However, other peculiarities (e.g. wording of the questions and the length of the interview) also require attention.

Based on our findings in combination with the conclusions of a recent methodological review presented in Roberts (2007), the following key strategies could be recommended to researchers who choose to study informal patient payments: (1) considering a broad country-specific definition of informal patient payments when designing the questionnaire and an adequate measurement unit that is meaningful to the population being sampled; (2) opting for face-to-face interviews at the respondents' home to ensure that the interview situation is adequately conducive to respondents but simultaneously, to enable a high response rate; (3) administering the questions on informal patient payments as an anonymous self-completion component within the face-to-face interview; (4) assuring respondents on the issues of confidentiality and explaining why the data on informal patient payments are important.

CHAPTER 3.

INFORMAL PAYMENTS FOR HEALTH CARE SERVICES - CORRUPTION OR GRATITUDE?

A STUDY ON PUBLIC ATTITUDES, PERCEPTIONS AND OPINIONS IN SIX CENTRAL AND EASTERN EUROPEAN COUNTRIES

Abstract

Governments in Central and Eastern Europe search for strategies that can help to eliminate informal patient payments. However, insight in the attitude towards these payments is lacking. Still, public opinion plays an essential role in dealing with informal payments since they reflect culture, social norms and historical developments in a country, and as a result, they influence individual attitudes and behavior. The acceptance of informal patient payments by the public enables the existence of these payments and may hinder the measures for their elimination. This study contributes to the knowledge by providing new insights on public attitudes towards informal patient payments. We compare public attitudes, perceptions and opinions regarding informal patient payments based on recent data for six Central and Eastern European countries. The results indicate that opponents of informal patient payments compose more than half of the country samples. Informal cash payments are more often associated with corruption compared to in-kind gifts to medical staff. However, significant differences among countries are observed. The ordinal regression results show that irrespective of the country, respondents who have ever been requested to pay informally have more negative attitudes towards informal patient payments. At the same time, those who have ever given cash and in-kind gifts express less socially desirable attitudes and perceptions. Also, three fourths of respondents support the eradication of informal payments. Hereby, governments should meet public expectations and implement a strategy for dealing with informal patient payments, applying information campaigns aimed at negative attitudes to both cash and in-kind gifts given to medical staff.

3.1 Introduction

In many Central and Eastern European (CEE) countries, informal (under-the-table) patient payments are an important payment channel (Stepurko et al., 2010, see Chapter 2). They help patients to avoid waiting lists and reduce waiting time, as well as to obtain more attention, better care or more specialized services (Lewis, 2007; Shishkin et al., 2003). A growing body of literature has studied the patterns and determinants of these payments (Gaal & McKee, 2005; Rechel & McKee, 2009; Shishkin et al., 2003; Szende & Culyer, 2006; Vian & Burak, 2006). Overall, the literature suggests that the existence of such payments is problematic because they affect not only households' standard of living (especially of low-income and vulnerable households) but also the overall efficiency and equity of health care provision.

Although countries have made efforts to eradicate informal patient payments (Atanasova et al., 2010; Baji et al., 2012), public opinions have not been considered broadly in these efforts. Still, public opinion plays an essential role in dealing with informal payments (Ensor, 2004) since they reflect culture, social norms and historical developments in a country, and as a result, they influence individual attitudes and behavior (Gatti et al., 2003). The acceptance of informal patient payments by the public enables the existence of these payments and may hinder measures for their eliminations. Moreover, public opinions towards a social phenomenon (such as informal payments for health care) may affect behavior of individual patients and providers, and thus, the specific patient-provider relation where informal payments originate from.

Therefore, it is not surprising that empirical studies on informal patient payments focus on this issue. Two cross-country studies, carried out in CEE countries about 10 years ago, confirm the variation in attitudes across the region (Belli, 2002; Cockcroft et al., 2008). In particular, Hungary and Poland are indicated as countries where negative feelings about informal out-of-pocket payments prevail while attitudes among the Romanian population are less negative (Belli, 2002). Also, a study in the Baltic countries reports that half of households perceive informal payments to a health care professional as a form of corruption (Cockcroft et al., 2008).

This chapter contributes to the literature by providing new insights on public attitudes, perceptions and opinions regarding informal patient payments based on recent data for six CEE countries. More specifically, the chapter aims to compare the public opinions on informal patient payments in six CEE former-socialist countries, namely Hungary and Poland (developed Central European countries), Bulgaria and Romania (less advanced Eastern

European countries), Lithuania (former Soviet republic, EU-member) and Ukraine (non-EU member, former Soviet republic).

The subsequent section provides additional information to the previously presented background information (see Chapter 1) about countries included in the study and about the circumstances that accompanied informal patient payments. This is followed by the sections on methods and results. The discussion of the results is used to draw conclusions about policy and research.

3.2 Background

Across the CEE region, health care systems proceed on their own road of development, failures, and achievements. As described in Chapter 1 and illustrated by Table 1.1, Figure 1.2 and Appendix A, this is accompanied by notable differences in other areas: governance, laws, economic and socio-political situation, including levels of corruption, cultures of moral and financial incentives in obtaining services at state facilities. Thus, the transition period resulted in a mixture of values as well an absence of clear goals, an obsolete institutional base, a crisis of public trust, and passive civil opposition (Berend, 2007; Gorobets, 2008). The prevalence of public moods of nostalgia for lost security or vice versa the intention to escape the communist past urgently (e.g. joining EU) also differs among countries (Berend, 2007). Despite these general differences across the region, out-of-pocket payments have become a common feature of health care delivery (as previously mentioned in Chapter 1). Although some governments in the region continue to ignore the existence of informal practices in the health care sector, others have employed varying strategies (although not always effectively) to eliminate informal payments. For example, in Hungary, official charges for physician visits and hospitalizations were introduced in 2007 and one of their main policy objectives was to replace the informal payments by formal ones. The formal charges were later abolished due to strong opposition of the public expressed in a nation-wide referendum (Baji et al., 2010). Nevertheless, the practice of informal payments continues to exist (Baji et al., 2012).

Another strategy for dealing with informal patient payments relates to anti-corruption campaigns. Although for Bulgaria, evidence is lacking, it is suggested that in the case of Poland, this campaign (in combination with other policy measures) has contributed to a substantial reduction of informal patient payments in recent years (Golinowska, 2010). Indeed, the Corruption Perception Index in 2010 (presented in Appendix A) confirms the existence of moderate corruption in Poland, while in Bulgaria this problem is not under

control and still extensive. This questions the effectiveness of the anti-corruption campaigns in the Bulgarian health care sector.

The introduction of official charges and anti-corruption campaigns are not the only strategies for the eradication of informal patient payments. The literature suggests several important reasons for the prevalence of informal payments (Allin et al., 2006; Belli, 2001; Gaal et al., 2010; Lewis, 2007; Rechel & McKee, 2009; Thompson & Witter, 2000):

- health care, e.g. poor quality, access and administration, as well as insufficient funding;
- state, e.g. lack of accountability and transparency, as well as poor governance resulting in a failure to establish the rule of law and to adequately enforce patient rights;
- consumers, e.g. tradition of “gifts giving” expressed by patients and the specific supply-demand relation in health care.

Thus, only drastic measures can be effective to decrease the scope and the scale of informal patient payments. Each country should develop a wise and well-organized combination of strategies in order to achieve this aim. In order to contribute to the development of such strategies, we provide evidence on the consumer perceptions of informal payments. Such evidence is essential for understanding the general public attitudes and opinions regarding informal patient payments and for designing effective government policies to eradicate informal payments.

3.3 Data and methods

The data for our analysis are collected in July 2010 in identical household surveys conducted simultaneously in Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. During this period, the political and economic situation in all countries was relatively stable.

For the purpose of the surveys, a national representative stratified random sample was drawn in each country following a multi-staged random probability method. Firstly, the sampling points in each country were distributed proportionally to regional, urban/rural and ethnic characteristics of the population. Secondly, 8-10 addresses/households per sampling point were selected using the random route method². Thirdly, one adult member (older than 18 years) per household was selected using the “last birthday” principle (Gaziano, 2005;

² For each sampling point, a starting point and direction were determined. The household selected for the survey, was every fourth address on the left-hand side of the street in urban areas, turning left at intersections and, after reaching a dead end, going back to the last crossing and further proceeding at random. In a block-of-flats of up to four floors, every fifth apartment household was selected, counting from the first apartment on the left of the ground floor.

Oldendick et al., 1988). If the respondent identified at stage 3 refused or was unable to take part in an interview after two call backs, a replacing respondent was identified following stage 2-3. The objective was to have 1000 completed interviews per country.

Prior to the data collection, the interviewers were trained. A high number of interviewers were involved in the surveys to avoid interviewer bias. The face-to-face interviews were based on a standardized questionnaire that was identical for all countries. The questionnaire was developed in English and then translated in local languages. The translation was verified using the method of backward translation. On average, the interview lasted 30 minutes. The English wording of the questions used in our analysis is presented in Table 3.1 and Table 3.2 as well as in Appendix D.

Respondents are asked detailed information about their attitude toward informal cash payment and gifts in-kind (public attitudes), and whether they associate cash or in-kind gifts with corruption and gratuity (public perceptions or opinions on corruption). In these questions, we separate cash payments and in-kind gifts since the perception of gifts is expected to be dissimilar to that of cash payments. Respondents are also asked to indicate their opinions about the acceptability of informal patient payments. In particular, respondents are asked whether they agree with the frequent excuse for the existence of informal patient payments describing them as inevitable due to the low health care funding, and whether they agree with the need of eradicating informal patient payments (public perceptions or opinions on acceptability). Additionally, we ask respondents about their past experience with informal payments: whether they have ever given cash or in-kind gifts to medical staff (incl. physicians) as well as whether they have been ever personally requested by medical staff to pay informally.

We compare the data for a country to the average estimates for all countries using χ^2 tests ($p < .05$). In addition to this, we compare the data across the countries using Mann-Whitney test ($p < .05$). Two-step cluster analysis is also applied to identify meaningful groups of public attitudes, perceptions and opinions in the countries. This method is chosen instead of hierarchical analysis or k-means clustering because of the large sample size and the binary/ordinal nature of the variables (Norusis, 2011). Three cluster analyses are carried out each using one group of perception variables: (1) attitudes towards cash informal payments and in-kind gifts; (2) perceptions of informal payments as corruption or gratuity; (3) opinions about the acceptability of informal patient payments. The clustering procedure is repeated several times in order to check the stability of the clusters.

Based on the three cluster analyses, three variables indicating cluster membership per respondent are created. The cluster membership variables are recoded to order the clusters of respondents from less in favor to more in favor of informal patient payments (i.e. from less problematic to more problematic from a policy point of view). Thus, the first cluster membership variable ranges from 1 – more negative attitudes to 4 – more positive attitudes, while the second cluster membership variable ranges from 1- stronger association with corruption to 4 – stronger association with gratitude. The third cluster membership variable ranges from 1 - lower acceptance of informal patient payments to 4 – higher acceptance of informal patient payments. Ordinal regression analysis is used to investigate the association between the value of the cluster membership variables and a set of independent variables (country variables, individual and household socio-demographic characteristics, and past experience with informal payments). The correlation between the independent variables included in the regression analysis is weak (correlation coefficient $< .6$) or insignificant ($p > .05$).

3.4 Results

Response rates vary between countries from the lowest in Poland and Ukraine (38% and 42% respectively) to the highest in Bulgaria and in Hungary (67% and 76% respectively). For Romania and Lithuania, the response rates are 56% and 52% respectively. Still, the percentage of those who refused to participate in our study is low (1-6% of non-respondents). The rest of the non-respondents were either unable to participate or could not be contacted by the interviewer at all. As explained above, all non-respondents were replaced by other respondents. The initial analysis of the samples presented in Appendix C indicate that the sample characteristics related to age, gender, place of residence and household income, are comparable to the countries' national statistics. This suggests that the procedure applied for the selection of respondents, resulted in samples that are fairly representative for the countries.

3.4.1 *Experience of making informal patient payments*

Table 3.1 shows the valid percentage of respondents, who report that they have ever paid informally in cash or in the form of in-kind gifts. This percentage of those who have ever given cash to medical staff is the lowest in Poland (17.3%) and Bulgaria (19.5%) and around

three times higher in Hungary and Romania. In Lithuania and Ukraine, this percentage is virtually the same as in the latter two countries. For all countries except for Hungary, a higher percentage of respondents report that they have ever made informal payments to medical staff in the form of in-kind gifts compared to cash payments. This is especially visible for Bulgaria and Poland where two times more respondents report that they have ever given in-kind gifts to medical staff. For the rest of the countries, the percentage of those who have ever given in-kind gift is about or slightly more than half of the respondents.

Table 3.1 also shows that each third respondent in the Ukrainian sample and each fifth respondent in the Romanian sample has been ever asked to pay informally for health care services, while in other countries (except for Hungary) about 15% of respondents report such requests. The Hungarian sample shows the lowest percentage of respondents who have been asked to pay informally (6.6%). Nevertheless, in all six countries, a major part of the sample does not know where or how to complain in case informal payments are requested.

3.4.2 Public attitudes, perceptions and opinions of informal patient payments

Table 3.2 contains the valid percentage and number of respondents per country, who stated their perceptions and attitudes toward informal patient payments. Generally, the attitudes towards informal cash patient payments are rather negative in all countries (72% of the respondents on average). The attitudes towards in-kind gifts are also negative but to a lesser extent (51% of the respondents on average). It should be noted however that negative attitudes towards informal cash payments are most often stated by respondents in Bulgaria and Poland (85% and 78% respectively) and least often by respondents in Hungary (48% of the respondents). For Lithuania, Romania and Ukraine, a negative attitude towards informal cash payments is reported by 72-75% of the respondents in these countries.

With regard to in-kind gifts, another pattern of countries appears. Respondents in Romania and Poland most often have a negative attitude towards these gifts (65% and 61% respectively), followed by Bulgaria and Ukraine (55% and 52% respectively), and by Lithuania and Hungary (45% and 32% respectively). In addition, we observe a relatively large percentage of Hungarians (about 35-37%) who have an indifferent attitude towards both informal cash payments and in-kind gifts.

Approximately 67% of all respondents agree that informal cash payments are similar to corruption. For Bulgaria and Poland, this percentage is much higher than the average for all countries. Nearly four-fifth of the respondents from these two countries perceive informal

cash payments as corruption. Less drastic are the perceptions in Romania and Ukraine, where slightly more than half of the respondents support this statement, and even less in Hungary, where only 47% support the statement. Overall, in-kind gifts are less often associated with corruption (40% of all respondents), especially in Poland, Bulgaria and Romania, and to a lesser extent in Hungary and Ukraine.

Concerning the perception of cash payments or in-kind gifts as an expression of gratitude, 40% of the respondents accept such comparison in case of in-kind gifts and practically the same percentage disagrees in case of cash payments. Bulgarians seem to be the most confident that informal cash payments cannot be an expression of gratitude (64% disagree), while for Ukraine, Romania and Hungary, this percentage is two times lower.

Most respondents (70% on average) support the statement that informal patient payments should be eradicated, and only about 9% of them think that this is not necessary. This pattern is observed for all countries, but to a lesser extent for Hungary and Ukraine (only

Table 3.1. Experiences with informal patient payments – a cross-country comparison

Data collection year: 2010 General population		Bulgaria N = 1003		Hungary N=1037		Lithuania N=1012		Poland N=1000		Romania N=1000		Ukraine N=1000		Total - all respondents N=6052	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Q.1.1. Have you ever personally paid informally in cash to physicians, medical staff or other personnel in health care facilities? ^a	No	794	80.5*	435	41.9*	525	52.0*	801	82.7*	410	41.2*	467	47.0*	3432	57.3
	Yes	192	19.5*	602	58.1*	484	48.0*	167	17.3*	586	58.8*	527	53.0*	2558	42.7
Q.1.2. Have you ever personally given any gift in kind to physicians, medical staff or other personnel in health care facilities? ^b	No	531	54.4*	468	45.1*	472	46.7	627	64.9*	373	37.6*	417	42.0*	2888	48.3
	Yes	446	45.6*	569	54.9*	539	53.3	339	35.1*	620	62.4*	576	58.0*	3089	51.7
Q.1.3. Have you been ever personally asked by physicians, medical staff or other personnel to pay informally in cash or to give a gift in kind? ^c	No	806	82.9	969	93.4*	887	87.9*	843	86.6*	774	78.3*	689	69.5*	4968	83.2
	Yes	166	17.1	68	6.6*	122	12.1*	130	13.4*	215	21.7*	303	30.5*	1004	16.8
Q.1.4. Do you know where to complain if physicians, medical staff or other personnel in health care facilities ask you to pay informally for medical services? ^d	No	650	64.8*	665	63.9*	757	74.8*	635	63.5*	734	73.4*	787	78.7*	4228	69.9
	Yes	353	35.2*	372	36.1*	255	25.2*	365	36.5*	266	26.6*	213	21.3*	1824	30.1

* Statistically significant difference between the country estimate and the average estimate for all countries (χ^2 ; $p < 0.05$)

^a No significant differences between Bulgaria – Poland and Hungary – Romania (Mann-Whitney U test; $p > 0.05$)

^b No significant differences between Hungary – Lithuania and Hungary – Ukraine (Mann-Whitney U test; $p > 0.05$)

^c No significant differences between Poland – Lithuania (Mann-Whitney U test; $p > 0.05$)

^d No significant differences between Hungary – Poland, Hungary – Romania and Poland – Romania (Mann-Whitney U test; $p > 0.05$)

Table 3.2. Public perceptions and attitudes towards informal patient payments – a cross-country comparison

Data collection year: 2010 General population		Bulgaria N = 1003		Hungary N=1037		Lithuania N=1012		Poland N=1000		Romania N=1000		Ukraine N=1000		Total - all respondents N=6052	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Q.2.1. What is your attitude towards informal cash payments to physicians, medical staff or other personnel in health care facilities? ^a	Negative	819	84.7*	496	48.1*	725	72.2*	780	78.3	716	72.3	738	74.9*	4247	71.6
	Indifferent	100	10.4	360	34.9	113	11.3*	202	20.3	178	18.0	130	13.2*	1083	18.1
	Positive	47	4.9	175	17.0	166	16.5*	14	1.4*	96	9.7	117	11.9*	615	10.3
Q.2.2. What is your attitude towards giving gifts in kind to physicians, medical staff or other personnel in health care facilities? ^b	Negative	522	54.5*	330	32.0*	449	44.7*	601	60.5	647	65.0*	508	51.6*	3057	51.2
	Indifferent	179	18.7*	386	37.4*	124	12.3*	304	30.6	203	20.4*	188	19.1*	1384	23.2
	Positive	257	26.8*	315	30.6*	432	43.0*	89	9.0*	146	14.7*	288	29.3*	1527	25.6
Q.2.3. Informal cash payments to physicians and medical staff are similar to corruption. ^c	No	28	2.9*	207	20.1	106	10.6	35	3.5*	176	18.1*	120	12.2*	672	11.3
	Somewhat	135	13.9*	338	32.8	193	19.3	140	14.1*	200	20.6	294	29.9*	1300	21.9
	Yes	806	83.2*	484	47.0*	703	70.2*	815	82.3*	596	61.3	568	57.8*	3972	66.8
Q.2.4. Gifts in kind to physicians and medical staff are similar to corruption. ^d	No	260	27.2	428	41.4*	335	33.3	198	19.9*	262	26.8	366	37.3	1849	31.1
	Somewhat	276	28.9	305	29.5*	288	28.6	267	26.9*	244	24.9	319	32.5	1699	28.6
	Yes	420	43.9	300	29.0*	383	38.1	528	53.2*	472	48.3*	296	30.2*	2399	40.3
Q.2.5. Informal cash payments to physicians and medical staff are an expression of gratitude. ^e	No	610	64.0*	335	32.4*	455	45.4	578	58.8*	334	33.9*	338	34.2*	2650	44.6
	Somewhat	227	23.8*	374	36.2*	345	34.4	274	27.9*	358	36.3*	409	41.4	1987	33.4
	Yes	116	12.2*	325	31.4*	203	20.2	131	13.3*	293	29.7*	241	24.4	1309	22.0
Q.2.6. Gifts in kind to physicians and medical staff are an expression of gratitude. ^f	No	201	21.0	172	16.6	186	18.5	275	27.9*	245	24.8	171	17.2*	1250	21.0
	Somewhat	415	43.3	362	34.9	354	35.2	393	39.9*	394	40.0	401	40.4	2319	38.9
	Yes	342	35.7*	503	48.5*	467	45.4*	317	32.2*	347	35.2*	421	42.4	2397	40.2
Q.2.7. Informal cash payments and gifts in kind to physicians and medical staff are inevitable because of the low funding of the health care sector. ^g	No	527	62.8*	402	31.9*	470	47.7	548	57.6*	343	35.4*	254	25.9*	2589	44.5
	Somewhat	236	25.9*	319	31.1	271	27.5	273	28.7*	297	30.7*	293	29.9*	1689	29.0
	Yes	103	11.3*	306	29.8	245	24.8	130	13.7*	329	34.0*	433	44.2*	1546	26.5
Q.2.8. Cash or gifts in kind, given informally to physicians and medical staff, should be eradicated. ^h	No	51	5.5*	168	16.4*	82	8.4	46	4.8*	80	8.4	76	7.6*	500	8.6
	Somewhat	193	20.8	295	28.8*	182	18.6	175	18.4*	160	16.9	257	26.6*	1262	21.8
	Yes	685	73.7	561	54.8*	717	73.1*	729	76.7*	709	74.7	636	65.8*	4037	69.6

* Statistically significant difference between the country estimate and the average estimate for all countries (χ^2 ; $p < 0.05$)
Mann-Whitney U test; $p > 0.05$.

^a No sig. differences between Lithuania – Romania, Lithuania – Ukraine and Romania – Ukraine. ^e No sig. differences between Hungary – Romania, Hungary – Ukraine and Romania – Ukraine.

^b No sig. differences between Bulgaria – Ukraine, Hungary – Lithuania and Poland – Romania. ^f No sig. differences between Bulgaria – Romania, Hungary – Lithuania, Hungary – Ukraine, Lithuania – Ukraine and Poland – Romania.

^c No sig. differences between Bulgaria – Poland and Romania – Ukraine.

^d No sig. differences between Bulgaria – Romania and Hungary – Ukraine.

^g All countries differ significantly. ^h No sig. differences between Bulgaria – Lithuania, Bulgaria – Poland, Bulgaria – Romania, Lithuania – Romania, and Poland – Romania.

55% and 66% respectively supporting the statement). In total, 27% of all respondents accept the statement that informal payments for health care are inevitable because of the low health care funding. This percentage is especially high for Ukraine. About 44% of all Ukrainian respondents are inclined to find an excuse for the informal patient payments in the low funding of the health care system, while this statement is least often accepted in Poland and Bulgaria, around 14% and 12% of respondents respectively.

3.4.3 Results of the cluster analysis

In order to outline country specific patterns regarding attitudes, perceptions and opinions we perform three cluster analyses:

- cluster analysis 1: to create attitude clusters based on two variables that indicate the attitude towards informal cash payment and gifts in-kind respectively (Q.2.1 and Q.2.2 in Table 3.2);
- cluster analysis 2: to create corruption or gratitude clusters based on four perception statements about informal cash payment and gifts in-kind respectively being either corruption or gratitude (Q.2.3-Q.2.6 in Table 3.2);
- cluster analysis 3: to create acceptability clusters based on two opinion statements about the possible inevitability of informal payments due to low funding levels and the need of their eradication (Q.2.7 and Q.2.8 in Table 3.2).

For all three cluster analyses, four clusters appear to give the most meaningful solution. Table 3.3 presents the description of the clusters per cluster analysis and the distribution of the samples among these clusters. For each cluster analysis, the clusters are ordered in Table 3.3 starting with the cluster that indicates perceptions least in favor of informal patient payments to the cluster that indicates perceptions most in favor of informal patient payments.

As indicated in Table 3.3, the largest cluster in the first cluster analysis based on attitudes, is cluster 1 that indicates a predominantly negative attitude towards both informal cash payments and in-kind gifts. This cluster is largest for Romania, Poland and Bulgaria (62.3%, 58.7% and 54.5% of respondents respectively), and it is smallest for Hungary (only 29.6%). The last cluster (cluster 4) that indicates a predominantly positive attitude towards both types of informal payments is smallest for Poland - 5.4% and largest for Hungary (27.0% of respondents).

Table 3.3. Results of the cluster analyses – a cross-country comparison

Data collection year: 2010 General population		Bulgaria		Hungary		Lithuania		Poland		Romania		Ukraine		Total - all respondents	
		N	%	N	%	N	%	N	%	N	%	N	%	N	%
Cluster analysis 1 ^a Attitude clusters based on attitudes towards informal cash payments and in-kind gifts	Cluster 1	Negative towards both informal cash payments and in-kind gifts													
	Cluster 2	Negative towards cash payments but positive or indifferent towards in-kind gifts													
	Cluster 3	Indifferent towards both informal cash payments and in-kind gifts													
	Cluster 4	Mostly positive towards both informal cash payments and in-kind gifts													
Cluster analysis 2 ^b Corruption or gratitude clusters based on perceptions of cash informal payments and in-kind gifts as corruption or gratuity	Cluster 1	Perceive both informal cash payments and in-kind gifts only as corruption													
	Cluster 2	Perceive both informal cash payments and in-kind gifts mostly as corruption													
	Cluster 3	Perceive informal cash payments as corruption and mixed answers for in-kind gifts.													
	Cluster 4	Perceive both informal cash payments and in-kind gifts mostly as gratitude													
Cluster analysis 3 ^c Acceptance clusters based on the perception regarding the need to eradicate informal payments and the inevitability of such payments due to low-funding	Cluster 1	Disagree with the inevitability and support the eradication													
	Cluster 2	Uncertain about the inevitability but support the eradication													
	Cluster 3	Accept inevitability but support the eradication													
	Cluster 4	Accept inevitability and mixed answers about the eradication													

^a No significant differences between Bulgaria – Poland, Bulgaria – Ukraine and Poland – Ukraine (Mann-Whitney U test; $p > 0.05$)^b No significant differences between Bulgaria – Romania, Poland-Romania, Hungary – Lithuania, Hungary – Ukraine and Lithuania – Ukraine (Mann-Whitney U test; $p > 0.05$)^c No significant differences between Bulgaria – Poland and Hungary – Ukraine (Mann-Whitney U test; $p > 0.05$)

With regard to the second cluster analysis based on the four corruption/gratitude statements, a large part of the Polish, Bulgarian and Romanian samples (more than 50% of respondents) falls into the first two clusters. These clusters imply (to a different extent) that informal patient payments (cash and in-kind) are similar to corruption. For Hungary, these two clusters represent only 37.7% of respondents (smallest across the countries). At the same time, a considerable part of the Hungarian sample but also of the Ukrainian and Romanian samples falls in the last cluster (cluster 4) where both types of informal patient payments are considered an expression of gratitude (44.9%, 36.5% and 32.1% of respondents respectively). This last cluster is smallest for Poland and Bulgaria (around 15%).

Regarding the third cluster analysis based on statements related to the acceptability of informal patient payments, three out of four clusters are populated by those who support their eradication. Nevertheless, the opinion about the possible inevitability of informal payments due to the low funding level, ranges in these clusters from a predominant disagreement (cluster 1) to predominant agreement (cluster 3). The last cluster (cluster 4) represents a predominant agreement with the inevitability of informal payments and mixed answers on their eradication. This fourth cluster is largest for Hungary (45%). But it is also relatively large for the other countries ranging from 24% for Poland to 34% for Ukraine.

3.4.4 Results of the regression analysis

Table 3.4 presents the results of three ordinal regression analyses each of them using the cluster membership variable of one cluster analysis as dependent variable. The cluster membership variables range from 1 (cluster least in favor of informal patient payments) to 4 (cluster most in favor of informal patient payments). As explained in the method section, we use three groups of independent variables: country (Lithuania is taken as a base country category because the results for Lithuania are often close to the average, see Table 3.2), individual and household socio-demographic characteristics, and past experience with informal payments (ever made informal payments in cash or as in-kind gifts, and ever being requested to pay informally).

The regression results show that in all three models, Polish respondents express attitudes and perceptions that are less in favor of informal patient payments compared to those in Lithuania. In contrast, Hungarians are more in favor of informal payments in all three models. Also, compared to Lithuania, more negative attitudes towards informal payments prevail in Bulgaria, Romania and Ukraine.

Table 3.4. Ordinal logistic regression on cluster analysis variables

Data collection year: 2010	Attitude clusters	Corruption or gratitude clusters	Acceptance clusters
	[From 1- less in favor of informal payments to 4- more in favor of informal payments]		
	Coefficient (S.E.)	Coefficient (S.E.)	Coefficient (S.E.)
Bulgaria [0 – other countries; 1 – Bulgaria]	-0.409* (.096)	-.138 (.093)	-.231* (.096)
Hungary [0 – other countries; 1 – Hungary]	0.546* (.089)	.551* (.089)	.709* (.089)
Poland [0 – other countries; 1 – Poland]	-0.479* (.098)	-.272* (.093)	-.263* (.096)
Romania [0 – other countries; 1 – Romania]	-0.548* (.092)	.055 (.089)	.291* (.089)
Ukraine [0 – other countries; 1 – Ukraine]	-0.160** (.095)	.483* (.092)	.793* (.094)
Have you been ever personally asked by physicians, medical staff or other personnel to pay informally in cash or to give a gift in kind? [0 - No; 1 - Yes]	-0.740* (.079)	-.736* (.074)	-.441* (.075)
Have you ever personally given any gift in kind to physicians, medical staff or other personnel in health care facilities? [0 - No; 1- Yes]	0.244* (.065)	.262* (.063)	.337* (.064)
Have you ever personally paid informally in cash to physicians, medical staff or other personnel in health care facilities? [0 - No; 1- Yes]	0.703* (.060)	.749* (.059)	.458* (.059)
Age [Years]	-.004* (.002)	.000 (.002)	-.002 (.002)
Gender [0 - Male; 1 - Female]	-.124* (.054)	-.048 (.052)	-.027 (.053)
Residence place [0 - Village; 1 - Town; 2 - Small city; 3 - Large city; 4 - Capital]	.063* (.022)	.039** (.022)	.130* (.022)
Level of current education or current study [From 0 - Uncompleted primary education to 5 - Tertiary education]	-.035 (.027)	-.001 (.026)	-.039 (.026)
Health problems confirmed by a physician (e.g. diabetes, stroke, etc.) [0 - No; 1 - One or more health problems]	.131* (.060)	.080 (.058)	.056 (.056)
Number of adults in the household	.011 (.031)	-.008 (.030)	.017 (.030)
Number of children under the age of 18 in the household	-.014 (.032)	-.023 (.031)	-.011 (.031)
Net average household income per month ^a [From 0 - Less than 50 Euro to 17 – More than 3000 Euro]	.013 (.010)	.018* (.009)	.010 (.010)
Threshold =1	.025 (.170)	-1.121 (.167)	-.024 (.169)
Threshold =2	1.071 (.171)	.664 (.166)	.777 (.169)
Threshold =3	1.874 (.173)	1.668 (.168)	1.554 (.171)
Number of observations	5379	5287	5196
Pseudo R Square	.117	.103	.106

* $p < 0.05$; ** $p \leq 0.10$.^a Net average household income per month (i.e. after tax income) – considering all household members and all sources - wages, pensions, rents, etc.

When the labels of corruption or gratitude are given to informal patient payments, perceptions in Romanian and Bulgarian do not differ from those in Lithuania. Ukrainians, similarly to Hungarians, are more inclined to associate informal payments with gratuity and to accept the low health care funding as an excuse for their existence. The latter applies to the Romanian sample as well. Bulgarian respondents, similar to the Polish respondents, less often agree with the inevitability of informal payments and more strongly support their eradication.

Irrespective of the country, respondents who have ever been requested to pay informally have more negative attitudes and perceptions towards informal patient payments. At the same time, those who have ever given cash and in-kind gifts (the latter having a higher effect) express attitudes and perceptions that are more in favor of informal payments (i.e. less socially desirable attitudes and perceptions).

With regard to individual and household socio-demographic characteristics, only residence place is positively associated with all dependent variables (citizens of more populated sites show more positive attitudes/ less desirable perceptions). Other socio-demographic features do not show consistent associations across the countries. More specifically, having one or more health problems is associated with more positive attitudes towards informal patient payments whereas being member of a poorer household is related to a stronger association of informal payments with corruption.

3.5 Discussion

This chapter has explored the public perceptions towards informal patient payments using recent data from six CEE countries – Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine. Overall, we observe variation in public perceptions towards these payments across the countries. In particular, public perceptions in some countries (especially in Poland but also in Bulgaria) are less in favor of informal patient payments than in other countries (especially in Hungary and Ukraine). The less positive attitudes and perceptions towards informal patient payments in Poland can be attributed to the anti-corruption policies in the country, as described in the background section and in Chapter 1 (see Figure 1.2, SPACE matrix analysis). The same explanation holds for Bulgaria as well.

Nevertheless, as our results suggest, in all six countries, there are groups of respondents who favor informal patient payments, which might enable their existence. The challenges these public perceptions present to policy are subsequently discussed.

3.5.1 Informal payments – corruption or an ‘expression’ of gratitude?

Irrespective of the country, we observe consistent negative attitudes towards informal cash payments. Also, as the results of our cluster analysis suggest, informal cash payments are generally perceived as corruption, which is evidence of their social undesirability. The attitudes towards in-kind gifts are less negative and more mixed. These payments are more often perceived as gratitude than informal cash payments. Moreover, in the regression analysis, more positive perceptions of informal payments in general are observed among those who have ever given in-kind gifts than among those who have ever paid informally in cash. This difference in perceptions regarding informal cash and in-kind payments is reported in previous studies as well (Balabanova & McKee, 2002; Tatar et al., 2007) and it confirms the importance of distinguishing between them in policy analysis and research (Balabanova & McKee, 2002; Stepurko et al., 2010).

There are two factors that could explain the higher public acceptance of in-kind gifts compared to informal cash payments. First, some individuals might not see in-kind gifts as a payment (Gaal & McKee, 2005) because in some instances such gifts are a true expression of gratitude (Adam, 1989), i.e. they have a negligible monetary value and are given after the service provision by the thankful patient without any request or hint by the staff (e.g. chocolates, flowers). Such gifts can be observed in virtually any country around the world although the extent might differ (Abbasi & Gadit, 2008; Spence, 2005). Second, true gratitude payments seem to be sustainable for the patient and the patient’s family. Although such informal gifts should not be encouraged, they do not adversely affect efficiency in health care provision. Nevertheless, expensive in-kind gifts cannot be generally seen as true gratitude payments.

Another perspective on gift types is given by Drew and colleagues (1983) based on the time of giving the gift and its nature. The authors offer a distinction between gifts as ‘tips’ aiming to receive more personalized service, gifts to address the status imbalance in the doctor-patient relationship, and gifts as a sacrifice. Thus, among other things, in-kind gifts, like cash payments, can be used by patients as a means to obtain better and quicker services when the system fails to offer adequate service standards to all patients.

Still, the patient’s intention to benefit from achieving important service attributes through informal payment is not the only reason of the presence of bribes in health care provision. Medical staff can also ask for an informal payment (Balabanova & McKee, 2002; Shishkin et al., 2003; Vian et al., 2006). This is also indicated by our results for Romania and

Ukraine where more patients report that they have ever been requested to pay informally and more patients report ever having made such payments compared to other countries (therewith very few citizens know where to complain). Moreover, there is evidence that higher amounts of informal payments are given on the medical staff's request (Tomini et al., 2011). Thus, it is not surprising that in our study we observe a more negative attitude and opinion on informal payments among those who have ever been requested to pay informally. Such findings are also discussed in other publications (Balabanova & McKee, 2002; Cockcroft et al., 2008). The existence of requested informal payments is indicative of the financial troubles in the health care system rather than a cultural specificity (Cohen, 2012). Hence, urgent policy measures should include well designed financial and organizational health care reforms.

Meanwhile, irrespective of whether the informal payment is requested or not, and whether it is in cash or an in-kind gift, if there are no regulations on what a "thankful" patient should present to medical staff after the service delivery, expensive gifts may become customary. Such gifts might become expected or even requested (e.g. by giving a hint) by the medical staff. Since the differentiation "between a simple respectable gesture and underlying vested interests" (Abbasi & Gadit, 2008, p.281) is a challenging task, it would be more adequate to prohibit any type of in-kind gift in order to avoid favoritism (Abbasi & Gadit, 2008; Spence, 2005). Polite refusals, keeping records with the view of creating transparency, and mandatory training on ethics and law could be regarded as key strategies for physicians (Abbasi & Gadit, 2008). Strategies for dealing with corruption should also be followed (Shishkin et al., 2003; Vian, 2008). Also, patients should know that they have the right to health care service with adequate quality without any extra gifts. Raising social awareness in this direction is an important (although not the single) remedy for dealing with informal payments in general.

3.5.2 Social acceptance of informal payments as a policy challenge

Despite the difference in the general perceptions regarding cash and in-kind informal payments discussed above, we find positive and indifferent attitudes towards both types of payments in all six countries (though the largest clusters are based on negative attitudes). Indifferent attitudes by respondents do not seem a real expression of a lack of interest. In Shahriari, Belli and Lewis (2001), an ambivalent attitude is described as an expression of a deadlock situation (when payments for health care are perceived as a necessity) rather than lack of interest. Vian and Burak (2006) also provide evidence for respondents' feeling that

informal patient payments are unavoidable. In particular, the authors report that from the patients' perspective informal payments are "bad, but important" (Vian & Burak, 2006, p.399). Our analysis also confirms this. In particular, the results show that despite the overall public support for the eradication of informal patient payments, around half of the sample in each country perceives these payments as inevitable due to the low funding of the public health care sector. It is true that in all six countries, per capita government expenditures on health care is lower than in other countries in the region where informal payments are negligible, namely the Czech Republic and Slovenia (Leive, 2010; World Health Organisation, 2010). Thus, informal payments may well fill gaps in public health care funding in the six countries studied. Ensuring adequate health care provision and adequate salaries of physicians and other medical staff in public health care facilities are important policy measures to eliminate the need of informal payments. This is especially important for countries (e.g. Romania and Ukraine) where salaries of medical staff are below the national average and where the private sector is undeveloped (Holt, 2010a; Lekhan et al., 2010).

An underfunded health care sector and inadequate payments to medical staff provide an excuse for health care staff to request informal payments (as some respondents believe), as well as for policy-makers to remain passive when it comes to dealing with the problem of informal patient payments. However, when this is also the message for the public from policy-makers and health care providers, citizens start to perceive these payments as inevitable (as reported in our study). Our regression analysis suggests that the urban population (irrespective of the country) is more willing to accept informal patient payments than respondents living in rural areas. This can be explained by a lack of economic, social and cultural capital endured by village inhabitants that makes centralized health care services in urban areas less acceptable for the rural population (Siskou et al., 2008; Tomini et al., 2011).

Positive and indifferent attitudes towards informal patient payments, as well as the acceptance of these payments as inevitable, are perhaps the most challenging findings of our study from the point of view of policy-making. Strategies aiming at dealing with informal patient payments may not be successful if some health care consumers accept or do not mind paying informally for health care. This means that public campaigns to create social opposition towards all types of informal payments should be an important part of policy actions against these payments. However, the experience in Bulgaria suggests that isolated public campaigns are not sufficient. To be effective, they should be combined with other anti-corruption measures as was done in Poland (Golinowska, 2010). Indeed, the good governance case of Poland as noticed in Chapter 1, Figure 1.2 could be a good example to follow.

Possibly, anti-communist public moods, lack of nostalgia as well as the intention to join the EU has supported such responsiveness resulting in market-oriented reforms in virtually all sectors (Leven, 2005). In particular, we observe fierce negative attitudes and strong public perceptions against informal patient payments in Poland, as well as the lowest number of those who have ever made informal payments. Anti-corruption actions of the government in all sectors, supported by mass-media, seem to work effectively against informal payments. Mass-media could help to shed a negative light on informal patient payments and create public opposition towards these payments, as well as to raise social awareness about the patient right to adequate health care without informal payments. The knowledge and opinion of the public should be involved in a study of the role of the mass-media during health care reforms and information campaigns.

Meanwhile, neighbor countries such as Bulgaria and Romania demonstrate contrasting results on informal payments. However, they similarly label informal patient payments as gratitude or corruption in our study. EU incentives have facilitated improving the institutional base in Bulgaria and Romania, as well as its efficiency (Spendzharova & Vachudova, 2011). As described in Chapter 1 (Table 1.2. and Figure 1.2), the two countries have similar scores on the socio-cultural and political-regulatory dimensions, though Bulgarian's scores for economics and health systems indicate an environment less conducive to informal payments. Also, Bulgarian policies have changed with the recent changes among the political elites and policies to improve health care provision have been successful (Atanasova et al., 2010; Bartlett & Bozиков, 2012). This again confirms the multidimensional nature of informal payments where improvements in a single dimension cannot guarantee the eradication of informal payments.

Furthermore, Hungary and Lithuania show acceptable rates of governance and expenditures on health as presented in Table 1.2 and Figure 1.2 (see Chapter 1). However, we observe a high rate of respondents who have ever made informal payments and more positive opinions on these payments. This is evidence of the importance of public attitudes. Thus, similar to measures taken in Poland, creating public oppositions can improve the effectiveness of policy strategies to eradicate informal patient payments in these countries.

3.6 Concluding remarks

Our study does not go without limitations. Although self-administrated research tools are recommended when a sensitive issue (such as informal patient payments) is studied (Stepurko

et al., 2010, see Chapter 2), we have chosen for face-to-face interviews to assure a good understanding of the questions and properly filled in answers. We observe an insignificant number of refusals to answer the questions, which indicates that the sensitivity of the research topic is not a problem in the six countries included in the study. Moreover, we consider that the respondents' wish for discussing informal patient payments is not reflected in the response rate since the research theme contained more issues, i.e. it is presented to potential respondent as "willingness and ability to pay for medical services". Moreover, the share of non-respondents who refused to participate was rather low.

Our results indicate that across the countries, informal cash payments are perceived negatively, mostly as corruption, while in-kind gifts are often seen as gratitude. Despite the public support for the eradication of informal payments, there are groups of respondents who favor their existence and this should be in the focus of policy-makers. Unless there is an effective system to distinguish the nature of the informal payment (bribery/corruption or gratitude), it is important to prohibit the acceptance or request of any "gift". In parallel to this, there should be measures to assure a respectable wage for medical staff and to improve health care provision. Even when health care resources are insufficient and when medical staff's salaries are low, it is unethical when health care providers request/accept informal payments from patients, and when policy-makers overlook the practice of charging patients informally.

Also, previous research has shown that informal patient payments mostly prevail in countries with poor governance where well-designed and respectable rules that reflect performance are absent (Fiszbein et al., 2011). Lack of adequate regulation opens possibilities for patients to apply a "do-it-yourself approach" (Cohen, 2012) in ensuring adequate access and quality of public services. In addition to this, the topic of patient rights as well as population involvement in health policy developments (seen as a pressing issue in good-governed countries) appears irrelevant in countries where the law is not followed (Grødeland & Aasland, 2011). The need of creating regulations for wider issues is questionable if existing rules are not complied with. Thus, the governments in CEE countries should take the responsibility to secure adequate governance and provision of basic health care services, and eliminate informal patient payments. Our study could be useful in this direction. Still, it is only focused on the consumers' perspective of informal patient payments (public opinions). The government's and providers' point of view should also be studied. Results of opinion research combined with other important financing, organization and governance strategies can help to set up effective strategies to deal with informal payments.

CHAPTER 4.

TO PAY OR NOT TO PAY?

A MULTI-COUNTRY STUDY ON INFORMAL PAYMENTS FOR HEALTH CARE SERVICES AND CONSUMERS' PERCEPTIONS

Submitted for publication.

Abstract

Although the literature offers a variety of theoretical explanations for the existence of informal patient payments, empirical research has mostly focused on socio-demographic features as determinants of these payments. The role of patients' perceptions (beliefs) concerning informal payments is rarely taken into account especially in multi-country surveys. We examine the association between informal payments for health care services (actual behavior) and perceptions of health care consumers about paying informally (perceived behavior statements) as well as socio-demographic characteristics. The data are collected in 2010 based on national representative samples in six Central and Eastern European countries. The results of the cross-country comparisons suggest that health care users in Bulgaria and Poland are less inclined to make informal payments, while health care users in Romania and Ukraine most often report such payments. The informal payment rates for Hungary and Lithuania fall between these two groups. In all six countries, individuals who feel uncomfortable when leaving the physician's office without a gratuity and who feel unable to refuse the request of medical staff to pay informally, more often make informal payments. Such consumers' perceptions can undermine policy efforts to eradicate these payments. Public information campaigns combined with improvements in health care provision (organization, financing, and ethics) can reinforce social resistance to informal payments for health care services.

4.1 Introduction

The context of health care reforms contributes to the interest in the topic of informal patient payments. Empirical studies on informal (under-the-table) patient payments provide evidence on their diverse patterns in Central and Eastern European (CEE) countries (Cohen, 2012; Stepurko et al., 2010; Lewis, 2007). The results of a multi-country comparison, conducted about 10 years ago, indicate that at that time, informal patient payments presented a comparatively minor problem in the Czech Republic. However, in Poland, Hungary and Romania, they were significant even though a negative attitude towards these payments prevailed in the countries (Belli, 2002). Virtually at the same time, another cross-country study in Estonia, Latvia, and Lithuania reported gifts (by 14% of health care users) and informal payments (1-8% of users) to health care staff at government facilities (Cockcroft et al., 2008). Only about half of the general public in these countries stated that such payments can be a form of corruption. Although informal patient payments are still the focus of research, cross-country studies are solitary. The numerous single-country studies on informal patient payments (e.g. Özgen et al., 2010; Liaropoulos et al., 2008; Vian et al., 2006) do not allow for cross-country comparisons due to differences in the methodology used (Lewis, 2007; Allin et al., 2006).

Nevertheless, single-country studies are important because they provide an indication of the scale of informal payments in a country (Belli et al., 2004; Chawla et al., 1998; Delcheva, 1997), or of their determinants (Tomini et al., 2011; Tomini & Maarse, 2011; Özgen et al., 2010). Overall, respondents' socio-demographic features rarely appear significant in predicting whether an individual makes informal payments and in determining the size of the payments (Liaropoulos et al., 2008; Belli, 2002). Occasionally, age, education and household expenditures (or income) have a significant relation with the incidence of informal payments (a negative association with age and a positive association with the level of education and income/expenditure) (Tomini et al., 2011; Özgen et al., 2010; Cockcroft et al., 2008; Szende & Culyer, 2006). Besides, a significant positive relation is found between the levels of formal and informal out-of-pocket payments for health care (Belli, 2002). Although there are a number of descriptive studies on patients' attitudes and perceptions regarding informal payments in the public sector (Miller, 2006; Belli, 2004; Balabanova & McKee, 2002; Shahriari et al., 2001), attitudes and perceptions are rarely included in quantitative explanatory studies (Burak & Vian, 2007; Vian & Burak, 2006).

In view of the above, this chapter contributes to the current literature by presenting a quantitative cross-country study that aims to investigate the relation between informal payments made by an individual (actual behavior) and perceptions of health care consumers related to making such payments (perceived behavior statements) as well as socio-demographic characteristics. We define informal patient payments as payments for health care services in the public sector that occur outside the formal payment channels (i.e. patients do not get receipts for these payments). We consider both cash payments and in-kind gifts paid/given by the patients on the providers' requests or initiated by the patients' as a means to obtain better service or as an expression of true gratitude. With regard to perceptions, we focus on perceptions (beliefs) about making an informal payment stated by respondents given a hypothetical situation. We use these statements as indicators of individual acceptance or willingness to pay informally for health care. Beliefs about probable future behavior appear to be part of a disposition (Broko et al., 2007) that ensures specific behavior to occur in a given situation. Thus, we expect that patients' beliefs about making informal patient payments have more explanatory power than socio-economic characteristics. In contrast to previous studies, we combine quantitative data on individual perceptions and socio-demographic characteristics to explain variations in informal patient payments. Moreover, we apply the same analysis to data for six CEE countries, which allows for a cross-country comparison and for establishing the robustness of our findings.

The data for our analysis are collected in 2010 in Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine as it is described in previous chapter. First, we compare the past experience of paying informally for health care services and respondents' perceptions about making informal payments across countries. We use regression analysis to investigate whether individual perceptions and socio-demographic characteristics are associated with the experience of paying informally. These and other findings are presented in the results section, preceded by the description of the methods. Finally, a discussion of the key findings and conclusions are presented.

4.2 Methods

As in Chapter 3, we use cross-country data collected in CEE countries in 2010 via national representative samples based on structured face-to-face interviews (more details on research and sample design as well as wording of the question is available in Appendix B). Although we recognize that self-administrated modes of data collection would have been more suitable

for collecting data on a potentially sensitive topic, such as informal patient payments, we have used the face-to-face interview mode due to respondents' needs in interviewer's assistance that appeared during the pre-test. Nevertheless, we have considered strategies to improve the validity of data collection, such as the involvement of skilled interviewers (on average 100 trained interviewers per country), pre-tests of the wording of the questions, inclusion of the questions on perceptions (i.e. the most sensitive questions) in the middle of the questionnaire.

The response rate varies from 38% and 42% in Poland and Ukraine respectively, about 55% in Romania and Lithuania, till 67% and 76% in Bulgaria and Hungary respectively. The initial analysis of the samples prior to our study, indicated that the sample characteristics related to age, gender, place of residence and household income, were comparable to the countries' national statistics. This suggests that irrespective of the non-response, the procedure applied for the selection of respondents (namely replacing the respondents who refused or were unable to participate), resulted in samples that are representative for the countries.

This chapter analyzes data related to informal patient payments made by respondents (or respondents' families) for out- and in-patient services that they used during the last 12 months, in addition to data on respondents' perceptions about making informal patient payments and socio-demographic data. Both in-kind gifts and cash payments are included in the wording of the question when respondents are asked about the size of informal payments during the last 12 month. Respondents are also asked to confirm, deny, or express ambiguity about five perception statements that indicate individual acceptance or willingness to pay informally for health care (e.g. feeling uncomfortable when leaving the physician's office without a gratitude payment, or being unable to refuse to pay informally if asked). For comparative purposes, respondents are also asked to give a positive or negative answer on questions about ever being requested to pay informally and about ever giving cash or in-kind gifts to medical staff. The inclusion of these questions allows us to examine two recall periods – last 12 months and an unlimited time period. We primarily focus on the last-12-months period, and we use the infinite recall period for validation purposes. The English wording of the questions and the five perception statements used in our analysis is presented in Appendix D.

We carry out binary regression analysis to determine the extent to which individual perceptions about making informal payments, as well as socio-demographic features, are associated with actually making informal patient payments. We include only respondents who used out- or in-patient services during the last 12 months. Our binary dependent variable is

coded with 0 when the service user did not pay informally during the last 12 months and with 1 when the user paid informally during the last 12 months. The independent variables include socio-demographic indicators as well as two indicators for each of the five perception statements presented in Appendix D (thus 10 indicators in total). The first indicator (for each perception statement) has the value 1 for respondents whose response to the statement suggests a certain acceptance/willingness to pay informally and otherwise, the value of the indicator is 0. Similarly, the second indicator of the perception statement has a value 1 for respondents whose response to the statement suggests uncertainty about making informal payment (i.e. ‘somewhat’ or ‘don’t know’ response) and otherwise, the value of the indicator is 0. Respondents, whose responses to a given statement suggest a certain resistance to informal payments, are taken as base categories in the regression analysis (see Table 4.2). The correlation between the independent variables included in the analysis is weak (correlation coefficient < 0.6) or insignificant ($p > 0.05$).

In addition to this, we carry out a second regression analysis using the same set of independent variables, but with a different binary dependent variable: whether any of the respondents in the sample has ever made informal payments (either in cash or as gifts in-kind) assuming that each respondent has ever used health care (e.g. having at least one visit to a physician – GP or specialist). We also carry out linear regression analysis to examine variations in the size of informal patient payments made by an individual during the last 12 months.

4.3 Results

4.3.1 *Experience with informal patient payments*

Our preliminary analysis shows that the level of health care consumption is the lowest in Ukraine and Romania (59% and 65% of respondents are health care users respectively). This number is the highest for Hungary, where four out of five respondents report consumption of out- and in-patient services during the last 12 month. For other countries, about 75% of respondents report using health care services (data not shown).

Despite the comparatively low number of Romanian and Ukrainian respondents, who used out- and in-patient services during the last 12 months, the share of health care users who report informal patient payments (see Table 4.1) is the highest in these two samples (34.5% and 41% of health care users, with a total median payment of 36.6 and 15.3 Euro per health

care user per year respectively). This share is the lowest for Poland (8.4%) and Bulgaria (12.5%). In case of Bulgaria, the total median is also the lowest (12.8 Euro informal payments per health care user per year) compared to the other countries. However, for Poland, the total median is one of the highest (43.7 Euro informal payments per health care user per year). About 25% of all health care users in Hungary and Lithuania report to have made informal payments during the last 12 months, with a median of 53 and 43.5 Euro informal payments per health care user per year respectively. It should be noted however, that the median values are not adjusted for the variation in purchasing power across countries. Also, within the countries, the median values hide a wide variation since the mean values for all countries are much higher than the median values. For some countries, the standard deviations are much larger than the mean values (especially for Bulgaria, Romania and Ukraine).

For validation purposes, we include a second recall period by asking all respondents whether they have ever given either cash or in-kind gifts to medical staff (assuming that each respondent has ever used health care). Hence, when the recall period is extended to infinity, the cross-country pattern of respondents reporting informal payments (either cash payments or in-kind gifts) virtually does not change (see Table 4.1). Specifically, Ukrainians and

Table 4.1. Informal patient payments reported in the six countries

		Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine	Total
	Sample size	N = 1003	N = 1037	N = 1012	N = 1000	N = 1000	N = 1000	N = 6052
1. Number of users during the last 12 months who paid informally	No (N)	650	625	551	667	414	341	3248
	Yes (N)	90	206	185	61	218	237	997
	Yes (Valid%)	12.2	24.8	25.2	8.4	34.5	41.0	23.5
2. Amount of informal payments by those who paid during the last 12 months [Euro]	Median	12.8	53.0	43.5	43.7	36.6	15.3	30.6
	Mean	73.9	112.4	120.3	80.6	119.0	62.6	98.0
	St.Dev.	203.7	182.9	200.6	93.6	348.7	130.9	223.0
5. Number of respondents who have ever paid informally (either cash or in-kind gift)	No (N)	487	326	340	608	286	296	2343
	Yes (N)	486	719	669	356	708	700	3630
	Yes (Valid%)	49.9	68.6	66.3	36.9	71.2	70.3	60.8
6. Number of respondents who have been ever personally asked to pay informally	No (N)	806	969	887	843	774	689	4968
	Yes (N)	166	68	122	130	215	303	1004
	Yes (Valid%)	17.1	6.6	12.1	13.4	21.7	30.5	16.8
7. Number of respondents who know where to complain if asked to pay informally	No (N)	650	665	757	635	734	787	4228
	Yes (N)	353	372	255	365	266	213	1824
	Yes (Valid%)	35.2	36.1	25.2	36.5	26.6	21.3	30.1

Romanians considerably more often report ever being requested to pay informally (30.5% and 21.7% respectively) in contrast to the lowest rate of requests noted in Hungary (6.6%).

In all six countries, a major part of the sample does not know where or how to complain in case informal payments are requested by the providers (ranging from 78.7% in Ukraine to 63.5% in Poland).

4.3.2 Perceptions about informal patient payments

Table 4.2 presents data on respondents' perceptions about making informal patient payments measured through their responses to the five perception statements included in our analysis. The Bulgarian and Polish samples have rather similar perceptions about paying informally. For instance, 3 per 4 respondents in these countries do not feel uncomfortable to leave the physicians' office without any gratuity (the highest rate when compared to the other countries). Each second respondent in these countries states that he/she prefers to use private health care services instead of making informal payments for such services provided by public facilities (the same rate as in Lithuania and Romania).

Table 4.2. Behavior statements regarding informal payments (all respondents)

		Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine	Total
	Sample size	N = 1003	N = 1037	N = 1012	N = 1000	N = 1000	N = 1000	N = 6052
		Valid %	Valid %	Valid %	Valid %	Valid %	Valid %	Valid %
Feels uncomfortable to leave without giving gifts	No [base]	77.9	69.6	61.0	73.2	52.3	56.3	65.1
	Yes	6.8	14.4	16.4	12.6	22.1	14.7	14.5
	Uncertain	15.3	15.7	22.6	14.2	25.6	29.0	20.4
Would recognize the hint for informal payments	No [base]	5.4	14.8	16.0	21.8	13.1	10.5	13.6
	Yes	64.7	62.0	63.5	46.7	65.2	57.5	60.6
	Uncertain	29.9	23.2	20.5	31.4	21.7	32.0	26.4
Would refuse to pay informally if asked to make such payments	No	11.7	25.9	28.0	14.7	34.6	41.1	26.0
	Yes [base]	54.8	45.8	35.1	57.8	35.8	26.6	42.6
	Uncertain	33.5	28.3	37.0	27.5	29.8	32.2	31.4
Prefers to use private health care because of the informal payments	No	17.4	42.9	24.1	21.3	20.0	32.7	26.1
	Yes [base]	50.7	34.1	51.9	50.4	49.4	34.0	45.0
	Uncertain	31.9	23.0	26.7	28.3	30.6	33.3	28.9
Ready to pay informally in case of serious health problems	No	15.8	18.5	10.1	17.3	11.7	12.4	14.3
	Yes [base]	42.7	50.5	56.0	38.6	60.4	54.9	50.5
	Uncertain	41.5	31.0	33.9	44.0	27.9	32.7	35.1

Also, more than 2 per 4 respondents in Bulgaria and Poland would refuse to pay informally when requested (the highest rate for all countries), and less than 2 per 4 respondents are willing to pay informally if they have serious health problems (the lowest rate for all countries). However, in Bulgaria, 64.7% of respondents believe that they are able to recognize the hint for informal payments while fewer Polish respondents (46.7%) are experienced in recognizing hints. The rest of the countries do not demonstrate such similarities in respondents' perceptions. It should be noted however, that 41.1% of the respondents in Ukraine and 25-35% in the other three countries (Hungary, Lithuania and Romania) would not refuse to pay informally if asked. Also, 32.7% of Ukrainians and 42.9% of Hungarians (the highest rate among countries) have chosen the "no" answer on preferences for paying officially in the private health care sector instead of making informal payments in the public one.

4.3.3 Results of the regression analysis

Table 4.3 shows the results of the binary regressions carried out on data for respondents who report that they used out- and/or in-patient services during the last 12 months. We divide all respondents into respondents who used services and paid informally (coded with 1) and respondents who used services but did not pay informally (coded with 0). As explained in the method section, we use two groups of independent variables: socio-demographic characteristics as well as perception indicators. To validate these results, we also carry out binary regression analysis considering an infinite recall period (i.e. ever making informal payments). We include in this analysis all respondents assuming that every person has ever used health care services. The results of this regression are presented in Table 4.4.

Based on the models for the 12-months recall period, we find some consistent patterns across countries. In particular, those who feel uncomfortable to leave without a gratitude payment and who feel unable to refuse to pay informally if asked (certain and uncertain responses to both perception statements) more often report making informal payments during the last 12 months than the rest of the respondents. However, the statistical significance of the corresponding coefficients varies among the countries, which indicates differences in the explanatory power of these perceptions depending on the country. Only for Hungary and Poland, we find that respondents who are ready to pay as much as they have when they have serious health problems, significantly more often report paying informally for health care services compared to the rest of the sample. Also, only for Lithuania and Romania, we find a

Table 4.3. Binary logistic regression for informal patient payments experiences (recall period: last 12 months; 0=did not pay informally, 1=paid informally)

	Recall period: last 12 months					
	Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine
Feeling uncomfortable to leave without giving a gift [1- Yes]	1.257*	1.449*	1.134*	.750	1.031*	1.203*
Std.Error	.405	.248	.242	.471	.247	.282
Feeling uncomfortable to leave without giving a gift [1-Uncertain]	.782*	1.124*	.724*	1.179*	.756*	.420**
Std.Error	.299	.245	.230	.401	.230	.223
Is able to recognize the hint [1- Yes]	.112	.373	.527**	.514	.948*	.282
Std.Error	.694	.319	.306	.494	.333	.332
Is able to recognize the hint [1-Uncertain]	.154	-.052	.106	-.082	.607	-.435
Std.Error	.707	.365	.360	.542	.383	.358
Ready to refuse to pay if asked [1-No]	1.814*	1.293*	1.088*	2.105*	.492*	1.051*
Std.Error	.385	.245	.240	.415	.239	.256
Ready to refuse to pay if asked [1-Uncertain]	1.142*	.813*	.195	1.026*	.006	.673*
Std.Error	.304	.245	.245	.437	.253	.270
Private services preferences as response to IPP [1-No]	-.580	.520*	.256	-.137	.528**	-.422**
Std.Error	.401	.245	.249	.474	.290	.249
Private services preferences as response to IPP [1-Uncertain]	-.538**	.115	.259	.533	.408**	-.194
Std.Error	.313	.263	.231	.385	.233	.243
Ready to pay the last penny if serious health problem occurs [1- Yes]	-.069	1.528*	-.051	1.664*	-.056	.023
Std.Error	.464	.326	.332	.672	.328	.331
Ready to pay the last penny if serious health problem occurs [1-Uncert]	-.064	.793*	-.187	1.138**	-.063	-.077
Std.Error	.452	.358	.345	.672	.349	.343
Age [Years]	-.009	.006	-.005	-.020	-.020*	-.005
Std.Error	.011	.006	.008	.013	.008	.007
Gender [0-Male; 1-Female]	.551*	.393**	.444*	-.346	-.287	-.186
Std.Error	.265	.201	.205	.336	.199	.213
Residence ^a	-.098	.051	-.164*	.118	.280*	-.033
Std.Error	.114	.079	.077	.174	.086	.085
Education ^b	-.186	.132	.064	.053	-.079	-.097
Std.Error	.138	.085	.097	.173	.104	.100
Health problems [0-No; 1-One or more health problems]	.952*	1.110*	.706*	1.834*	.816*	.755*
Std.Error	.337	.222	.225	.435	.233	.224
Number of ADULTS in household	-.035	-.223	-.049	.049	-.246**	.000
Std.Error	.157	.124	.128	.172	.133	.121
Number of CHILDREN in household	-.100	-.076	.034	.221	.139	.121
Std.Error	.200	.116	.119	.215	.128	.130
Income ^c	.061	.074**	.061*	-.094	.067**	-.026
Std.Error	.053	.043	.031	.072	.038	.044
Constant	-2.882*	-5.659*	-3.334*	-4.661*	-1.613*	-.781*
Std.Error	1.155	.749	.747	1.264	.822	.796
Number of Observations	667	803	720	638	586	537
The Nagelkerke R Square	.181	.344	.198	.360	.189	.185

* p < 0.05; ** p ≤ 0.10

The coding of the questions is: ^a 4-Capital; 3-Big city; 2-City; 1-Town; 0-Village; ^b From 0-uncompleted primary education to 5-Tertiary education; ^c From 0 -less than 50 Euro till 17 – more than 3000 Euro

Table 4.4. Binary logistic regression for informal patient payments experiences (recall period: infinity; 0=did not pay informally, 1=paid informally)

	Recall period: infinity					
	Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine
Feeling uncomfortable to leave without giving a gift [1- Yes]	.744*	.923*	1.616*	-.199	1.206*	1.916*
Std.Error	.314	.268	.273	.296	.239	.380
Feeling uncomfortable to leave without giving a gift [1-Uncertain]	1.302*	1.120*	.846*	1.613*	1.325*	1.331*
Std.Error	.241	.259	.201	.284	.224	.221
Is able to recognize the hint [1- Yes]	.576**	.729*	.894*	1.075*	.897*	1.093*
Std.Error	.341	.213	.215	.248	.231	.272
Is able to recognize the hint [1-Uncertain]	-.036	.024	.600*	.697*	.609*	.120
Std.Error	.353	.241	.251	.262	.271	.281
Ready to refuse to pay if asked [1-No]	.964*	.615*	.993*	1.857*	1.116*	2.057*
Std.Error	.264	.207	.207	.268	.210	.235
Ready to refuse to pay if asked [1-Uncertain]	.946*	.546*	.697*	.765*	.684*	1.048*
Std.Error	.173	.196	.177	.208	.202	.218
Private services preferences as response to IPP [1-No]	-.148	-.235	-.368**	-.937*	.505*	-.684*
Std.Error	.234	.192	.210	.253	.256	.233
Private services preferences as response to IPP [1-Uncertain]	-.150	-.244	-.111	-.787*	.244	-.712*
Std.Error	.187	.217	.193	.224	.210	.230
Ready to pay the last penny if serious health problem occurs [1- Yes]	.555*	.887*	-.257	.713*	.293	.344
Std.Error	.248	.217	.289	.267	.288	.268
Ready to pay the last penny if serious health problem occurs [1-Uncert]	.337	.427**	-.501**	.362	-.122	.090
Std.Error	.237	.218	.292	.258	.301	.274
Age [Years]	.010	.012*	.013*	.033*	-.002	.005
Std.Error	.006	.005	.006	.007	.006	.006
Gender [0-Male; 1-Female]	.229	.553*	.610*	.277	.297**	.542*
Std.Error	.152	.155	.157	.175	.169	.185
Residence ^a	.011	-.186*	.031	.118	.181*	.195*
Std.Error	.068	.059	.063	.085	.083	.080
Education ^b	.093	.191*	.162*	.295*	.145	.091
Std.Error	.082	.073	.082	.095	.091	.094
Health problems [0-No; 1-One or more health problems]	.885*	1.002*	.694*	.947*	.338**	.692*
Std.Error	.182	.177	.172	.207	.199	.208
Number of ADULTS in household	.031	-.133	-.157	-.130	-.108	-.011
Std.Error	.086	.095	.102	.091	.103	.102
Number of CHILDREN in household	.121	.059	.218*	.236*	.090	.116
Std.Error	.108	.097	.096	.098	.095	.117
Income ^c	.067*	.034	.101*	.026	.073*	.082*
Std.Error	.031	.030	.025	.037	.030	.040
Constant	-3.219*	-2.153*	-2.935*	-5.166*	-2.187**	-2.902
Std.Error	.626	.499	.587	.655	.675	.683
Number of Observations	880	997	980	832	915	927
The Nagelkerke R Square	.240	.270	.280	.360	.255	.379

* p < 0.05; ** p ≤ 0.10

The coding of the questions is: ^a 4-Capital; 3-Big city; 2-City; 1-Town; 0-Village; ^b From 0-uncompleted primary education to 5-Tertiary education; ^c From 0 -less than 50 Euro till 17 – more than 3000 Euro

significant association of the ability to recognize the hint for an informal payment and actually paying informally. Specifically, those who recognize the hint, more often make informal payments. The direction of the regression coefficient (when significant) is not consistent across countries in case of the statement that indicates preferences to consume private services in order to avoid informal payments for public ones. Certain negative and/or uncertain responses to this statement are associated with a significantly higher probability of being an informal payer in Hungary and Romania but with a significantly lower probability of being an informal payer in Bulgaria and Ukraine.

The models for the infinite recall period suggest similar results however more significant relations are observed compared to models for the 12-months recall period. For example, in the infinite-recall-period models all countries show significant associations with the ability to recognize a hint. Also, the preference for private health care services consumption as a response to informal payment indicator appears to be significant in case of Poland and Lithuania. Regarding the willingness to pay the last penny, we observe a negative relation in Lithuania and positive relations in other cases.

In addition, as shown in Table 4.3 and Table 4.4, some socio-demographic features show consistent effects. Thus, being female (in Bulgaria, Hungary and Lithuania) and having a chronic or major health problem (in all countries and both recall periods), as well as belonging to a household with a higher income (in case of Hungary, Lithuania and Romania) and fewer family members (most countries) increases the probability of reporting informal payments during the last 12 months. However, being older and higher educated in Hungary, Lithuania and Poland, belonging to a household with higher income (Bulgaria, Lithuania, Romania and Ukraine) and being a woman (Hungary, Lithuania, Romania and Ukraine) increases the probability of a positive answer on ‘have you ever paid informally’ questions.

Although we apply linear regression to analyze the variation in the size of informal patient payments during the last 12 months, we do not present these results because of the small number of observations for some countries (namely Bulgaria and Poland) and because of the few significant associations for the other countries. Thus, our data do not show any cross-country pattern regarding the relation between the size of informal payments on the one side, and behavioral perceptions and socio-demographic variables on the other side. However, education (in Lithuania) and income variables (in Romania and Ukraine) have a positive significant association with the size of informal payment.

4.4 Discussion

Although informal patient payments exist in all countries included in the survey, the share of health care users who pay informally as well as the size of the informal payments differs among the countries. This finding confirms the results of previous research (for a review see Stepurko et al., 2010; Lewis, 2007) that informal patient payments in CEE countries are characterized by huge variability (irrespective of the recall period). In our study, Bulgarians and Ukrainians report the lowest median values of informal payments per respondent per year (12.8 and 15.3 Euro respectively) but we observe that a 3 times smaller number of patients paid informally in Bulgaria than in Ukraine. Similarly, in Poland and Lithuania, this median value of annual informal payments is about 43.5 Euro per respondent while Lithuanian health care users are 3 times more likely to report making informal payments than those in Poland.

The amounts of money paid informally per year by health care users in all six countries are considerable, especially when compared to the minimum wage in these countries (see Eurostat, 2010). The mean informal patient payments per respondent per year that we find in our study, is equal to half of the monthly minimum wage in Bulgaria, Hungary, and Lithuania, and about one minimum wage in Ukraine and Romania. In contrast in Poland, the average payment is 4 times less than the minimum wage. Moreover, for each country, the median value is much lower than the corresponding mean value, which indicates a large disparity in informal patient payments within the countries as well. Nevertheless, the above comparison suggests that informal payments represent a considerable burden on households, especially for low-income households, and this necessitates the urgent attention of policy-makers in these countries.

Our findings differ from those reported about 10 years ago (Belli, 2002) that informal patient payments were equally significant in Poland and Hungary, and widespread in Romania. We provide evidence on a much lower number of informal payers in Poland than in Hungary (while in Romania they remain widespread). Also, the difference between Bulgaria and Ukraine regarding the ability to refuse to pay informally when requested was not observed in previous research (Miller, 2006). In contrast, we find that at present Bulgarians feel more confident that they can refuse to pay informally than Ukrainians. This difference in results indicates that the prevalence and level of informal payments has changed during the years, as well as consumer perceptions related to informal payments.

Indeed, Golinowska (2010) reports on a reduction of informal payments in Poland after public campaigns against such payments. These campaigns have taken place in addition

to overall intensive fights with corruption that might have changed attitudes in the country. In Bulgaria, the current government elected in 2009 has also emphasized the need to fight corruption in all social spheres, including the informal payments for health care. This was extensively reflected in public debates and mass media, and might have affected the attitudes of the Bulgarian population. At the same time, the country has one of the highest private expenditure on health care in Europe (about 42.8% of the total health expenditure in 2007) most of which consists of out-of-pocket payments in both the public and the private health care sector (World Health Organization, 2010). Thus, given the experience in Poland and Bulgaria, and the favorable results for these countries reported in this chapter, we can conclude that public campaigns and anti-corruption measures are important elements in dealing with informal payments in a country.

Also, as shown by the Bulgarian experience, it is important to develop the private health care sector. Private health care services provide an alternative for those patients who prefer to escape informal extortions in public sector (Pavlova et al., 2010). The descriptive data from our survey show that there is less inclination in Hungary and Ukraine to use private services as a response to informal payments. Moreover, the different directions of the significant coefficients (related to this aspect of perceived behavior) in the regression models seem to reflect private service availability and other peculiarities in a single country, e.g. for Hungary and Romania. Such diversity in associations in these and other countries can be explained by different levels of private sector development, the spread of corruption, lack of stability and transparency which do not facilitate investments and donations, in addition to the specificity of regulations, monitoring measures and ensuring quality mechanism applied in the countries (Lewis, 2006; Ensor & Witter, 2001). Overall, developed private markets supported by health insurance schemes to prevent extraordinary high out-of-pocket payments, can create a competitive climate, which can bring improvements in public health care service provision (Ensor & Witter, 2001; Thompson & Witter, 2000; Preker & Feachem, 1996).

Meanwhile, thankfulness, “just a habit” to pay informally (Aarva et al., 2009; Belli et al., 2004; Betliy et al., 2007) and feeling uncomfortable are quite popular answers to the reason of informal payment question. The later is shown by our results as well. This indicates the need of a deeper look in the situations that lead to informal patient payments in order to identify the real roots of these payments. In particular, it is necessary to recognize that it is not always the patient who chooses to bribe the physician. Informal payments can also be initiated by physicians. The ability of medical staff to press patients to pay informally has been extensively discussed in previous studies (Vian et al, 2006; Shishkin et al., 2003;

Balabanova & McKee, 2002). This is also indicated by our results for Romania and Ukraine, which provide evidence that more patients are being requested to pay informally and more patients make such payments compared to other countries. Furthermore, Romanian and Ukrainian patients are less likely to decline a physician's request for informal payments especially when compared to Poland and Bulgaria, but also to Hungary and Lithuania. From the patients' perspective, the obedience to the requests of medical staff to pay informally can be due to expectations for better treatment but also due to fear that the treatment can be denied (Lekhan et al., 2007; Belli et al., 2004). Consumers' inability to refuse to pay informally is conditioned not only on their individual values but also on external pressures (e.g. by low-paid medical staff, who in the absence of free patient choice, brings informal practices in the patient-physician relation), the latter having a greater impact in resorting to unethical behavior (Miller, 2006; Aarva et al., 2009).

Salaries in the health care sector of most of CEE countries remain lower than in the industrial and other sectors (Czupryniak & Loba, 2004; International Average Salary Income Comparison; Lekhan et al., 2010). This makes that patients are obliged to pay extra to the physician, and at the same time gives an excuse to the medical staff to request informal payments. However, nowadays in some of these countries (e.g. Romania), salaries of medical staff are increasing with a consequent light decrease in the informal payments (Vlădescu et al., 2008). In addition, medical staff's disposition against accepting informal payments, cherished by adequate working conditions and a system of penalties, can also provide the desired effect (e.g. shifting from informal to formal practices). When health care providers do not request or give a hint for a gift by a "nobody values my work" expression but receive adequate official remuneration, and remind patients who initiate informal payments, about the professional ethics (Miller, 2006; Grodeland et al., 1998), patients can be discouraged to search for informal payment channels.

When compared to perceived behavior statements, we find that socio-demographic characteristics are less relevant in predicting whether a health care user makes informal payments. Such irrelevance of typical characteristics was also shown in previous studies (Özgen et al., 2010; Liaropolous et al., 2008; Vian & Burak, 2006; Belli, 2002). Our findings emphasize the importance of incorporating perceived behavior aspects in research on informal patient payments. In particular, the differences between the two groups of users should be studied at the individual perception level rather than in socio-demographic characteristics. It should be pointed out however, that neither behavior statements nor socio-demographic characteristics included in our analysis explain the variations in the total size of informal

payments. An analysis of this issue would require collecting more detailed information on factors causing these payments, for example, on the type of illness and treatment procedures.

Meanwhile, we noticed cross-country differences in coefficient significance and in its explanatory power within two time periods (last 12 month and infinity) and among two groups of respondents – the general population and health care users. Such findings can provide a new field for further research. Possibly, those respondents who had negative experiences with health care consumption and have less resistance towards paying informally (measured in undesirable perceptions), try to avoid visiting physicians. This also corresponds to under-consumption in Ukraine and Romania as suggested by our results (Danyliv et al., 2012).

As diversity in associations as well as differences in descriptive statistics have suggested, that a universal solution applied to all countries will not work. Thus, a country-specific anti-informal patient payment strategy is a topical issue. In particular, we observe a high level of requested payments in Romania and Ukraine, indicating an urgent need for funding increase and efficiency improvements as well as in medical ethics obedience. However, the Hungarian case present primarily users' initiated informal payments, so other directions of relevant measures can be suggested, such as developing options for better quality services as well as informational campaigns against informal payments. Though informal payments continue existing in Poland, a good case of individual resistance to informal payments is present. Hence, public support of governmental actions, their effectiveness, fighting with corruption should be key strategies to decrease informal patient payments.

4.5 Conclusions

This chapter has focused on the importance of patients' perceptions about making informal patient payments in explaining actual informal payments. As expected, our analysis confirms that behavioral perceptions (willingness to pay informally) are strongly associated with actual behavior (i.e. paying informally). The extension of the recall period does not change this conclusion. These findings are an indication of the theoretical and convergent validity of our results. Thus, for policy-makers, it is highly important to focus on changing consumer perceptions about making informal payments to be able to deal with these payments on the consumer side. Hence, raising patient awareness about their right to health care services with adequate quality and access with no informal charges or gratitude payments, as well as empowering the patient to object to paying informally and to discourage physicians to

request/collect informal revenues are essential policy strategies for the elimination of informal patient payments (Pavlova et al., 2010; Vian, 2008; Vian & Burak, 2006). In this regard, it is essential to create a simple, easily accessible and effective system for filing complaints by patients who are asked to pay informally for health care services, as well as to disseminate information about this system among the public at large. As suggested by our results, the latter is still lacking in the countries studied.

Hence, consumers' and providers' resistance against this type of behavior has to be supported by multi-dimensional measures. Indeed, the development of a supportive environment is highly important in countries where patients try to avoid the formal channels associated with inadequate service (poor access and/or quality due to underpaid personnel, lack of funds, or inefficient resource allocation) and choose to pay informally to obtain better services even though they resent such payments. In this regard, the improvement of health care provision (its organization, transparency and efficiency) seems to be an important measure to restrict the need of informal payments. Governments should also assure continuous investments in the improvement of health care quality and access to health care, as well as an adequate funding for the normal functioning of the public health care system.

CHAPTER 5.

PATTERNS OF INFORMAL PATIENT PAYMENTS IN BULGARIA, HUNGARY, AND UKRAINE:

A COMPARISON ACROSS COUNTRIES, YEARS AND TYPE OF SERVICES

Submitted for publication.

Abstract

Informal payments for health care services are a well-known phenomenon in many health care systems around the world. Deeply ingrained informal practices accepted by both providers and consumers, and neglected by the government, seem to be a major impediment to ongoing health care reforms. This chapter aims to study the size and pattern of informal patient payments for out-patient and in-patient services in three former-socialist countries: Bulgaria, Hungary and Ukraine. The data are collected in 2010 and 2011 based on national representative samples. The results of the cross-country comparison suggest a relatively higher prevalence of informal patient payments in Hungary and Ukraine than in Bulgaria, where patients also meet formal service charges in the public sector. More than 35% of health care users in Ukraine report informal payments for physician visits during the preceding 12 months. In Hungary, this share is more than 20% while in Bulgaria it is less than 10%. Regarding hospitalizations, the percentage of service users who report informal payments is also higher in Hungary and Ukraine (more than 40%) and lower in Bulgaria (10-20%). We do not observe major differences in the magnitude of the annual informal payments across the two years. Variations in payment size are mainly explained by the nature, type and need for services, fee awareness, and, on some occasions, household income. Differences in structural factors (e.g. regulations, funding, user fees, anti-corruption policies) also contribute to the cross-country diversity of informal patient payments.

5.1 Introduction

As previously described in Chapter 1 as well as in other chapters, informal payments for health care services include not only small gifts given by the thankful patients after the service provision, but also unofficial cash payments and in-kind gifts requested by health care providers who misuse their market power (Ensor, 2004). Although often tolerated by the government, informal payments aggravate the efficiency and equity problems in the health care system. Since the informal cash-flow goes directly from patients to medical staff and remains unregistered, these payments hinder the estimation of actual health care expenditure as well as future funding requirements of the health care sector (Delcheva et al., 1997; Ensor, 2004). Thus, deeply ingrained informal practices accepted by both providers and consumers, and neglected by the government, can become a major impediment to ongoing reforms (Lewis, 2002).

The measurement of informal patient payments is a challenging task given their hidden nature. There is a great variety of empirical studies in terms of health care providers studied, data collection modes as well as recall periods, not to mention the diverse definitions of informal patient payments used in the studies (Stepurko et al., 2010). This makes cross-study comparisons of their results difficult, if not impossible. Convincing cross-country and pooled evidence on the scope and scale of informal patient payments is lacking.

This chapter aims to study the size and patterns of informal patient payments for out-patient and in-patient services in three former-socialist countries: Bulgaria, Hungary and Ukraine using data for two subsequent years - 2010 and 2011 (such data are not available for the other three countries, discussed in the previous two chapters). These countries present an interesting case for comparison because the existence of informal patient payments is a well-recognized characteristic of their health care systems while the level of their socio-economic development differs. The countries once shared a common socio-political orientation under the communist regimes. However, their transition to a market-oriented economy proceeded at different speed, which places them at the moment at different stages of development. Nevertheless, informal patient payments present a policy challenge in all three countries (Atanasova et al., 2010; Baji et al., 2012; Danyliv et al., 2012; Rechel et al., 2011; Stepurko et al., 2011). Hence, we compare the size and patterns of informal patient payments in these countries taking into account the diversity of the countries' health care systems and their general context.

Another important contribution of our analysis is the distinction between purely informal payments paid to the health care provider for service provision, and payments for goods brought by the patient to the health care facilities although these goods are supposed to be provided free-of-charge to the patient (Allin et al., 2006). This type of patient payments is rarely addressed in the literature but is considered to be important for the estimation of total out-of-pocket payments in a country.

The chapter is organized as follows: the background section describes key structural factors (e.g. patient payments regulations) in Bulgaria, Hungary and Ukraine, the methods section presents the data collection process and introduces the variables used in the analysis, after that results are described. Discussion and conclusion complete the chapter.

5.2 Background

Informal patient payments are often attributed to cultural, economic and policy factors, as mentioned in the literature (Balabanova & McKee, 2002; Gaál & McKee, 2005; Tomini & Maarse, 2011) and in Chapter 1. However, these factors alone do not explain variations in the patterns of informal patient payments. Indeed, the share and size of informal payments are closely coupled with the type of service consumed, as well as with the assertiveness and rank of medical staff (Kornai, 2000; Belli et al., 2004; Lewis, 2007; Tomini & Maarse, 2011). Overall, informal payments are found to be more extensive in case of hospitalizations than physician visits, and in case of surgeons and gynecologists than other specialists (Stepurko et al., 2010). In addition to this, social structures, which inherently include culture (Giddens, 1984), also shed light on the diversity in informal patient payments. Relevant structural factors include overall corruption, the manner of health care provision, lack of patients' satisfaction and lack of patients' knowledge about service consumption, e.g. official service price and exemption rules (Cohen, 2012; Radin, 2009). Mokhtari and Ashtari (2012) also confirm that well-informed patients have a lower probability of paying informally.

Taking into account the variety of factors that influence informal patient payments and already described environment of the countries in Chapter 1 and Chapter 3, in this section we provide more details on the specificity of the three countries included in our analysis. This provides a background for a better understanding of our cross-country pooled results on informal patient payments.

Given the diversity in general context, the health care systems in the three countries differ as well. In Hungary and Bulgaria, social health insurance has replaced the old

Semashko system. However, the health care reforms did not always have an even nature. This is especially visible in the delayed structural changes in hospital care provision in Bulgaria (Atanasova et al., 2011). At the same time, the Ukrainian health care system has not achieved visible improvements, i.e. public health care services are still funded via line-item budgets, the infrastructure has remained the same as that during the Soviet time, and the system of GPs (family physicians) is still undeveloped (Danyliv et al., 2012; Lekhan et al., 2010). Also, official salaries of medical staff continue to be perceived as “low”, and in fact, they are lower than the average wage in the industrial sector (State Statistics Committee of Ukraine, 2012).

In addition to the informal patient payments reported in the three countries (Atanasova et al., 2011; Baji et al., 2012; Danyliv et al., 2012; Rechel et al., 2011; Stepurko et al., 2011), there are various formal and/or quasi-formal fees for public health care services. In Bulgaria, patients are obliged to pay flat-rate fees for each out-patient visit and each day hospitalization, with a maximum of 10 days per year. Emergency care is officially free-of-charge and some socio-economics groups are fully or partially exempted. However, patients are not always conversant with the exemption mechanism as well as with the exact fee size (Atanasova et al., 2010; Rechel et al., 2011).

In Hungary, formal fees for basic health care services were introduced in 2007 and abolished in 2008 after a population-wide referendum (Baji et al., 2012). Nowadays, formal co-payments for services are only applicable in case of dentist services, free choice of a physician, use of services without a referral, extra meal and accommodation during hospitalization. Qualitative data suggest that Hungarian patients would accept official service fees if they would receive an adequate service provision, which they assure at the moment via informal payments (Baji et al., 2011).

In Ukraine, the Constitution guarantees free-of-charge health care services and thus, it impedes the attempts to introduce formal service fees. Nevertheless, a short list of patient fees for “luxury” health care services is introduced by a government decree (Lekhan et al., 2010). Also, given the chronically underfunded health care system, unregulated “charitable contributions” to health care facilities (quasi-formal payments) became a common practice.

In our comparative study, we explore the association between informal patient payments and the combined structural factors in the countries, which are represented in empirical data by a country membership variable in addition to variables related to patients’ knowledge about the fee, type of service consumed, purpose of informal payments as well as its initiator.

5.3 Methods

We use national representative data collected in two successive survey waves (July-August 2010 and 2011) in Bulgaria, Hungary, and Ukraine. The country samples are drawn based on a multi-staged random probability approach: after the selection of sampling points (according to regional, urban/rural and ethnic characteristics), about 10 addresses/households per sampling point are chosen using the random route method. One household member older than 18 years is selected for the survey using the “last birthday” principle. The data collection is finalized after having about 1000 and 800 effective interviews per country in 2010 and 2011 respectively. A description of key socio-demographic variables and response rates per country per year can be found at Appendix C. Individuals, who refused or were unable to participate, were replaced following the same selection approach.

Each respondent is interviewed face-to-face in his/her home using a standardized questionnaire identical for all countries. Appendix B presents the exact wording of the questions used in this chapter. In 2010 and 2011, respondents are asked about their consumption and expenditure (total and informal) on out- and in-patient health care services during the preceding 12 months. For informal patient payments, respondents are asked to include both cash payment and the value of in-kind gifts. Socio-demographic data are surveyed as well in both years.

In 2011, more detailed information is collected on payments for the last visit to a physician and last hospitalization, including type of care, size of formal and informal payments, purpose and mechanism of the informal payment, as well as payments for other goods (e.g. medical supplies, pharmaceuticals, bed linen, food) that the patient brought for the treatment. To reduce recall bias, we only include information on the last physician visit and last hospitalization that have taken place in the preceding 2.5 years (since 2009). In addition to potential recall bias, the limitations of our study are also related to the length of period covered (only 2-3 subsequent years), cross-sectional design of the surveys, and the sensitive nature of questions on informal patient payments.

We use binary regression analysis to determine the extent to which socio-demographic features as well as other factors (e.g. country context, year of service consumption, type and/or quantity of services used) including structural factors (country membership, fee awareness, nature, type of service) are associated with the experience of paying informally (either within the year preceding the survey or for the last visit/hospitalization) and bringing goods during the last hospitalization on staff’s requests. This part of the analysis includes only

health care users. The correlation between the independent variables included in the analysis is weak (correlation coefficient < 0.6) or insignificant ($p > 0.05$).

Also, we carry out linear regression analysis with the amounts paid informally (either during the year prior to the survey or for the last visit/hospitalization), as well as with the monetary value of goods brought during the last hospitalization on staff's requests. In case of the last visit/hospitalization, we use an extended set of independent variables, which also includes structural factors such as the purpose of the informal payment (better attention, better services or other reasons) and the initiator of the payment (expected/required by medical staff or solely initiated by the patient). This part of the analysis includes only health care users who paid informally.

We first run the regressions per country. Then, we pool the data for the three countries and analyze them together including country indicators (Hungary is taken as a reference category). Compared to the country models, the pooled-data models do not lead to different conclusions although occasionally we miss some significant or insignificant effects per country. In this chapter, we only present the pooled-data regression models. In all pooled-data models, we include an interaction between year and country indicators to check for time trends per country.

All variables that present amounts in national currency (payments or value of goods) are first adjusted for inflation (base year 2010) using data provided by the World Bank's Consumer Price Index (World Bank, 2012). The adjusted amounts are then converted into Euro using the average exchange rate for 2010 (ECB, 2012). We also run the linear regression analysis after a conversion of the amounts into Int.\$ PPP but we do not observe significant differences. Thus, we only present results for amounts in Euro.

5.4 Results

5.4.1 Descriptive statistics

As Table 5.1 and 5.2 indicate (for both the preceding 12 months and last visit/hospitalization), patient payments for health care services exist in all three countries. However, in Bulgaria, these are mainly official payments since the share of service users who pay informally (in case of both in-patient and out-patient services), is much lower than the proportion of users who make any payment. In contrast, in Hungary, these two proportions are rather similar per service type, which means that informal payments predominate in this country. By the same

token, in Ukraine, both types of payments are prevalent. In all three countries, the proportion of in-patient service users who pay informally is higher compared to that in out-patient care.

The annual informal payments for out-patient services are highest in Hungary followed by those in Ukraine and then by those in Bulgaria (see Table 5.1). These findings are supported by the data on informal payments for the last physician visit (see Table 5.2). In case of in-patient services, the cross-country pattern of annual informal payment and informal payments for the last hospitalization is virtually the same (Tables 5.1 and 5.2). In all three

Table 5.1. Health care services consumption and payments during the last 12 months ^a

			Bulgaria		Hungary		Ukraine	
			2010	2011	2010	2011	2010	2011
Use of out-patient (physician) services during the last 12 months	No	N(%)	239 (24.5)	226 (27.7)	207 (20.0)	123 (15.3)	426 (42.7)	345 (43.2)
	Yes	N(%)	735 (75.5)	589 (72.3)	826 (80.0)	682 (84.7)	572 (57.3)	454 (56.8)
	Number of visits	Median	3.00	3.00	4.00	4.00	2.00	2.00
		Mean (SD)	5.81 (6.48)	5.50 (5.74)	6.58 (6.29)	6.51 (7.05)	3.45 (4.25)	2.88 (3.82)
Payments for out-patient (physician) services by users	No	N(%)	172 (24.2)	92 (16.0)	594 (72.7)	483 (70.8)	246 (43.3)	213 (47.1)
	Yes	N(%)	540 (75.8)	483 (84.0)	223 (27.3)	199 (29.2)	322 (56.7)	236 (52.6)
	Total payments	Median	6.1	5.2	36.4	37.8	19.2	20.7
		Mean (SD)	27.33 (83.3)	19.0 (51.4)	80.3 (115.5)	73.9 (101.8)	60.8 (123.5)	85.8 (153.1)
Informal payments for out-patient (physician) services by users	No	N(%)	658 (90.3)	539 (91.8)	647 (78.8)	540 (79.2)	359 (63.3)	294 (65.0)
	Yes	N(%)	71 (9.7)	48 (8.2)	174 (21.2)	142 (20.8)	208 (36.7)	158 (35.0)
	Total informal payments	Median	14.1	10.4	36.4	37.8	9.6	10.4
		Mean (SD)	29.1 (36.2)	23.8 (35.9)	61.3 (80.1)	75.3 (100.8)	32.2 (62.4)	52.8 (121.2)
Knowledge of the official fees for physician's services	Never	N(%)	88 (12.7)	88 (15.9)	570 (69.4)	468 (68.7)	280 (49.0)	284 (62.6)
	Somewhat	N(%)	207 (29.9)	172 (31.0)	185 (22.5)	163 (23.9)	227 (39.7)	130 (28.6)
	Always	N(%)	397 (57.4)	294 (53.1)	66 (8.0)	50 (7.3)	65 (11.4)	40 (8.8)
Use of in-patient (hospital) services during the last 12 months	No	N(%)	831 (83.0)	689 (84.3)	817 (78.9)	656 (81.5)	816 (81.6)	647 (81.1)
	Yes	N(%)	170 (17.0)	128 (15.7)	219 (21.1)	149 (18.5)	184 (18.4)	151 (18.9)
	Number of hospitalizations	Median	1.00	1.00	1.00	1.00	1.00	1.00
		Mean (SD)	1.73 (2.59)	1.52 (0.96)	1.88 (2.17)	1.69 (1.82)	1.48 (0.81)	1.34 (0.81)
Payments for in-patient (hospital) services by users	No	N(%)	52 (33.1)	45 (36.9)	115 (53.2)	58 (38.9)	48 (27.0)	37 (25.2)
	Yes	N(%)	105 (66.9)	77 (63.1)	101 (46.8)	91 (61.1)	130 (73.0)	110 (74.8)
	Total payments	Median	25.6	25.0	90.9	75.6	95.9	155.3
		Mean (SD)	91.1(153.1)	103.0(197.4)	134.8(131.3)	121.5(126.4)	195.9(235.2)	219.2(219.5)
Informal payments for in-patient (hospital) services by users	No	N(%)	120 (78.4)	108 (88.5)	119 (55.1)	62 (42.2)	87 (89.9)	84 (57.1)
	Yes	N(%)	33 (21.6)	14 (11.5)	97 (44.9)	85 (57.8)	89 (51.1)	63 (42.9)
	Total informal payments	Median	10.2	31.3	100.0	75.6	38.3	51.8
		Mean (SD)	98.5(188.7)	113.2(236.3)	123.7(122.8)	107.1(101.1)	81.2(121.1)	145.0(185.7)
Knowledge of the official fees for hospital services	Never	N(%)	31 (20.3)	32 (23.5)	154 (70.6)	100 (67.6)	87 (47.3)	96 (63.6)
	Somewhat	N(%)	46 (30.1)	44 (38.3)	47 (21.6)	36 (24.3)	65 (35.3)	38 (25.2)
	Always	N(%)	76 (49.7)	39 (33.9)	17 (7.8)	12 (8.1)	32 (17.4)	17 (11.3)

^a All amounts in the table are presented in Euro. Firstly, in local currency for 2011 and 2009 amounts are converted to 2010 values based on Consumer Price Index per country (source: World Bank), then converted from local currency to Euro based on average conversion rate for 2010 (source: ESB).

Table 5.2. Informal payments for the last physician visit/hospitalization

Last 30 months ^a			Bulgaria	Hungary	Ukraine
Date of the last visit to/by physician	2009-2011 (30 months)	N(%)	683 (84)	722 (90)	546 (68)
	Before 2009	N(%)	59 (7)	23 (3)	52 (7)
	None	N(%)	56 (7)	45 (5)	178 (22)
	Do not know	N(%)	19 (2)	15 (2)	24 (3)
Physician's specialization - last visit	General practitioner	N(%)	458 (67)	446 (62)	67 (12)
	Internist	N(%)	61 (9)	99 (14)	283 (59)
	Obstetrician-gynecologist	N(%)	33 (4)	56 (8)	58 (11)
	Other specialist	N(%)	130 (19)	120 (16)	138 (20)
Payment for the last visit to a physician	No	N(%)	148 (22.4)	613 (85.0)	314 (58.0)
	Yes	N(%)	514 (77.6)	108 (15.0)	227 (42.0)
	Payment size	Median	1.0	18.8	10.4
		Mean (SD)	5.5 (24.8)	24.6 (25.6)	42.7 (107.9)
Informal payment for the last visit to a physician	No	N (%)	651	652	404
	Yes	N (%)	27 (4.0)	70 (9.7)	138 (25.5)
	Payment size	Median	10.4	11.3	8.8
		Mean (SD)	17.1 (29.5)	25.7 (30.0)	19.1 (39.8)
Main purpose of the informal payment for the last physician visit	Better attention	N(%)	4 (13.3)	35 (50.0)	63 (45.3)
	Better service	N(%)	17 (56.7)	19 (27.9)	35 (25.2)
	Other purpose (e.g.	N(%)	9 (30.0)	16 (22.8)	41 (29.5)
Requested informal payments for the last physician visits	Requested by staff	N(%)	18 (58.1)	4 (5.8)	57 (41.3)
	Initiated by the patient only	N(%)	13 (41.9)	65 (94.2)	81 (58.7)
Date of the last hospitalization	2009-2011 (30 months)	N(%)	201 (25)	275 (34)	219 (27)
	Before 2009	N(%)	230 (28)	178 (41)	72 (21)
	None	N(%)	369 (45)	180 (22)	390 (49)
	Do not know	N(%)	17 (2)	22 (3)	26 (3)
Type of last hospitalization	Emergency (not planned)	N(%)	86 (43)	114 (41.5)	140 (64.2)
	Surgery (not procedure)	N(%)	57 (28.5)	100 (36.4)	42 (28.7)
	Delivery	N(%)	18 (9)	23 (8.4)	28 (12.9)
Payment for the last hospitalization	No	N(%)	75 (40.1)	145 (53.5)	59 (29.4)
	Yes	N(%)	112 (59.9)	126 (46.5)	142 (70.6)
	Payment size	Median	20.8	56.7	87.7
		Mean (SD)	73.1 (151.6)	76.1 (63.9)	162.8
Informal payment for the last hospitalization	No	N(%)	167 (85.6)	152 (51.9)	122 (59.5)
	Yes	N(%)	28 (14.4)	120 (44.1)	83 (34.4)
	Payment size	Median	25.6	52.2	43.8
		Mean (SD)	74.7 (174.2)	68.6 (57.5)	103.8
Pharmaceuticals brought by the patient to the hospital	No	N(%)	166 (84.3)	221 (80.4)	48 (22.2)
	Yes	N(%)	31 (15.7)	54 (19.6)	168 (77.8)
	Total monetary value	Median	15.6	8.5	62.1
		Mean (SD)	37.8 (99.3)	14.2 (16.1)	104.51(117.
Medial supplies brought by the patient to the hospital	No	N(%)	179 (90.9)	245 (89.1)	91 (42.3)
	Yes	N(%)	18 (9.1)	30 (10.9)	124 (57.7)
	Total monetary value	Median	15.3	21.6	10.4
		Mean (SD)	276.7	33.6 (31.8)	21.0 (27.4)
Bed linen and food brought by the patient to the hospital	No	N(%)	168 (84.8)	241 (87.6)	108 (49.5)
	Yes	N(%)	30 (15.2)	34 (12.4)	110 (50.5)
Main purpose of the informal payment for the last hospitalization	Better attention	N(%)	24 (44.4)	97 (48.0)	54 (44.6)
	Better service	N(%)	12 (22.3)	81 (40.1)	38 (31.4)
	Other purpose	N(%)	18 (33.4)	24 (11.9)	29 (23.3)
Requested informal payments for the last hospitalization	Requested by staff	N(%)	14 (26.4)	21 (10.4)	51 (42.9)
	Initiated by the patient only	N(%)	39 (73.6)	181 (89.6)	68 (57.1)

^a All amounts in the table are presented in Euro. Firstly, in local currency for 2011 and 2009 amounts are converted to 2010 values based on Consumer Price Index per country (source: World Bank), then converted from local currency to Euro based on average conversion rate for 2010 (source: ESB).

countries, payments for in-patient services are higher than those for out-patient services. Table 5.2 provides additional information on the main reason for the informal payment during the last visit or hospitalization and on the payment initiator (staff or patient).

About half of the respondents in the Bulgarian sample always know the fee size (for both in-patient and out-patient services) in contrast to the much smaller shares in Hungary and Ukraine (see Table 5.1). Though, about 14% of out-patients and about 21% of in-patients in Bulgaria report that they have never known the size of the formal fee.

In addition to the informal payments, in all three countries, respondents also report that they brought goods for their last hospitalization at the medical staff's request (see the data at the bottom of Table 5.2). This includes pharmaceuticals, medical supplies, but also bed linen and food. The percentage of those who brought such items to the hospital is rather similar in Bulgaria and Hungary: 15-20% in case of pharmaceuticals, about 10% in case of medical supplies, and 12-15% in case of bed linen and food. In Ukraine, these shares are much higher. Also, the data show a relatively moderate median value of pharmaceuticals brought by patients in Bulgaria (15.3 Euro) and Hungary (8.2 Euro) in contrast to Ukraine (59.9 Euro). At the same time, the median value of medical supplies brought by patients is the highest in Hungary (21.6 Euro).

5.4.2 Results of the regression analyses on informal patient payments

Table 5.3 presents the results of the binary and linear regression analyses based on the annual informal payments for out-patient and in-patient services, and for the last visit/hospitalization. The results indicate that compared to Hungary (reference country), the number of out-patient users who pay informally is significantly higher in Ukraine and lower in Bulgaria. This applies to both the preceding 12 months and the last visit. For hospitalization a similar trend is found. Bulgarian out-patients who pay informally spend less per year on such payments while Ukrainians pay less for the last physician visit compared to Hungary. In in-patient care, we do not observe any cross-country difference in the size of the annual informal payments across the countries except for the last hospitalization in Bulgaria (amounts paid informally are higher than in Ukraine and Hungary).

A significantly higher number of users report informal payments to a specialist compared to GPs. Also, significantly more frequent and higher payments are noted for surgery and pregnancy/childbirth except for emergency childbirth. For the last hospitalization, we also observe that patients pay higher amounts when the reason for the informal payment is

Table 5.3. Informal payments for services - results of the regression analysis ^{a,b}

		Physician visits				Hospitalizations			
		Annual, year		Last visit, 30 months		Annual, year		Last hospital., 30 months	
		User made informal payments [0-No;1-Yes]	SIZE in Euro	User made informal payments [0-No;1-Yes]	SIZE in Euro	User made informal payments [0-No;1-Yes]	SIZE in Euro	User made informal payments [0-No;1-Yes]	SIZE in Euro
Bulgaria	Coefficient	-0.987*	-34.218*	-1.266*	-9.110	-1.036*	-29.625	-1.511*	104.855*
	Std. Error	(.193)	(13.681)	(.338)	(11.498)	(.313)	(32.978)	(.571)	(53.477)
Ukraine	Coefficient	1.154*	-12.516	1.007*	-18.827*	.516**	-17.817	.827**	12.672
	Std. Error	(.172)	(11.901)	(.266)	(8.438)	(.287)	(28.549)	(.452)	(33.761)
Year ^c	Coefficient	-.028	10.291	.259	-9.344**	.470*	-16.277	.220	5.423
	Std. Error	(.136)	(9.526)	(.155)	(5.334)	(.231)	(21.235)	(.163)	(11.763)
Bulgaria*2011	Coefficient	-.221	-8.291	.012	-9.572	-1.058*	43.499	-.068	-52.502
	Std. Error	(.254)	(19.194)	(.279)	(9.620)	(.431)	(48.892)	(.354)	(32.750)
Ukraine*2011	Coefficient	.005	13.802	.152	13.727*	-.634**	96.414*	-.335	23.383
	Std. Error	(.194)	(13.001)	.134	(4.037)	(.331)	(31.553)	(.269)	(19.309)
Number of visits/hospitalizations	Coefficient	.059*	3.664*	-	-	.150*	14.354*	.010	.254
	Std. Error	(.007)	(.454)	-	-	(.057)	(4.564)	(.008)	(.391)
Fee awareness ^d	Coefficient	.213*	7.180**	.435*	-6.222**	.254*	23.028*	.398*	-1.819
	Std. Error	(.066)	(4.376)	(.115)	(3.438)	(.107)	(10.400)	(.144)	11.090
Internist ^e	Coefficient	-	-	.974*	5.668	-	-	-	-
	Std. Error	-	-	(.227)	(7.126)	-	-	-	-
Obstetrician-Gynecologist ^e	Coefficient	-	-	1.026*	-3.828	-	-	-	-
	Std. Error	-	-	(.292)	(9.620)	-	-	-	-
Other specialist ^e	Coefficient	-	-	.770*	12.872**	-	-	-	-
	Std. Error	-	-	(.233)	(7.586)	-	-	-	-
Emergency ^e	Coefficient	-	-	-	-	-	-	.073	8.942
	Std. Error	-	-	-	-	-	-	(.254)	(21.351)
Surgery ^e	Coefficient	-	-	-	-	-	-	1.254*	37.595**
	Std. Error	-	-	-	-	-	-	(.281)	(21.024)
Childbirth/pregnancy ^e	Coefficient	-	-	-	-	-	-	2.554*	93.941*
	Std. Error	-	-	-	-	-	-	(.546)	(34.695)
Emergency*Surgery ^e	Coefficient	-	-	-	-	-	-	-.157	24.941
	Std. Error	-	-	-	-	-	-	(.428)	(30.539)
Emergency*Childbirth/pregnancy ^e	Coefficient	-	-	-	-	-	-	-.688	-54.516
	Std. Error	-	-	-	-	-	-	(.661)	(39.214)
Surgery*Childbirth/pregnancy ^e	Coefficient	-	-	-	-	-	-	-1.512**	-68.342
	Std. Error	-	-	-	-	-	-	(.825)	(44.576)
Paid for better service ^e	Coefficient	-	-	-	10.664	-	-	-	37.670**
	Std. Error	-	-	-	(6.894)	-	-	-	(20.363)
Paid for better attention ^e	Coefficient	-	-	-	-.061	-	-	-	-9.789
	Std. Error	-	-	-	(6.195)	-	-	-	(19.534)
Asked to pay informally ^e	Coefficient	-	-	-	4.713	-	-	-	99.744*
	Std. Error	-	-	-	(5.802)	-	-	-	(19.600)
Age [Years]	Coefficient	-.003	-.056	-.002	-.268	-.005	.052	.001	.540
	Std. Error	(.003)	(.202)	(.006)	(.172)	(.005)	(.510)	(.007)	(.593)
Gender	Coefficient	.363*	.596	.289**	7.667	.124	-3.593	.313	-24.878
	Std. Error	(.093)	(6.514)	(.170)	(5.371)	(.151)	(15.284)	(.210)	(16.458)
Residence	Coefficient	-.006	1.413	.114**	-.446	-.089	5.279	-.027	6.646
	Std. Error	(.036)	(2.342)	(.061)	(1.906)	(.063)	(5.943)	(.080)	(6.086)
Education	Coefficient	.051	3.589	-.037	2.878	.039	-6.928	-.115	3.885
	Std. Error	(.041)	(2.864)	(.075)	(2.331)	(.072)	(7.250)	(.090)	(6.832)
Health problems ^{e,f}	Coefficient	.487*	7.644	.206	9.041**	.434*	27.738	.354**	47.721*
	Std. Error	(.106)	(7.299)	(.167)	(5.032)	(.188)	(19.178)	(.198)	(20.144)
Number of persons in household	Coefficient	-.022	5.519**	-.025	1.002	-.081	6.125	-.214*	6.769
	Std. Error	(.040)	(2.860)	(.071)	(2.303)	(.067)	(7.063)	(.100)	(7.858)
Household income	Coefficient	.055*	-.094	.051	.443	.083*	6.139*	.102*	5.426**
	Std. Error	(.018)	(1.286)	(.032)	(.999)	(.030)	(3.070)	(.040)	(2.961)
Constant	Coefficient	-2.782*	-6.143	-4.026*	27.782	-1.254	-1.958	-1.885	-134.553
	Std. Error	(.286)	(20.471)	(.603)	(20.012)	(.471)	(51.790)	(.722)	(63.872)
Pseudo R Square / R Square		.166	.135	.194	.179	.162	.103	.271	.322
N of observations		3518	762	1787	218	888	371	613	222

* p < 0.05; ** p ≤ 0.10.

^a Amounts in Euro are used in the analyses. Firstly, in local currency for 2011 and 2009 amounts are converted to 2010 values based on Consumer Price Index per country (source: World Bank), then converted from local currency to Euro based on average conversion rate for 2010 (source: ESB).^b Coding of socio-demographic variables is noted in the Appendix D.^c Coding for annual model: 0-2010; 1-2011; Coding for last visit/hospitalization model: 0-2009; 1-2010; 2-2011.^d Coding: 0-Never, 1-Sometimes, 2- Always^e Coding: 0-No; 1-Yes^f Indicator of a presence of a severe or chronic health problem registered by a physician.

better service as well as when it is requested by medical staff.

We observe some significant differences across the years for annual informal payments for hospitalization. In Hungary, more in-patients paid informally in 2011 than in 2010 while in Bulgaria and Ukraine, the reverse situation is observed. Also, the annual size of informal payments for in-patient care as well as the size of informal payment for last physician visit in Ukraine was higher in 2011 than in previous years.

Also, those who use health care more frequently per year and those who are more aware of the size of the formal fee, have a higher probability of paying informally and make higher annual informal payments. However, the last physician visit model suggests that poor knowledge of the formal fee size is associated with higher amounts paid informally for the last physician visit.

Regarding socio-demographic characteristics, a higher probability of making informal payments is observed among female out-patients, among those who have more health problems, and among members of wealthier households who also pay higher amounts for in-patient care.

5.4.3 Regression results on goods brought by patients during the last hospitalization

Table 5.4 presents the results of the regression analyses carried out for bringing pharmaceuticals, medical supplies and food, bed linen for the last hospitalization. For all three types of goods, we find a significantly more extended practice of bringing goods to the hospital in Ukraine in contrast to Hungary. In Bulgaria, compared to Hungary, a significantly higher number of in-patients bring bed linen and food to the hospital (the latter is similar to Ukraine). Although there are no significant differences across years for Hungary and Ukraine, the value of medical supplies brought by Bulgarian patients is increasing. Fee awareness and length of hospitalization do not have a significant relation with the dependent variables.

The value of medical supplies brought by the patients is significantly higher for surgery (compared to procedures), and for planned surgery (compared to emergency surgery and procedures). In case of a hospitalization due to pregnancy/childbirth, we observe a higher number of patients who bring pharmaceuticals, medical supplies and food, bed linen but much less when this hospitalization is an emergency one or involves surgery (pharmaceutical and medical supplies only) as well as lower amounts spent on medical supplies. We do not observe any significant socio-demographic features in the goods-related models, except for health problems.

Table 5.4. Goods brought by patients during the last hospitalization - regression results^{a,b}

		Pharmaceuticals		Medical supplies		Food, linen
		User brought such goods [0-No; 1-Yes]	SIZE in Euro	User brought such goods [0-No; 1-Yes]	SIZE in Euro	User brought such goods [0-No; 1-Yes]
Bulgaria	Coefficient	-.528	71.118	.090	-227.906	.908**
	Std. Error	(.563)	(61.126)	(.670)	(165.930)	(.537)
Ukraine	Coefficient	2.468*	62.679**	2.811*	-51.422	2.206*
	Std. Error	(.495)	(36.216)	(.536)	(83.850)	(.494)
Year ^c	Coefficient	.278	4.097	.244	-17.916	-.081
	Std. Error	(.192)	(18.902)	(.243)	(49.493)	(.225)
Bulgaria*2011	Coefficient	-.202	-25.500	-.468	404.507*	-.387
	Std. Error	(.351)	(39.561)	(.446)	(111.396)	(.374)
Ukraine*2011	Coefficient	-.075	22.143	-.147	31.906	.313
	Std. Error	(.306)	(22.090)	.316	(55.641)	(.300)
Fee awareness ^d	Coefficient	.192	-11.122	.317	29.109	.078
	Std. Error	(.241)	(10.638)	(.267)	(25.793)	(.243)
Length of hospitalization [Days]	Coefficient	.015	.600	.011	.134	.005
	Std. Error	(.010)	(.367)	(.010)	(.757)	(.007)
Emergency ^e	Coefficient	.203	20.920	.248	-17.355	-.095
	Std. Error	(.273)	(19.221)	(.299)	(46.656)	(.281)
Surgery ^e	Coefficient	.290	35.254	.484	179.366*	.518
	Std. Error	(.314)	(25.146)	(.374)	(61.889)	(.331)
Childbirth/pregnancy ^e	Coefficient	1.224*	39.384	2.420*	-170.911**	.991**
	Std. Error	(.562)	(42.947)	(.581)	(89.361)	(.527)
Emergency*Surgery ^e	Coefficient	-.123	29.175	.336	-184.956*	.019
	Std. Error	(.495)	(35.186)	(.534)	(79.964)	(.487)
Emergency*Childbirth/pregnancy ^e	Coefficient	.097	-45.514	-2.124*	178.781**	-.325
	Std. Error	(.744)	(47.037)	(.728)	(103.223)	(.659)
Surgery* Childbirth/pregnancy ^e	Coefficient	-2.341*	32.971	-1.792*	-11.999	-.956
	Std. Error	(.884)	(68.741)	(.895)	(123.336)	(.813)
Age [Years]	Coefficient	.007	.174	.007	1.878	-.011
	Std. Error	(.008)	(.562)	(.009)	(1.417)	(.008)
Gender	Coefficient	.092	-9.284	-.153	37.345	.213
	Std. Error	(.229)	(15.876)	(.250)	(37.848)	(.233)
Residence	Coefficient	-.038	.436	.071	-18.725	.026
	Std. Error	(.089)	(6.730)	(.096)	(15.691)	.090
Education	Coefficient	.036	1.887	.085	14.230	-.158
	Std. Error	(.100)	(7.195)	(.113)	(16.977)	(.104)
Health problems ^{e,f}	Coefficient	.727*	20.143	.502*	-70.611*	.025
	Std. Error	(.251)	(14.944)	(.222)	(33.857)	(.251)
Number of persons in household	Coefficient	.046	2.667	.025	-7.606	-.122
	Std. Error	(.098)	(6.176)	(.108)	(13.705)	(.103)
Household income	Coefficient	-.063	-.189	.022	-4.508	.082**
	Std. Error	(.042)	(2.980)	(.047)	(6.076)	(.044)
Constant	Coefficient	-2.640*	-50.786	-4.266*	-9.380	-1.842
	Std. Error	(.812)	(58.462)	(.920)	(151.003)	(.821)
Pseudo R Square / R Square		.438	.211	.386	.344	.269
N of observations		623	214	623	146	624

* p < 0.05; ** p ≤ 0.10.

^a Amounts in Euro are used in the analyses. Firstly, in local currency for 2011 and 2009 amounts are converted to 2010 values based on Consumer Price Index per country (source: World Bank), then converted from local currency to Euro based on average conversion rate for 2010 (source: ESB).^b Coding of socio-demographic variables are noted in the Appendix D.^c Coding for annual model: 0-2010; 1-2011; Coding for last visit/hospitalization model: 0-2009; 1-2010; 2-2011.^d Coding: 0-Never, 1-Sometimes, 2- Always^e Coding: 0-No; 1-Yes^f Indicator of a presence of a severe or chronic health problem registered by a physician.

5.5 Discussion

Our results demonstrate that there are significant differences in informal patient payments across countries and types of services, and to a certain extent across years. However, we cannot draw strong conclusions about time trends since the time period studied is only 2-3 years. We also find other relevant relations with structural factors such as the strong association between the patients' fee awareness and making informal payments. Also, the purpose of the payment and its initiator appear significant on some occasions as well as some socio-demographic features of respondents. The findings on the impact of the separate structural factor on patients' payment behavior are subsequently discussed.

5.5.1 Country context factor

All our findings consistently show a lower extent of informal patient payments in Bulgaria and a higher extent in Ukraine when compared to Hungary, which is in accordance with previous studies (Health Consumer Powerhouse, 2010; Lewis, 2007).

The difference between Hungary and Bulgaria is puzzling at first glance given the traditionally better indicators in Hungary, e.g. higher health care funding and political stability (Pavlova et al., 2012). The relatively low frequency of informal payments in Bulgaria could be explained by the institutional/structural framework (see background section). Also, in Bulgaria, the participation of public organizations in decision making and recent anti-corruption measures required for entering EU, play an important role in the country and facilitate the creation of negative attitudes towards informal patient payments (Atanasova et al., 2010; Health Consumer Powerhouse, 2010). In contrast, in Hungary, the positive and indifferent attitudes towards informal patient payments are more extensive (Stepurko et al., 2011). Also, the private health care sector in Bulgaria is growing and provides formal alternatives for patients who are willing to pay for better and quicker services. This is coupled with widely adopted formal fees for public health services, which is in contrast to Hungary. Additionally, the inadequate public health care provision and the need to further reduce government expenditure on health care may hold back policy attempts in Hungary to eliminate informal payments (Baji et al., 2011). This also applies to Bulgaria.

Although lower than in Hungary, we find that informal patient payments are wide spread in Bulgaria as well, especially for hospitalizations. The delayed structural changes in Bulgarian hospital care (Atanasova et al., 2011), may well explain our finding and underline

the need of such changes. Also, the Bulgarian government needs to adopt measures specifically targeting informal patient payments, such as concordance of out- and in-patient care provision reforms, adequate (more efficient) service funding as well as better monitoring of the financial flows in the health care sector.

In comparison to Bulgaria and Hungary, the Ukrainian case seems to be a rather despairing one. The Ukrainian government maintains the ‘status quo’ in providing goods to patients, while the quality- and access-related challenges in public health care provision faced in the 1990s have not been solved during the transition period (Lekhan et al., 2010; Rechel & McKee, 2009). Nevertheless, the responsibility for sufficient service funding has been implicitly shifted from the state to the patient. This is evidenced by high private expenditures most of which are informal or quasi-formal (Danyliv et al., 2012). The inadequate health care funding in Ukraine is also supported by our results on goods brought by patients. The lack of consistent policy goals, an adequate management culture, an up-to-date institutional base and an undeveloped private sector further aggravates the quality and access problems in the Ukrainian public health care provision.

5.5.2 Services and supply-side factors

As reported in our study and as confirmed by previous empirical evidence (Szende & Culyer, 2006; Tomini & Maarse, 2011; Vian et al., 2006), in-patient health care consumption leads to more widely-spread and higher amounts of informal patient payments compared to out-patient care. We find that in in-patient care, informal payments in case of surgery and childbirth/pregnancy are higher compared to other in-patient services, which is comparable to previous findings (Kornai, 2000; Shahriari et al., 2001). Also, we find lower informal payments for GP services than for other out-patient specialists which are also reported in previous studies (Vian et al., 2006).

Our results suggest the relevance of service quality in explaining informal patient payments. Although this relation is not significant in our regression models, a considerable number of informal payers in our study report ‘better attention’ as the main reason of informal payment. In Central and Eastern European countries, the lack of a favorable attitude of medical staff to patients may be founded in physicians’ social status inconsistency (when professional prestige and education do not correspond to salary/income) that results in personal doctors’ discordance, e.g. in aggressiveness of medical staff (Cockcroft et al., 2011; Geschwender, 1967; Lewis, 2000). However, in order to stimulate effective and ethical

performance, regional and facility administration should ensure not only adequate salary of medical staff, but should also apply additional motivational tools like intangible and monetary stimuli. In this regard, as Lewis (2007, p.993) notices that “payment methods are the cornerstone of incentives for productivity and performance”, while simple increasing size of the salary may just decrease aggressiveness as a reflection of status inconsistency. Therefore, the following policy measures are suggested: competition and transparency in hiring and promotion of medical staff, alternatives to salary payment mechanisms (bonuses, capitation), and clear policies for misconduct (Lewis, 2007).

We also observe a positive relation between being asked to pay informally and the size of informal payment for a hospitalization. Hence, it is important to strengthen the norms of ethical behavior among medical staff, i.e. professional training, involvement of professional committees and possibilities for patients to complain when asked to pay informally.

When we examine the size of the informal payment for hospitalization, obtaining better services also emerges as an important purpose of informal payments. Thus, health care provision is organized in such way that the patient is prompted to pay informally to obtain adequate care. Specifically, governments have no resources or ability to assure services with adequate quality for all. But introducing formal charges for better quality/access contradicts equity principles. As a result, access to desirable attributes of health care services depends on patients’ ability to pay informally (Cohen, 2012; Gaál et al., 2006).

5.5.3 Factors of knowledge of the size of the official payment for health care services

Patients’ access to information on the fee size is highly important for an adequate health care system. As our results suggest, in all three countries, more efforts are needed to increase patients’ knowledge about the size of the official fees.

However, contrary to our expectations and previous results (Mokhtari & Ashtari, 2012), we observe a higher probability of informal payments among well-informed patients. Patients, who know the size of the formal fee, may better pursue opportunities for informal payments. These patients may also better distinguish the presence of informal payments since they know the size of the official fee. However, we observe a negative association between fee awareness and the size of the informal payment for the last physician visit. Despite these differences, our findings support the policy recommendation to provide easily accessible information on the formal services price to patients. Complicated schemes and regulations regarding health care provision can also be attributed to lack of knowledge (Belli et al., 2004).

Therefore, the service consumption mechanisms should be clear for any patient. Mobilization of nongovernmental organizations and civil societies, which are currently emerging in Central and Eastern European countries, can help in achieving this objective.

5.6 Conclusions

This chapter has focused on the comparison of informal patient payments in Bulgaria, Hungary and Ukraine. The results confirm the existence of wide-spread informal payments in all three countries though the patterns vary greatly across countries, services and years (although the time period studied is very short). Differences in regulatory mechanisms, the extent of “internal and external competition”, and level and sources of funding explain the cross-country diversity (Ensor, 2004). Nevertheless, in all three countries, informal patient payments (both “bribes and gifts”) provide a means for patients to obtain the health care they desire, and which the government is not able to guarantee.

When patients perceive service provision to be poor and hence apply ‘do-it-yourself’ policies (informal payments, using connections) in an attempt to benefit of better service (Cohen, 2012), this may lead to a shift in achieving the goals stated by the government. Policy-makers should consider the purposes of informal payments in the country and select corresponding measures to eliminate this type of payment. In case patients need better attention of medical personnel, it is important to motivate the staff (via salaries, bonuses, work conditions, trainings). At the same time, because of the lack of regulations (protocols) and sanctions, it is mainly physicians (still underpaid and unmotivated) who make the decision on the service they provide to patients (Thompson & Xavier, 2004). Hence, wise regulations coupled with incentives/disincentives may decrease the level of informal payments for health care provision.

CHAPTER 6.

INFORMAL PATIENT PAYMENTS IN MATERNITY HOSPITALS IN KIEV, UKRAINE: RESULTS FROM A QUALITATIVE STUDY

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Abstract

Maternity care in Ukraine is a government priority as well as one of the UN Millennium Goals. However, it has not undergone substantial changes since the collapse of the Soviet Union. Like the entire health care sector in Ukraine, maternity care suffers from inefficient funding, which results in low quality and poor access to services. The objective of this chapter is to explore the practice of informal payments for maternity care in Ukraine, specifically in case of childbirth in Kiev maternity hospitals. The chapter provides an ethnographic study on the consumers' and providers' experience with informal payments. The results suggest that informal payments for childbirth are an established practice in Kiev maternity hospitals. We find that there are two groups of patients in the Ukrainian maternity care ward: "individual patients" who have agreed with the obstetrician about the childbirth services and related payments, and "emergency room patients" who do not have a "personal obstetrician" though they may still pay a variety of charges. Two push-factors can lead to a search for a "personal obstetrician" in Ukraine: the need for twenty-four-hour access to reliable information and the need for psychological comfort during the childbirth. Moreover, the obstetricians share with us their experience of informal payments redistribution among medical staff quite openly. Still, all groups of respondents would prefer avoid this informal practice, if there are other options for higher salary for providers and for formal options to get better quality care for consumers. To deal with informal payments in Kiev maternity hospitals, there is a need of: (1) regulation of the "quasi-official" patient payments at the health care facility level as well as (2) improvement of professional ethics through staff training. These strategies should be coupled with improved governance of the health care sector in general, and maternity care in particular in order to attain international quality standards and adequate access to facilities.

6.1 Introduction

In Ukraine, maternity care is proclaimed to be a government priority (Cabinet of Ministers of Ukraine, 2006). It is also one of the UN Millennium Goals. However, it has not undergone substantial changes since the collapse of the Soviet Union. In 2004, reproductive health expenditures represented 10% of the total health care spending and 0.8% of GDP (Gotsadze et al., 2006). This rate is higher than in other countries at a similar level of economic development. Nevertheless, the allocation of available resources is inefficient, which is evident (especially in rural areas) from the poorly functioning telephone lines, lack of pharmaceuticals and consumables, absence of fuel and outdated equipment (Gryga et al., 2006; Lekhan et al., 2010). These are major obstacles in providing maternity care.

Public health care facilities (Gotsadze et al., 2006; Lekhan et al., 2010; Nizalova & Vyshnya, 2010) are the main providers of maternity care because the private health care sector in Ukraine is still underdeveloped. Except for a few luxury services, services at public health care facilities (including maternity care) are officially free of charge (Lekhan et al., 2007; Gryga et al., 2010). However, patients meet other payment obligations as well. In particular, there are charitable contributions (Lekhan et al., 2010), which are officially voluntary payments but are often expected by the facility staff. This makes them a type of quasi-official charges as defined by Thompson and Witter (2000). Also, similar to other former-socialist countries (Allin et al., 2006; Burak & Vian, 2007), Ukrainian patients frequently have to motivate the low-paid health care staff by informal (unofficial) payments in order to receive services with better quality and shorter waiting times (Balabanova et al., 2004; Betliy et al., 2007). Although these payments have negative effects on equity and efficiency of health care provision, they are often neglected by policy-makers who struggle with financial difficulties, since these payments fill gaps in public health care funding (Ensor & Savelyeva, 1998; Kornai, 2000; Cohen, 2012). The share of informal patient payments in Ukraine is one of the highest in Central and Eastern European (CEE) countries (Stepurko et al., 2011), though in comparison with other former-soviet-union countries, the percentage of those who pay informally is one of the lowest (Balabanova et al., 2004).

Studies from the region indicate that informal payments are higher and more frequent in case of services of obstetricians, gynecologists, and surgeons (including childbirth) compared to other services (Kornai, 2000; Shishkin et al., 2003; Belli et al., 2004; Baschieri & Falkingham, 2006; Liapopoulos et al., 2008; Baji et al., 2012). Therefore, our aim is to study the situation that accounts for the widespread and higher informal payments for

childbirth. In particular, we explore the practice of informal payments in maternity hospitals in Ukraine, specifically in case of childbirth in Kiev maternity hospitals. In contrast to previous research on informal payments, which has mostly focused on quantitative measures, we explore the qualitative aspects of the process of informal payments, e.g. how informal prices are determined and how such payments are requested and paid. We use data collected during face-to-face semi-structured interviews with young mothers and obstetricians.

6.2 Maternity care in Ukraine

Although some birth indicators in Ukraine have improved during the last decade (e.g. a 44% increase of the birth rate since 2001, 11.1 live births per 1000 in the population in 2009, and a 28.5% decrease of infant mortality since 1992, 10 infant deaths per 1000 live birth in 2008), the population growth coefficient remains negative (- 4 net change per 1000 population in 2009) and maternal mortality (15 maternal deaths per 100 000 live births in 2000-2009) is high in comparison to other European countries (State Statistics Committee of Ukraine, 2010; World Health Organization, 2010). Based on Glatleider (2006) and Richard, Witter and Brouwere (2010), it is expected that the quality and access problems mentioned above, contribute to this high maternal mortality.

There is a variety of prenatal care providers in Ukraine such as outpatient 'women's consultation' units, feldsher and midwife points (FAPs) in rural areas, obstetrics-gynecological inpatient clinics and departments in various hospitals (Gotsadze et al., 2006). Nevertheless, prenatal care is commonly oriented on detecting and treating pathologies during pregnancy rather than on disease prevention (Berghold et al., 1998).

With regard to childbirth, public health care facilities still remain virtually the only service providers. Home birth is forbidden by the Ministry of Health and private maternity hospitals are not common in Ukraine. There are 87 maternity hospitals or maternal departments (11 maternity facilities in Kiev), which offer about 45.19 delivery beds per 1 000 deliveries (in Kiev, 28.83 delivery beds per 1 000 deliveries) (Ministry of Health, 2009). Some deliveries take place in other non-hospital facilities. Most maternity hospitals in Kiev are specialized, e.g. typical examples are a specialization in obstetric care in case of advanced labor (these hospitals have a well-equipped resuscitation departments) or in obstetric care for pregnant women with infectious disease, such as HIV/AIDS. In response to the low quality of public health care services, a private maternity hospital was opened in Kiev in 2004. This private clinic can be seen as an alternative to public facilities but it is mainly available for rich

people because the services of the hospital are described as “expensive services with high quality” (MedExpert, 2009). The average annual number of births in this hospital is about 575 per year (according to the website of this hospital).

Registration, presence of complications, and sometimes preferences of the patient (the pregnant woman) determine the public facility which has to provide childbirth services. Generally, a gynecologist from an out-patient facility, who has observed the pregnancy course, refers the patient to a maternity home to sign the *obminna karta* (an exchange case record, which is a medical file where all the examination results and, thus health status are noted during the pregnancy; if this card is not signed, the ambulance brings the women to any maternity home when the delivery starts). Thus, the first visit to the in-patient maternity facility occurs in the 35th week of pregnancy if no complications have occurred before.

In case of childbirth in urban areas, high-qualified medical staff is available (e.g. obstetrician-gynecologists, anesthesiologist, neonatologist), while FAPs provide services by a midwife only. According to Health for All data (World Health Organisation, 2010), there are about 26 obstetrician-gynecologists and 49 midwives per 100 000 population (for Kiev this rate is 32 obstetrician-gynecologists and 30 midwives per 100 000 population). These numbers are high compared to Western European countries. On the whole, in 2007, 99 % of births were attended by skilled health care personnel, whereas in the period 1995-2005, this rate was 100 % (World Health Organisation, 2010).

Childbirth in Ukraine follows the so called technocratic model (Davis-Floyd, 2001; van Teijlingen et al., 2009), notably it “stresses mind-body separation and sees the body as a machine”. The obstetrician-gynecologist (hereafter referred to as the obstetrician) is the key professional during childbirth while the midwife plays a secondary role (unless an obstetrician is not available in the facility, e.g. in FAPs). The overall organization of obstetric services runs counter to most international standards. In particular, standards such as demedicalization, minimal set of interventions, evidence-based care as well “intellectual, emotional, social, and cultural needs of women, their babies, and families” are to be considered (Chalmers et al., 2001). Glatleider (2006) outlines the following key problems: “over-medicalization, inappropriate use of technology, unnecessary hospitalizations, and ineffective and/or harmful interventions”. Childbirth services are also described as non-user oriented, and the communicative skills of most medical personnel do not meet the requirements of patient-oriented care (Gryga et al., 2006).

During the last decade, some innovations have been introduced. In particular, the presence of the partner during labor, free choice of positions during labor, and rooming-in are

now allowed in some facilities. Early breastfeeding is sometimes stimulated by Mother and Infant health project (USAID). Also, relatives may visit child and mother during the stay in the post-delivery department. Women are now discharged within 3 days in case of normal childbirth and 5-7 days after a caesarean section. These are positive improvements initiated by international projects. However, they are not systematic but rather fragmented clinical and organizational innovations.

To obtain the childbirth services that they desire, expecting mothers and their partners search for alternative options to secure a direct contact with a desirable obstetrician prior to the childbirth. As it has been observed in some Post-Soviet Union studies (Brown & Rusinova, 1997; Salmi, 2003; Shishkin et al., 2003), patients tend to use either informal relations or informal patient payments that can help to secure the attention of the obstetrician and other medical staff during the childbirth.

6.3 Methods

We applied the method of ethnographic study that enables us to learn more about local specificity of human behavior related to the process and nature of informal patient payments for childbirth (LeCompte & Schensul, 2010). This method facilitates discovering the “culture” of informal practices in maternity homes. The data on informal patient payments for this study were collected in Kiev, in the period of December 2008 - April 2009. Given the sensitive nature of data on this type of payments, we relied on qualitative research methods, namely face-to-face semi-structured interviews. Three groups of respondents were included: key informants (experts), young mothers and obstetricians. The method of convenience sampling was used in case of key informants and mothers, while obstetricians were included based on the snow-ball sampling method.

In the first stage of the data collection, we conducted face-to-face semi-structured interviews with three key informants (experts) who were highly qualified specialists in obstetrics and gynecology field. Particularly, they have been working as obstetricians-gynecologists for many years and now hold consultant positions in government bodies or top managers of private prenatal facilities. They have broad experience in this medical field, and they did not represent other groups of respondents at the moment of the study. Based on the responses of the key informants, we made adjustments in the wording of questions used for interviewing young mothers and obstetricians. The questions are aimed to obtain more understanding on informal payments for childbirth, attitudes towards these payments, as well

as possible solutions to overcome them. Based on an operational definition of informal patient payments provided in Chapter 2, we define these payments as cash payments or in-kind gifts given to medical staff by the young mothers or their relatives before, during or after the use of services that had to be provided free-of-charge. The term “informal patient payment” was used only in the interviews with key informants. When interviewing the mothers, we used the term “gratuity” and “payment on the doctor’s request”. In the interviews with obstetricians, we asked about “patient’s gratitude” and “expression of understanding of medical staff misery”.

In the second stage of the data collection, face-to-face semi-structured interviews were conducted with young mothers (i.e. women who gave birth to a child within two years preceding the interview) in Kiev, and obstetricians from Kiev public maternity hospitals. A two-years recall period was considered as appropriate since the birth of a child is a major event that remains in a woman’s memory for a long period of time. The interview guide for the two groups of respondents differed slightly. Women were asked about their selection of a physician, how they reached an agreement about the informal payment (when applicable), what was the form, amount and moment of the payment. During the interviews with the obstetricians, we asked about the form, amount and moment of the informal payments for obstetric services, their expectations on their income level in case the informal payments would be completely eliminated, and their ideas on how to change the situation (i.e. the elimination of “envelope” payments among staff). Other common topics for both groups of respondents were the reasons for giving or taking informal payments and the attitude toward such payments.

In total, twenty respondents participated in the study: eleven women who gave birth during the last two years; six obstetricians who worked in Kiev maternity hospitals; and three key-informants. All respondents gave an informed consent. They agreed to participate in the study and were aware of the study content and ethical considerations (confidentiality, presenting analyzed data without indicating real names and institutions of respondent). In case of interviews, regulations in Ukraine do not require a prior approval by an ethics committee.

We analyze the data qualitatively using analytic induction methodology (Miles & Huberman, 1994). In particular, we first search the transcripts of the interviews for themes that are related to the patient payment practice and bargaining process in maternity care. Then, we group these themes into broader categories to assure clarity of presentation. Although, we indicate in the results section whether a certain qualitative finding is supported by the majority of our respondents, we do not aim at representative findings and we do not

look for statistically significant associations. Our objective is to better understand the process of informal patient payments in case of childbirth. The inclusion of three groups of respondents enables us to study the phenomenon from different angles and therefore, it helps to improve validity (Creswell & Miller, 2000).

6.4 Results

Our results indicate that all three groups of respondents (key informants, newly mothers and obstetricians) are familiar with unofficial patient payments and describe these payments as part and parcel of the health care sector of Ukraine, especially in maternity care.

6.4.1 Types of “patients” at the maternity hospitals

One of the most relevant finding of the study is the obstetricians’ classification of patients in maternity hospitals. Indeed, obstetricians divide the expecting mothers (i.e. their patients) into two groups: individual patients (*pryvatni*) and emergency-room patients (*po shvydkiy*). The first group includes women who make a preliminary agreement with an obstetrician. Thus, they are prepared to pay to the physician to get the “full package”, which includes information support, medicines, immediate help and additional attention. Women who do not have any agreement with an obstetrician before they arrive at the maternity hospital (usually they arrive by emergency ambulance) are the “emergency-room patients” and they receive “standard care”. Nevertheless, any kind of arrangement may take place during or after the childbirth. When we apply this obstetricians’ classification to the group of mothers included in our study, we observe that the majority of women-respondents belong to the group of “individual patients”, one woman belongs to the group of “emergency-room patients”, and one woman does not belong to any of these groups as she used obstetric services provided by a friend.

6.4.2 The search for an obstetrician

The search for an obstetrician before the childbirth is the initiative and decision of the parents-to-be. Still some couples decide not to make an agreement with an obstetrician in advance and come to the maternity hospital “through the emergency room”. The mothers-respondents in our study indicate that there is no single information centre where couples could go for reliable information and advice about pregnancy and childbirth. The parents-to-be usually have to use various sources of information, i.e. online forums, newspapers, books,

Box 6.1. Ann's story

Ann and her husband planned a child. After this decision was made, she started to take additional care for her health, underwent examination and medical tests as she believed that having a good physical condition can help during pregnancy and childbirth.

After they found out that she was pregnant, Ann joined courses for future parents. Among plenty of useful information, Ann got to know that all women, who were in her group, had agreements with personal doctors. The tutor of the group also gave important information on how to choose the obstetrician and presented a list with important questions that must be asked to the obstetrician. Moreover, she also said: "No matter whether you have personal obstetrician or not, you can call the ambulance once your delivery starts and they will provide all care that is needed". Eventually, Ann was completely informed about the processes, about her needs and requests. She knew that she needed an obstetrician who will be oriented on natural childbirths, without medical interventions, and who can provide psychological comfort.

Her friend Kate made an arrangement with one obstetrician and gave him a prepayment. Since that obstetrician had to leave the city, he placed Kate in a maternity home on the 40th week of pregnancy and gave her a birth stimulating injection. Kate almost lost the baby during that childbirth. After all, the baby spent one week at the reanimation department. Looking at this experience, Ann thought that the choice of an obstetrician was a very important one and she had to ensure herself from any risks. Ann thought that she needed to trust her doctor.

Ann's friend who gave birth two years ago, recommended one obstetrician. From the very beginning, Ann and her husband agreed that some things that might cause inconvenience to her, should be solved by her husband. Notably, all informal "transactions" will be done by her husband. Further, when they met the recommended obstetrician, he explained all the nuances that can arise (e.g. he encourages the presence of a husband during the childbirth); additionally, the cost of the childbirth was discussed during that meeting as well (US\$260 (1,300 hryvnias) in 2006): *"During the 35th week of pregnancy, we agreed the price for the childbirth. The sum was within the limits of what I was expecting."*

The family also asked the obstetrician whether they have to pay additional money to the midwife, anesthesiologist or to make some charity contribution. The obstetrician said that they had to pay only him since they made an agreement with him and he would take care of the rest. Since Ann had a good psychological contact with the doctor and she could call him even in the middle of the night if she had questions or wanted to share something, she had a strong feeling that this is what she had to pay to him for. Ann said that for example in Switzerland, there was a hotline in the maternity home where people could call any time. If we had something like that in Ukraine, it would certainly solve some problems, in her opinion.

Her husband took an active part in all consultations. He arranged the exchange of the *"obminna carta"* and participated in the childbirth process. Additionally, he was the one who settled the financial agreements with the obstetrician. Since the obstetrician brought confidence and trust in the expecting couple, they were very thankful. They paid more than it was agreed also because they felt attention, and really wanted to say "thank you". They also presented cognac and candies.

Ann would certainly recommend that obstetrician to her friends and will return to him again with her next pregnancy, because she was satisfied with the care that she received.

conversations with friends who have children, parental courses, and women consultation in polyclinics. These sources help to narrow down the circle of “skilled obstetricians”.

We note several reasons for having a “personal obstetrician”. The majority of mothers-respondents express the opinion that the most important thing in the process of childbirth is to have a skilful obstetrician. Firstly, mothers feel a need for psychological comfort and try to decrease feelings of anxiety. The chance of having an absolutely unknown obstetrician during the delivery is perceived as “an additional unnecessary risk”. Moreover, according to the mothers-respondents, the “personal obstetrician” may supply better conditions during the childbirth and organize a team of professionals. The search for a reliable obstetrician is also motivated by respondents’ knowledge of negative childbirth experiences of other women.

To ensure that the obstetrician selected for the childbirth, meets the couple’s expectations, parents-to-be “interview” several obstetricians. The couple aims to identify an obstetrician with whom they can establish a good psychological contact since the expecting mothers hope for psychological comfort during childbirth. Among other things, the psychological comfort during the childbirth is associated with the obstetrician’s personality.

6.4.3 Quasi-official payment at the maternity hospitals

When answering the question about the payment for childbirth, the mothers-respondents indicate payments to the maternity hospital in addition to other payments to the obstetrician, and other medical staff. Payments to the maternity hospital are charitable contributions by nature, i.e. a kind of quasi-formal payments since these are payments at the cash-desk for which they receive a receipt even though the services are officially free-of-charge. Mothers note that childbirth in a hospital located in a district other than the respondents’ district, as well as the option to have a more comfortable room, are subject to charitable contributions. Health care facilities usually have two bank accounts: one is for state funding while the other serves for additional funds filled by patients (experts’ opinion). Moreover, upon arrival at the maternity hospital, women are also asked to bring some necessities to the maternity home, such as paper towels, liquid soap, and some medicines.

The amount of the charitable contribution is fixed by the administration of the maternity hospital. Thus, it depends on the hospital. Mothers included in the study told us that the amount of charitable contributions was about US\$ 100 (or about 750 Ukrainian hryvnias)

per childbirth paid upon the arrival or first visit to the hospital (when *obminna karta* had to be signed).

6.4.4 The “bargaining” process

Except fixed-price quasi-official payments, mothers-respondents indicate that the financial aspect of the childbirth arises after the preferred obstetrician is selected. If the “negotiations” with the obstetrician do not bring the expected result with regard to the childbirth in general, the issue of payment does not arise. Although pregnant women usually have information about an average informal “tariff” of the childbirth in a public hospital, they discuss the “price” with the obstetrician in order to avoid “offending” the obstetrician with a too small amount after the childbirth, and to avoid paying unnecessarily high amounts. Mothers-respondents note that they avoided obstetricians who asked for an informal payment before the childbirth. Overall, the mothers indicate that they felt comfortable in the discussion with the obstetrician, including the discussion of the financial aspect of the childbirth.

In total, the majority of “individual patients” indicate that they agreed on the amount of the informal payment before the childbirth. However, only few obstetricians say that the “price” of the childbirth is negotiated prior to the childbirth.

6.4.5 The informal payments for childbirth

Virtually all mothers-respondents indicate that they have given informal payments in cash to medical staff supplemented occasionally with gifts in-kind. Only in one case, the respondent says that she considered giving cash unethical because of her friendship with the obstetrician. Gifts in kind (e.g. candies, drinks, flowers) are also given to paramedical staff.

The obstetricians in our study confirm the prevalence of cash payments in the obstetric practice. Moreover, they note that the form of the payment depends on the type of assistance provided to the delivering mother. According to the obstetrician-respondents, payments for childbirth are mostly monetary, while payments for other services are done mainly in the form of food or drinks. However, some of the obstetricians argue that patients gave cash or nothing, or even that the obstetrician can tell the patient what the obstetrician wants to receive.

We asked the mothers-respondents about the amount of money they paid to the obstetrician. Based on their answers, we observed that probably “prices” have increased since 2007 and depend on the complications during the childbirth. In 2007, “emergency-room patients” paid on average US\$ 50 (about 250 hryvnias) for childbirth and also presented

candies. One “individual patient” had a difficult delivery and the obstetrician did not indicate the amount of the informal payment. So, the mother searched for a reference on internet-forums and decided to pay US\$ 700 (3 500 hryvnias) since (as she says) “an ordinary birth costs US\$ 300” (1500 hryvnias). Other mothers in our study, belonging to the group of “individual patients”, paid to the obstetrician amounts ranging from US\$ 300 (1 500 hryvnias) in 2007 till US\$ 500 (2 500 hryvnias) in 2008. Key informants mention similar informal payments. They note that the “price” of a childbirth ranges from US\$ 300 – 500 to US\$ 4 000 – 5 000 (from 1 500 – 2 500 hryvnias to 20 000 – 25 000 hryvnias).

Usually, this price includes the “full package”, i.e. medicines and the work of the obstetrician, anesthesiologist, and other staff. Thus, according to mothers-respondents, the obstetrician shared his/her informal payment with the team who worked during the childbirth. Obstetricians confirm that the money that is received informally is divided among the team: anesthesiologist, midwife, surgical nurse, junior nurse, and more rarely neonatologist. They also confirm that such practice of sharing the informal payment is widespread. However, the exact distribution of the amount among the team members depends on the traditions in the department and “moral quality” of the obstetrician. Nevertheless, some mothers-respondents confirm that they made an extra payment for the work of midwives or anesthesiologist on the request of the obstetrician.

Nearly all “individual patients” in our study made non-monetary payments to mid-level staff in addition to the cash payments. In some instances, paramedical staff also requested cash payments. A nurse who prepared documents asked to put money in her pocket “in order to help for children with defects”. Indeed, such reason is often pronounced by paramedical personnel since children with defects are sometimes left by mothers (these children spend the first months in the hospital where they are born although no budget funds are provided for these cases). Additionally, support medical staff is not limited with such moral obligations as physicians, who swear Hippocratic Oath. Thus the ethical behavior is supposed to be a personal characteristic. In the result, it brings such negative patients’ experience (e.g. direct requests of informal payment) when dealing with paramedical personnel. Nevertheless, the highest amount of money is paid to the obstetrician who assists during the childbirth, while the other small payments are paid at the request of other medical staff. Most mothers-respondents state that they have saved money for childbirth or note that their income was sufficient and therefore, they do not consider the cost of childbirth an excessive financial burden.

6.4.6 *The moment of payment*

Typically, mothers-respondents pay to the obstetrician after giving birth. In detail, the “emergency-room patients” paid after discharge from the hospital. Patients with arrangements (“individual patients”) paid informally immediately after the childbirth as the physician had “to settle the accounts” with his/her team. However, pre-payment practices are also observed in case of a request of the obstetrician.

All obstetricians in the study indicate that they took a payment for assistance only after successful completion of the childbirth or other procedures related to it. All obstetrician-respondents say that in case of patients who come “through the ambulance”, gratuity is usually given and its size is determined by the patient (i.e. the mother or her husband). In contrast, “individual patients” payment is determined by the obstetrician. None of the obstetricians admitted that he/she requested the informal payment, but all confirmed that some of their colleagues were experienced in this.

6.4.7 *Reasons for informal patient payments*

The obstetricians and mothers in our study emphasize that the low salaries of medical staff is the main reason for informal payments. In addition to the low salaries, the mothers-respondents indicate also other key reasons for giving informal payments, such as “to

Box 6.2. Olga’s story

Olga has two children. As she was not happy with the first childbirth, Olga was interested to find another obstetrician. The friend of Olga’s husband, who is gynecologist, recommended an obstetrician when she was pregnant. She searched websites for references on this physician. For Olga, it was important to have plenty of attention and psychological comfort. She met the doctor two months before the childbirth and agreed everything, including price and all possible expenses. Olga and her husband had not saved up money for the childbirth but the sum of money that they paid was acceptable in Olga’s opinion. They paid the doctor about US\$ 650 (3,400 hryvnias) and around US\$ 140 (700 hryvnias) as charity to the maternity home. They also paid to the midwife. Olga thought that US\$ 650 was the regular price that this obstetrician indicated to his patients no matter the difficulties that arose during the childbirth process.

According to the situation that arose in the health care sector of Ukraine, in Olga’s opinion it is normal that medical doctors take money from patients: “If doctors did not have the possibility to receive money from patients, they would all emigrate. The reasons for receive money from patients is the low salary, the existing “tradition to say ‘thank you’ to the doctors and the absence of government regulation on this problem”.

stimulate doctors' responsibility" and "to receive high-quality services". These respondents also state that informal payments keep the good specialists in the country meaning lower emigration rates of medical personnel. In addition, a mother-respondent expresses the belief that if the obstetricians got the job after paying (unofficially) a certain amount to the hospital management, they probably have an excuse for charging informally "in order to recover this money".

Obstetricians also indicate that their low salary is the main reason for taking informal payments, although we gather that their unofficial income from such payments seems to be several times higher than their official salary. In fact, the obstetricians believe that a normal monthly salary of a qualified obstetrician should be around US\$ 3 500 (25 000 hryvnias in 2009) in contrast to the average official obstetrician's salary of about US\$ 170 (1 300 hryvnias in 2009) observed in 2008 – 2009 (according to obstetricians-respondents) and the country average income of about US\$ 240 (1 900 hryvnias in 2009). We asked about cases where the mothers did not "thank" the obstetrician by an informal payment, and most obstetricians do not consider these cases to be the "normal practice". These cases seem to be exceptional. Some obstetricians-respondents feel that "emergency-room patients" make an informal payment to thank for the positive attitude, attention and good quality of the obstetricians work. When it comes to "individual patients", according to the obstetricians, they pay in order to ensure themselves against risks and to get more attention.

Still, obstetricians have to invest their own sources in serving "individual patients", thus, pre-payment given by "individual patient" decreases the risk of providers' overspending. More specifically, the obstetricians as well as the anesthesiologists have to purchase medicines; obstetricians have to arrange their teams for childbirth assistance who expect some kind of compensation. Hence, when the price is not agreed at the beginning, it may appear that patient's "compensation for additional work" is not enough to cover the obstetrician's expenditures on medicine and personnel. Furthermore, the physician cannot request a very high payment from such a patient since it is perceived as extortion that may result in a discharge from the hospital.

6.4.8 Attitude toward informal patient payments

The obstetricians and mothers in our study express a negative attitude towards informal payments before the childbirth. We observe that the attitudes toward payments after the delivery vary. On the one hand, an award fee is expected if overtime work (telephone support,

more frequent visits to patient or better attitude, organization of supportive environment etc.) is requested by the patient. On the other hand, patients should not make the payment for the physician's work that is paid by the state anyhow. Some obstetricians in our study raise ethical issues such as that the physicians have to treat patients instead of to interact informally with patients (taking gifts and cash). When it comes to the health care system in general, one obstetrician says, "this is not the way to be because it is humiliating for the physician".

One key informant believes that overtime work with "individual patients" should be paid, while other key informants consider monetary payments as a negative phenomenon, although they consider the practice of non-monetary "gratitude" payments as normal practice in the absence of other mechanisms to motivate physicians.

6.4.9 *"Solutions" to the problem of informal payments*

When we asked the three groups of respondents about solutions to the problem of informal patient payments, they suggested different strategies. Besides the most popular answer "to increase physicians' official salary", some mothers-respondents appeal to the introduction of social health insurance that may transform informal payments into formal. However, some mothers-respondents indicate that there is no need to change anything in the system. They support the possibility to have access to better services with higher quality even if they have to pay informally.

Most obstetricians in our study also support the idea that a higher salary will eliminate unofficial payments. However, some of them mention that patients' mentality (to present gifts) will stay the same. They also mention that there is a need of dealing with corruption and an adequate regulation system although they did not give further details.

According to key informants, the government should not only increase physicians' salary but (1) should also reorganize the system of salary calculation (based on the education degree and the content and quality of the work); and (2) should increase labor productivity. Two experts propose a rapid solution to make the income of physicians "more official" by introducing a tax. In particular, physicians could be asked to pay a tax to the state for informal payments they receive in order to improve the sustainability of the facilities (as well as private entrepreneurs in other fields). In their opinion, this way, "a lot of money will come out from the shadow". However, these opinions are contradictory, i.e. such tax does not seem to be a good incentive to declare money received informally. Moreover, if a physician pays the tax, it cannot be used for facility improvement.

Although the introduction of social health insurance in Ukraine is not the topic of discussion, the vast majority of all respondents believe that it can solve the problem. However, several obstetricians oppose health insurance because there is a lack of funding from the state and from patients' pockets to pay for health insurance and expensive surgery, and also, the benefits for physicians are uncertain.

6.5 Discussion of the study design

In spite of the potential sensitivity of the topic of our research, respondents were willing to speak openly and described in detail their experience with informal payments. Among other things, this could be due to the fact that we paid special attention to the terminology applied in the study. In particular, we avoided the use of terms such as “corruption”, “illegal schemes” and even “informal payments” since they may influence the respondents' willingness to answer the questions and the quality of their answers. We considered “patients' gratitude” as an appropriate term for conversation with physicians, while “bribes and gratuity for doctors” was absolutely acceptable for the young mothers.

Our qualitative study has some limitations. The vast majority of women-respondents have higher education, similar income levels and all of them work or study at the university. We recognize that women with lower education and lower income may respond differently as suggested by Salmi (2003). Also, the study took place in the capital of Ukraine, where households' incomes and expenditures are higher than the country average. This limits the possibility for extrapolating our results to the country as whole. Data from other regions could shed light on the extent of the phenomena of “personal obstetricians” and informal payments for maternity care in the country. Moreover, in-kind payments might be more common in rural regions and regions with lower average income, such as it is in Kazakhstan (Ensor & Savelyeva, 1998).

6.6 Discussion of the results

Our results show that informal payments for childbirth are a well-known practice in Kiev. There are different motivations and mechanisms of such payments. We discuss these results in the light of previous research and the specificity of the Ukrainian context.

6.6.1 *Classification of maternity care patients*

An important finding of our study is the differentiation between “individual patients” and “emergency-room patients” by obstetricians. This classification allows understanding the patient-physician interaction and the process of informal payments by patient types. In particular, “individual patients” search in advance for a “skilled obstetrician” and bargain about obstetrician’s services and payments before the delivery in order to assure attention of the obstetrician and staff. It should be underlined however that most pregnant women have no medical education and have no possibility to check the proficiency of the obstetricians. Thus, the qualification “skilled obstetrician” is based on the experience of the significant others, e.g. an obstetrician who delivered the friend’s baby without any problems. Similarly, young mothers are not able to identify health outcomes for themselves and infants.

At the same time, the “emergency-room patients” arrive at the hospital with no preliminary arrangements and receive “standard care” if no additional agreement (payment) is made. Despite the fact that only one “emergency-room patient” is present in our study (but she has paid as well), it is questionable whether the care provided to such patients is really standard in terms of quality. Perhaps, “standard care” is used by respondents (in particular the obstetricians) to indicate the contrast to higher quality services provided to “individual patients”.

It is necessary to add to this classification, a third type of patients whose friend works at the hospital, i.e. “individual friend-patient”. These patients do not search for an obstetrician, do not have to bargain and do not make cash payments. However, similar to “individual patients”, they receive more attention and comfort during the hospital stay. Probably, the lack of any capital (social or monetary capital as well as information) will result in being an “emergency-room patient”.

Our qualitative study does not provide information on the extent of the “emergency-room patients”, “individual patient” and “individual friend-patient” practices in Kiev maternity hospitals. However, the results of a recent quantitative study (Stepurko et al., 2012) indicate that in Ukraine, most individuals who use maternity care pay high informal payments, which might evidence the domination of “individual patient” practices.

6.6.2 *Push-factors for selecting a “personal obstetrician”*

The results of our study suggest that informal patient payments for childbirth are mostly connected with the practice of having a “personal obstetrician”, i.e. being an “individual

patient”. The phenomenon of “personal obstetrician” practice is not unique to Ukraine. Women in Georgia and Thailand, for example, also report that they choose obstetricians and pay them informally (Belli et al., 2004; Riewpaiboon et al., 2005). Overall, we identify in our study two push-factors for searching for a “personal obstetrician”: the need of twenty-four-hour access to reliable information and the need for psychological comfort during the childbirth. In particular, our study suggests that women lack an adequate formal source of information. The information collected via newspapers and internet forums create myths and uncertainty for women. Therefore, a “personal obstetrician” could help them to fill in this information gap. However, searching for a “skilled obstetrician” is a protracted and tense procedure, which also contributes to the existence of an informal payment channel. A possible policy response to this issue could be the maintenance of an official telephone hot-line or an official website with information for pregnant women. In many countries, such sources allow direct access to reliable maternity care information.

Based on our study, the desire to receive high-quality services combined with the feelings of anxiety can be regarded as the second push-factor to avoid receiving “standard care” and to search for a “personal obstetrician”. Many women perceive maternity care as high risk care, which might explain why most women-respondents in our study became “individual patients”. A good understanding of what makes such care even more risky from the perspective of the expecting mother in a former-socialist country, is given by Danishevski and colleagues (2006) who describe the situation in Tula, Russia: when the patient stays in the maternity ward nobody explains what is happening, obstetricians usually make decisions without consulting with the patient or her relatives, and without mentioning benefits and risks of possible interventions. Measures for improving the quality and organization of maternity care in Ukraine supported by mass-media may result in ensuring the women’s trust in the quality of maternity care and hence, reduce the need of a “personal obstetrician”, and in turn it might also reduce the practice of informal payments for securing such obstetrician.

6.6.3 The contract model of informal payment for childbirth

According to our results, the bargaining process, probably guided by mentality or culture (Miller et al., 2000; Thompson & Witter, 2000), is an important part of the pre-delivery arrangements, including the informal payment. It can be regarded as a bargaining process before signing a contract where the price is formed after all service details are discussed. Nevertheless, sometimes patients characterize such payment as gratitude. It should be noted,

that the informal payments resulting from this bargaining process are neither gratitude payments per se, nor requested payments. Such payments can be best described as payment for “extra work” (Miller et al., 2000) following the “contract model”. In this case, the “extra work” refers to the provision of “services with higher quality” as agreed prior to the delivery, compared to patients who do not pay informally.

We observe however, that the informal character of these payments is not well accepted by consumers and providers. Similar to other studies (Belli et al., 2004; Tatar et al., 2007; Cockcroft et al., 2008), we also observe that the practice of gratitude payment is supported by most respondents while payments requested before childbirth are not well accepted. Nevertheless, the fact that obstetricians bargain over informal payments suggest that medical ethics of obstetricians (and physicians in general) requires the attention of Ukrainian policy-makers.

6.6.4 Redistribution of informal patient payments

Obstetricians in our study were quite open about the redistribution of the informal payments among medical staff. Such practice is reported in previous research as well. Belli, Gotsadze and Shahriari (2004) describe the experience in Georgia where physicians share revenues from informal payments with their colleagues. Moreover, the authors suggest that Georgian physicians also use informal patient payments to buy essential non-labor inputs and primarily drugs due to insufficient funding to purchase these items. Shishkin and his colleagues (2003) also report that the redistribution of cash informal payments in Russian health care facilities is well-organized by administration or by facility staff. Our results (specifically the response of the obstetricians) suggest that various forms of redistribution are present. As a result, informal payments not only add to the salary of the obstetricians but also to the salary of other staff.

In fact, the low salary of medical staff (incl. obstetricians) was indicated by both obstetricians and mothers in our study, as the main cause for the existence of informal payments. Obstetricians regarded these payments as necessary for the physicians’ survival, and believed that a higher salary would eliminate informal patient payments. However, the “popular excuse of poor pay” does not justify the existence of informal payments (Miller et al., 2000). Even if the official salary of obstetricians is increased, it would be difficult to reach instantaneously the level of US\$ 3 500 (25 000 hryvnias) per month stated in our study (a deserved but high amount indeed). In addition to this, given the market power of health care providers, informal payments might continue to exist even after a salary increase (Gaal et al.,

2010), especially if there is a lack of transparency and control over physicians' behavior. Maternity care professionals might be interested to work in public facilities and receive informal earnings rather than to work in better conditions in private maternity homes with a higher official salary.

Since unofficial patient payments for maternity care (e.g. the requested charitable contributions as well as some informal payments) also fill gaps in the hospitals' budget, adequate funding of maternity care might be an important condition to deal with these payments. The respondents in our study underline the need for additional sources of funding like social health insurance. Ensor and Ronoh (2005) provide evidence that indirect methods of funding (e.g. prepayment and insurance) are a more preferable option when maternity care is regarded, compared to user fees. As argued by Richard, Witter and de Brouwere (2010) as well as Ensor and Ronoh (2005), the development of the financing mechanisms for maternal care should aim at equal access (e.g. for urban and rural population), transparent funding and no demand-side costs of services. Nevertheless, Nizalova and Vyshnya (2010) suggest that positive changes in maternal care could also occur under inexpensive interventions with an effective training of the staff. Indeed, such effect is observed in some pilot districts in the "Mother and Infant health program (Ukraine-Switzerland)".

6.7 Conclusions and policy recommendations

The results suggest that both quasi-official and informal payments for childbirth are an established practice in Kiev maternity hospitals. Underfunding of the system complemented with inefficient resource allocation and a lack of state regulations make "private" obstetrician practice in public maternity facilities possible. As a result, maternity services provided by public providers become more attractive to patients because of better attention and a "private approach". This also assures a source of income for "enterprising" providers. Although this practice gives more possibilities for some patients who are willing to pay informally, and most of the providers, it should not be considered as an acceptable measure for adequate health care provision. When the health of future generations is on the chopping block, it is urgently necessary to assure access and equity in maternity care provision. Mothers' life and newborns' health should be the focus of the health care policy agenda. Any pregnant woman in Ukraine should have the right to adequate health care service provision without doubtful health outcomes.

The current system of maternity care provision, based on patients' ability to pay, does not consider key important principles of equity and efficiency. The lack of state initiatives and lack of funding result in facility level initiatives which do not take into account the socio-economic status of the household. Hence, under the state's unwillingness to be responsible, health care facilities should consider exemptions in their "patient payments practices".

Furthermore, to be able to deal with informal patient payments, several strategies could be followed. In particular, there is a need of regulating patient-physician interactions and increasing patients' awareness. Betliy and colleagues (2007) indicate that the professional ethics of medical staff in Ukraine leaves much to be desired. Staff training may improve the situation as is shown by international initiatives in pilot regions. A new task for non-governmental bodies (as more effective structures) can be seen in informing the population about their rights. Particularly, pregnant women should be informed about their right to receive good quality care and suitable informational support during pregnancy and birth without having to pay informally.

Finally, policy makers in Ukraine need to start taking responsibility for improving governance of the health care sector, and the organization of maternity care in particular. Transparency in health care provision and funding as well as monitoring of physician behavior are important tools in eliminating informal payments.

CHAPTER 7.

GENERAL DISCUSSION AND CONCLUDING REMARKS

Parts of this chapter are published as:

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7.1 Introduction

The purpose of this dissertation has been to contribute to the understanding of informal payments for health care services in Central and Eastern European (CEE) countries. In particular, in a multi-country European comparison, public opinions, individual beliefs and the actual behavior of paying informally have been compared filling the gap of cross-country peculiarities in the field as well as the associations between actual behavior and attitudes towards it. These findings have been reported in the light of the aim of the dissertation to study informal payments for health care services in CEE countries and to compare the level, scope and consumer perceptions of informal patient payments in this region. The methods to measure the extent and size of informal patient payments have been systematically reviewed with regard to the sensitivity of the topic. Published empirical studies on informal patient payments and literature on research methods have been the source of data in this desk study. Based on the results of the review, data collection instruments have been developed to study the patterns of informal patient payments in six CEE countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine), as well as the attitudes of consumers in these countries towards informal patient payment. For the purpose of data collection and data analysis, informal patient payments have been defined as unregistered payments for publicly-funded health care services. Both quantitative and qualitative data have been collected and analyzed. Cross-national surveys among health care consumers were conducted in 2010 and in 2011 in the six CEE countries as part of an international research project to collect quantitative data. In particular, respondents have been asked about their spending on health care services, as well as about their perceptions on informal payments. In addition, a small-scale single-country qualitative study was conducted in 2009 in Ukraine in order to obtain a better understanding of the mechanisms of informal payments, specifically for childbirth.

This chapter discusses the key research findings reported in the dissertation. First, six statements that reflect the main study results are presented, accompanied with their explanation. This is followed by a discussion of the study limitations and suggestions for further research. A general discussion and concluding remarks complete the chapter.

7.2 Main findings

Informal patient payments are seen in the literature as a multifaceted phenomenon (see Chapter 2). However, their definition varies across countries (Lewis, 2000). In particular, the

informality of the payments is determined by the country-specific formal rules and legal framework (Cohen, 2012). Thus, the diversity of regulations and norms across countries are an obstacle to provide a unique definition of informal patient payments applicable in all studies. Moreover, patient payments policies are not always clearly pronounced in the legislation, which blurs the borders between formal payments, quasi-formal payments (resulting from fees set by providers) and informal payments for health care even within a single country. In most single-country studies, researchers use an operational definition of informal payments based on the available regulations in the country. However, this approach is inapplicable in a multi-country study. Also, the differences in the definitions used in single-country studies (usually designed in different ways) invalidate cross-country comparisons of informal patient payments based on their results.

Hence, the definition of informal patient payments for cross-country comparisons appears to be an important but challenging task. Therefore, the development of an operational definition of informal patient payments applicable to different countries has been the focus of this dissertation with regard to the first research objective outlined in Chapter 1. This brings us to the first key statement of the dissertation.

When studying informal patient payments, it is more relevant to focus on their characteristics than to try to formulate an encompassing definition.

The literature review in Chapter 2 suggests that in all countries, informal patient payments possess the unique feature of being unregistered (no official receipt of payment) and payments take place outside the official payment channels. However, two opposite conceptions of these payments emerge in the literature: “bribe” and “gratitude”, also known as “fee-for-service” and “donation” (Gaal & McKee, 2005; Cockcroft et al., 2008; Miller et al., 2000; Shahriari et al., 2001). While gratitude mostly refers to the side of the patients, a bribe can refer to both patients (who try to obtain the services desired) as well as to health care providers (who use their market power to extract additional income). To distinguish truly gratitude informal payments that have practically no impact on health care service provision, from other types of informal payments (bribes) that undermine the functioning of the health care system, an operational definition of informal patient payments that reflects the key characteristics of these payments, is required.

In Chapter 2, we outline these key characteristics and we argue that they should be considered in cross-country comparisons (but also in single-country studies to allow for a

cross-country comparison) instead of a universal definition. In particular, we suggest that researchers should not only aim to study the amount of the informal patient payment, but also to answer the questions on who is the initiator of the payment (consumer or provider), who pays (patient or family), and who is the beneficiary (individual provider, team of providers or institution). Also, the nature (monetary or not), moment (ex- or post-ante), purpose (obtaining better quality or access), and subject (out-patient or in-patient, surgery or laboratory tests) of the informal payment should be considered. Last but not the least, the key characteristics of informal patient payments studied, should also include the perceptions and attitudes towards these payments, which may vary within and across countries. The combinations of key characteristics listed above, determine possible types of informal patient payments.

We demonstrate the usefulness of these key characteristics in reviewing existing studies on informal patient payments (incl. cross-country comparisons and single-country studies). The review shows that in practice, different combinations of payment types fill in the space between the “bribe” and “gratitude” conceptions of informal patient payments mentioned above. While “gratitude” payments mostly refer to small in-kind gifts to medical staff initiated by the patient after the services provision, “bribe” payments can take many different forms. The latter seems to appear in the context of the government’s inability to provide the quantity and quality of health care service demanded by consumers, and to assure the reimbursement level expected by the health care providers.

However, the lack of sufficient funding and adequate governance may also lead to the unavailability of basic materials and equipment within the health care facilities, which may result in patient payments for goods ‘that are meant to be covered by the health care system’ (Lewis, 2000). In particular, health care providers may ask patients to bring pharmaceuticals and medical supplies, even food and bed linen in case of hospitalization, to be able to provide for the treatment. Although patients pay for these goods formally outside the health care facilities, these payments remain unregistered at the place of service provision. Thus, although some authors include the ‘self-supply of public goods’ in the definition of informal patient payment (Gaal et al., 2006; Lewis, 2007), we see these patient payments as quasi-informal payments.

As the results of the systematic literature review (see Chapter 2) indicate a great variety in the types of informal patient payments reported in empirical studies, we have examined some of the patterns of informal patient payments in CEE countries (related to the third research objective outlined in Chapter 1). This provides a base for the next statement.

The 20-years transition period brought CEE countries to different levels of socio-economic development and created a diversity in their health care systems. However, informal patient payments remain a characteristic feature of most of these systems.

The literature review in Chapter 2 confirms the presence of informal patient payments in the CEE countries regardless the level of their economic development. The empirical analyses in the rest of the dissertation confirm that informal patient payments are widespread in the six CEE countries included in the study. In particular, we observe (1) a variety of patterns (e.g. based on initiators, purposes, and subjects) of informal patient payments as well as (2) a mixture of patient payment policies that accompany informal payments.

Based on the quantitative data collected for this dissertation, we observe in Chapter 4 that the annual proportion of informal payers varies from the lowest in Poland and Bulgaria (8% and 12% of health care users respectively), followed by Hungary and Lithuania (25%), to the highest portion in Romania and Ukraine (35% and 41% respectively). This cross-country pattern remains virtually the same when in-kind gifts and cash payments are examined separately (see Chapter 3). Though, with respect to the amounts paid informally, other cross-country patterns appear: Bulgarians and Ukrainians report the lowest median values of informal payments per respondent per year (about 14 Euro) while in other countries, the median annual payment is much higher (37 Euro in Romania, 44 Euro in Lithuania and Poland and 53 Euro in Hungary). For each country, the median value is much lower than the corresponding mean value, which indicates a large disparity in informal patient payments within the countries as well, for example lots of zero payments and extremely high amounts in some instances (see Chapters 4 and 5). For instance, in Hungary, the mean annual value of informal payment is 112 Euro, but median value is about two times lower, whereas in Romania and Ukraine, median value is three-four times lower. Additionally, when we compare mean informal patient payments per respondent per year with the minimum wage in the countries (see Eurostat, 2010), it appears to be virtually equal to a quarter of the minimum monthly wage in Poland and up to one monthly minimum wage in Ukraine and Romania. This indicates a considerable burden on households caused by informal patient payments (especially for lower-income households and in lower-income countries).

It is worth to mention that informal patient payments can co-exist with other types of patient payments such as quasi-formal and official patient payments. When a clear regulation of the basic package and formal patient charges is lacking, patients experience a mixture of financial obligations. For example in Chapter 5, we observe one prevalent type of patient payment in countries with more transparent regulations (e.g. in Bulgaria mostly formal and in Hungary mostly informal payments), in contrast to Ukraine where informal payments are a

wide-spread supplement to also widespread quasi-formal payments. Thus, the level of economic development and governance practice (also illustrated by SPACE-matrix analysis in Figure 1.2 in Chapter 1) are reflected in the mixture and extent of informal payments.

Informal payments are more spread and higher when they are solicited or expected by providers. Generally, higher amounts of informal payments are given at the medical staff's request as suggested by our results (see Chapter 5) and by previous studies (e.g. Tomini et al., 2011). The more patients are being asked to pay informally the more patients make such payments as is seen in Romania and Ukraine (Chapter 4). Nevertheless, the relatively high prevalence of informal patient payments in Hungary does not follow this logic since informal payments in Hungary are mostly initiated by consumers (Chapter 4 and 5). As suggested by Cohen (2012), solicited informal payments can be seen as an indicator of major financial troubles in the health care system, while patient-initiated informal payments can be related to unmet patients' expectations of better service quality. In Chapter 5, we show that a considerable number of informal payers (also in Hungary) report 'better attention' and 'better quality' as the main reason of informal payment.

It is recognized that patients' access to adequate information on health care services and formal charges is highly important for an adequate health care provision, especially because of information asymmetry (Allin et al., 2006; Ensor & Witter, 2001; Fotaki, 2009; Gaal & McKee, 2005; Lewis, 2006). However, contrary to our expectations and previous results (Mokhtari & Ashtari, 2012), we observe a higher probability of informal payments among well-informed patients. As described in Chapter 5, patients, who know the size of the formal fee, may better pursue opportunities for informal payments. These patients may also better distinguish the presence of informal payments since they know the size of the official fee. However, as expected, we observe a negative association between fee awareness and the size of the informal payment for the last physician visit. Overall, we find in Chapter 5 that CEE patients are poorly informed about the size of the formal fees. Even in case of Bulgaria, where formal payments for health care services have been broadly applied since 2000, only about half of the patients always know the exact fee size.

Furthermore, the probability and the size of the informal payment is to a great extent determined by the type of service consumed (GP or specialist, out-patient or in-patient care). In our study described in Chapter 5 and in previous studies (Vian et al., 2006), the trend of a higher number of users who make more expensive informal payments to specialists when compared to GPs remains noticeable. It is similar for surgery and childbirth compared to other hospital interventions (Kornai, 2000; Shahriari et al., 2001; Szende & Culyer, 2006; Tomini & Maarse, 2011; Vian et al., 2006).

Given the peculiarities of obstetric services and taking into account the importance of maternal care in health of the nation development, we had a deeper look at the informal payments and behavioral patterns related to childbirth (see the fourth research objective outlined in Chapter 1). As a result, the next statement is formulated.

Childbirth is expensive in CEE countries. To secure adequate maternity care, families pay considerable amounts via informal payment channels.

The quantitative results presented in Chapter 5 suggest that the number of payers and the amounts paid (including informal payers) are highest for hospitalizations related to childbirth or pregnancy. For example, in Hungary and Ukraine, about half of the in-patients report informal payments for pregnancy or delivery, although the median value of these payments is about 70 – 100 Euro in Hungary and about 263 Euro in Ukraine (more than 3 monthly minimum wages in the country). We extend our understanding of this finding in Chapter 6 focusing on Ukraine.

Although the discussion of a childbirth plan between expecting parents and obstetric care provider is a well-known health care practice to reduce fear and pain in child delivery (Lundgren et al., 2003), it is applied in Ukraine in a unusual form. Indeed, the results from our qualitative study (see Chapter 6) suggest that in Ukraine, expecting parents discuss with their “personal obstetrician” not only the childbirth process but also the informal payments related to it. In fact, we find that there are two groups of patients in the Ukrainian maternity care ward: “individual patients” who have agreed with the obstetrician about the childbirth services and related payments, and “emergency room patients” who do not have a “personal obstetrician” though they may still pay a variety of charges. The phenomenon of the “personal obstetrician” practice – to choose the obstetrician in advance and to pay informally – is also observed in Georgia and Thailand (Belli et al., 2004; Riewpaiboon et al., 2005).

Two push-factors can lead to a search for a “personal obstetrician” in Ukraine: the need for twenty-four-hour access to reliable information and the need for psychological comfort during the childbirth. Thus, the desire to receive better “service wrapping” (reliable information, better attention, responsiveness) against the background of feelings of anxiety can be also seen as a strategy to avoid “substandard care”. Though, when clear standards in health care provision are lacking, service quality can be artificially lowered by physicians (Gaal & McKee, 2005). Hence, “substandard care” appears in the context of providers

misusing their market position as well as government's failure to ensure the necessary financial and regulatory framework in health care provision.

Obstetricians in Ukraine (as well as in other CEE countries) usually make decisions about possible interventions without consulting with the patient or her relatives, and without mentioning the benefits and risks of the interventions. The lack of information among patients leads to a perception of maternity care as a high-risk care (Danishevski et al., 2006; Lundgren et al., 2003). With respect to these peculiarities, informal payments for obstetrician services cannot be classified as a gift or donation, they have more the character of a fee-for-service or payment for "extra work" (Miller et al., 2000) following the "contract model" (Shishkin et al., 2003).

Moreover, the obstetricians in our qualitative study (see Chapter 6) were quite open about the redistribution of the informal payments among medical staff as well as the use of money to buy pharmaceuticals and to maintain physicians' wards. Such practices have also been reported in previous research (Belli et al., 2004; Shishkin et al., 2003). As a result, informal payments not only add to the salary of the obstetricians but also to the salary of other staff and to the budget of the hospital facility. In fact, the low salary of medical staff was indicated by both obstetricians and mothers in our study as the main cause for the existence of informal payments. Thus, informal payments remain an unregulated tool that ensures extra payments to health care providers when adequate reimbursement policies are lacking.

Although many patients accept the poor remuneration of medical staff as an excuse for the existence of informal payments, their attitude towards these payments is not always positive especially in case of ex-ante, requested and monetary informal payments (Balabanova & McKee, 2002; Shahriari et al., 2001). It is important to study patients' attitude and perceptions of informal patient payments as they reflect the willingness of consumers to follow this behavioral pattern in the future as well as the opportunities for policy changes. Therefore, this dissertation has focused on the investigation of attitudes and perceptions about informal payments with regard to the second research objective outlined in Chapter 1. This brings us to the next key statement of the dissertation.

The positive or indifferent attitude of consumers towards informal patient payments in CEE countries presents an obstacle for the elimination of these payments.

As described in Chapter 3, the attitude towards informal cash payments and to a lesser extent towards in-kind gifts is generally negative among the general public of the six CEE countries.

Public attitudes are most negative in Bulgaria and Poland, while a relatively large percentage of the people in Lithuania, Romania, Ukraine, and even more in Hungary are not afraid to voice a positive attitude. Also, a high share people who are indifferent to informal payments, is noticed in Hungary. Generally, a negative attitude does not mean that no informal payments are paid in practice. From the patients' perspective informal payments are sometimes "bad, but important" (Vian & Burak, 2006, p.399) since they facilitate the access to health care services or improve quality. A similar ambiguity is hidden in "indifferent attitudes". Such attitudes may present either a lack of interest or a deadlock situation where informal payments are perceived as an unavoidable necessity (Shahriari et al., 2001). Besides, a link between attitudes, perceptions, opinions and experience of making informal patient payments has been found in our study (see Chapter 3). We observe less favorable attitudes and perceptions of informal payments among those who have ever been requested to pay informally, as well as more favorable attitudes and perceptions among those who have ever given any in-kind gift or cash to physician. These findings support the contradictory nature of informal patient payments with regard to their monetary or nonmonetary nature and with regard to their motivation – request by physicians or patient own initiative.

Furthermore, similar to our results in Chapter 3, previous studies have also reported on the prevalence of negative attitudes towards informal payments as well as a more positive attitude to in-kind gifts compared to cash payments (Balabanova & McKee, 2002; Belli, Gotsadze, & Shahriari, 2004; Cockcroft et al., 2008; Tatar et al., 2007). Although in-kind gifts (the same as cash payments) can be considered as a means to obtain better and quicker services when the system fails to offer adequate service standards to all patients, in-kind gifts are not supposed to induce expenditures beyond the patient's strength. Tokens of gratitude are common practice all over the world but the extent of the gift-giving practice might differ (Abbasi & Gadit, 2008; Spence, 2005) as in some countries clear regulations of physician behavior are more developed and adhered to (Gaufberg, 2007; Kutzin, 2010; Rechel et al., 2011). Moreover, when gifts are not expected and encouraged, they do not adversely affect efficiency in health care provision (Gaal & McKee, 2005). Still, as suggested by Balabanova and McKee (2002) "attitudes towards gifts are an important barometer" that indicate the gift-giving practices in a country.

Another dimension of consumers' acceptance of informal transaction is to label it as 'corruption', 'bribery' or 'gratuity'. Indeed, Poland is the only country in our study, where consumers demonstrate not only a negative attitude, but they also associate informal patient payments with corruption and express non-acceptance (compared to Lithuania). Attitudes and

perceptions of Bulgarian consumers are comparable to those of Polish consumers, specifically in their non-acceptance and negative attitudes, and association with corruption. Opposite attitudes, perceptions and opinions exist in Hungary which suggests a huge challenge for the elimination of informal patient payments in this country.

Labeling informal payment as gratitude or as corruption can provide a framework for the differentiation between types of informal payments since “corruption” is associated with negative and stigmatized effects, while “gratitude” seems as solely initiated by the giver without expectations of reciprocity. However, empirical data as well as the literature suggest a more complex reality. For example, does a gift given to a friend as a birthday present have the same connotation as a present given to a public service provider? Key differentiation points are easier to envision using the question offered by Polese (2008) “Why somebody spontaneously (1) decides (2) to offer a gift (3)?” The question contains three key pitfalls that can shed light on informal payments from a gratitude perspective. In particular, we observe that some groups of consumers report on (1) feeling uncomfortable to leave physician’s office without gratitude, (2) a preference for the private sector as uninfected with the “gift” virus as well as on (3) underfunding of the health care sector as a key factor for the presence of informal patient payments. Therefore, do health care service users really “spontaneously” (instead of planned intentional action) “decide” (instead of being requested or feel obliged) to give a “gift” (not donation, fee-for-service, bribe) to a provider? The question should be adjusted to reality and should ask about reasons, motives of resorting to “gratitude money” or “non-monetary gifts” to physicians including institutional (political, cultural, economic) pressure.

Indeed, the key challenges in the eradication of informal payments become more visible when the scope of and attitudes towards informal payments are considered in the light of economics and governance (see Chapter 1, Table 1.2). In particular, Hungary demonstrates relatively high government expenditures and good governance, so payments demanded by providers are rarely observed. Conversely, the main initiator of informal patient payments is mostly the patient who aims to obtain quicker access and better services or needs more attention. In Romania and Ukraine, the public is willing to change their pattern of behavior but as SPACE-analysis matrix demonstrates (see Chapter 1, Figure 1.2), poor governance, economic development and low health care funding leave much to be desired. Importantly however, in all six countries included in our study, per capita government expenditures on health care is lower than in other countries in the region where informal payments are negligible, namely the Czech Republic and Slovenia (Leive, 2010; WHO, 2010). Thus,

informal patient payments may well fulfill the role of supplementing inadequate health care funding.

Except public attitudes, it is important to have a deeper look at consumers' perceptions. Specifically, disposition (attitudes coupled with previous experience) is a personal construction that ensures a specific behavior to occur in a given situation and that is seen as a regulatory mechanism of human behavior (Uznadze, 1966). However, it is difficult to measure, especially in case of informal patient payments. Therefore, we have studied the relation between perceived behavioral statements related to informal payments (that indicate personal disposition towards these payments) and the actual informal payment behavior (also related to the second objective outlined in Chapter 1). The next statement describes our key finding.

Informal patient payments are more determined by individual payment disposition than socio-demographic characteristics.

When we compare the relation between perceived behavior statements and socio-demographic features with actual behavior of making informal payments to health care providers (see Chapter 4), we find a lower relevance of socio-demographic characteristics compared to perceived behavior. Indeed, in Chapter 4 of the dissertation, we show that the behavioral pattern of making informal patient payments is mostly associated with patient's perception statements while socio-demographic features play a minor role in explaining this pattern. Thus, consumer's willingness to resort to informal patient payment behavior should be searched in individual perceptions rather than in socio-demographic characteristics. In line with previous studies (Belli, 2002; Liaropoulos et al., 2008; Tomini et al., 2011) where significant relations of informal patient payments with age, gender, education, place of residence, or income are reported, we also observe an inconsistent association of socio-demographic features with actual behavior. Still, personal disposition is much stronger and more consistently associated with informal patient payments. Specifically, we observe in Chapter 4 that those who feel uncomfortable to leave without a gratitude payment and who feel unable to refuse to pay informally if asked, more often report making informal payments. Hence, policy-makers should develop strategies on informal patient payments elimination taking into account these personal constructions.

Meanwhile, when the cross-country pattern of associations is considered, virtually all relations of actual informal payment behavior with perceived informal payment behavior have

a consistent sign except for the preferences to use the private sector as a response to informal payments. The latter suggests that access to private medical services is at a different level of development in different countries. It should be pointed however, that the statistical significance of the relations varies among the countries, which indicates a dissimilar explanatory power of the consumer perceptions depending on the country. It is virtually impossible to examine the cross-country pattern of the time-related changes in individual perceptions as longitude data are lacking. Still, the difference between Bulgaria and Ukraine that we observe, was not revealed in previous research (Miller, 2006). In particular, the ability to refuse to pay informally when requested, was similar for Bulgarian and Ukrainian citizens about a decade ago, whereas currently, we find that Bulgarians feel more confident in refusing to pay informally than Ukrainians. This difference in results may indicate that consumer perceptions related to informal payments have changed during the years. Overall, the obedience to the requests of medical staff to pay informally can be conditioned by patients' expectations for better treatment or by a fear that the treatment can be denied (Lekhan et al., 2007; Belli et al, 2004). The latter one is explained by the market power of health care providers, who do not always follow moral principles, as well as by external pressure (e.g. by low-paid medical staff, who in the absence of free patient choice, brings informal practices in the patient-physician relation) (Miller, 2006; Aarva et al., 2009).

Except for informal payments for health care service, other patient payments with an informal nature may also occur. Thus, following Lewis (2000), we have also explored the quasi-informal payments (as defined in the discussion of the first statement above) for goods brought by patients for their treatment (specifically for hospital treatment), which goods should have been provided to the patients free-of-charge. As a result of this, the following statement is formulated (related to the third objective outlined in Chapter 1).

Patients in CEE countries not only pay formally and informally, but they are also requested to bring medical goods for their treatment, which are supposed to be provided to them free of charge.

In Chapter 5 of the dissertation, we have explored payments for goods (e.g. pharmaceuticals, medical supplies) that had to be provided to patients for free, but which patients were requested to bring for their treatment. Such requests are explained by the staff by the lack of sufficient funding and consequently the absence of basic materials for the adequate service provision. Patients usually purchase these goods officially but outside the health care settings,

e.g. at private pharmacies (Ensor, 2004; Fotaki, 2009; Gaal et al., 2006). Therefore, these payments are not formally registered as treatment costs. We define these payments as quasi-informal payments (see the discussion of the first statement) although some authors (Gaal et al., 2006; Lewis, 2007) see them as a type of informal payments. However, these payments are neither “fee-for-service” nor “donation” informal payments but “fee-for-goods” payments. It is important to separate these payments from pure informal payments in order to understand better the out-of-pocket payment patterns in a country.

In Chapter 5, we have studied payments for goods brought by patients in Bulgaria, Hungary and Ukraine in case of hospitalization. While in Hungary and Bulgaria, about 15% of in-patients report such payments, they are much more common in Ukraine. Overall, the practice of patients bringing goods for hospital treatment shows a government failure in health care provision (Cohen, 2012; Falkingham et al., 2010). However, when some patients have to bring also their bed linen and food for their hospitalization (as Chapter 5 shows), it is an indicator of the major drawbacks in hospital care and the need of immediate reforms (Falkingham et al., 2010).

Still, we cannot deny the possibility that patients are asked to bring goods for their hospital treatment not only due to the actual absence of basic materials in the hospital, but also due to the health care providers’ misuse of their market power. Since the costs of these goods are already included in the hospital reimbursement or hospital budget, when patients bring the goods for their treatment, the hospital saves funds and can use the “savings” for other purposes, e.g. an increase of staff’s income (i.e. informal income). Such situation occurs when adequate monitoring and control of the hospital practice is absent. The literature suggests that similar to hospital services, out-patient care in CEE country also suffers from the problem of quasi-informal payments (Balabanova et al., 2004; Gotsadze et al., 2005; Siskou et al., 2008).

7.3 Limitations of the study and suggestions for further research

Although informal patient payments can be seen as a sensitive research question given their hidden and unregistered nature, we have observed a willingness of respondents to share their informal payment experience and attitudes towards these payments. The non-response to these questions has been negligible (less than 5%) in most of the countries. Hence a face-to-face data collection mode has been applied reasonably well. However, in countries such as Poland and Bulgaria, where the label of corruption is often given to such payments by policy-

makers and mass-media, researchers should be especially careful when selecting the data collection mode. In these countries, general anti-corruption campaigns in addition to public arrests of physicians highlighted by mass-media could have increased the citizens' awareness of the negative aspects of informal patient payments. Mass-media messages following politicians' point of view might have a strong reflection in public opinion on corruption matters. This could have made respondents in these countries more reluctant to fully reveal their informal payment practice and their true attitudes. Therefore, researchers should consider possible apprehension of respondents. For example, the face-to-face interviews can be combined with self-administrated questionnaire to collect more precise data on informal payments. Future research may well focus on the impact of different data collection modes on the data on informal payment collected.

Moreover, we have mainly focused on the cross-country comparison of the informal payment practice. As cross-country investigations have little to do with country-specific regulations of patient payments, single-country studies will still be necessary to fill this gap. The identification of informal patient payments that is based not only on the key characteristics of the informal patient payments outlined in Chapter 2 but also on country specific regulations (if there are any) can be a good reference point for future more detailed cross-country comparisons.

Although we have contributed to the cross-country comparison of informal patient payments and consumers' attitudes towards these payments, a few issues related to the examination of informal patient payments have not been addressed within this research. As we have been limited in the number of countries as well as in the number of questions to be studied, future investigations should include not only CEE countries where socio-cultural dimensions are comparable, but also countries from other regions. Countries from different parts of the world should be examined for a better understanding the peculiarities of the cultural, economic and regulatory environment of informal patient payments. For example, researchers could study the role of professional associations and their directives to physicians, which may ensure a negative physician disposition toward informality in the physician-patient relations.

Furthermore, we have not included in our study the social capital dimension. Overall, studies on corruption often emphasize the importance of social capital or networks for borrowing funds for or adequate public services provision (Gatti et al., 2003; Knack & Keefer, 2011; Leive & Xu, 2008). The presence of medical specialists in the patient's social network is usually considered as a means to attain either valid medical information, or access,

or better quality of care (Balabanova et al., 2004; Ensor & Witter, 2001; Patico, 2002; Salmi, 2003). Thus, investigation of the use of social capital and/or social network (instead of informal payments) in order to obtain better service will be necessary.

We have conducted two waves of quantitative data collection, which do not practically present us with any trend. Longitudinal cross-country data could enable us to follow changes in informal patient payments with regard to changes in health care delivery policies and in the general context of the country. Moreover, our quantitative studies included only the consumer perspective. Data on the attitudes and experience of other stakeholders can provide a broader view on the acceptance, causes and effects of informal patient payments. Also, we present nation-wide data which do not allow for examining the informal payments on the level of regions and health care facilities. Since our data suggest cases of non-payers, it can be useful to explore the organizational culture of different facilities and regions in order to reveal the good managerial and regulatory practices in health care delivery. Thus, case-studies of facilities considering the experience of consumers, providers and administrations should be carried out.

Furthermore, in our study, we have mostly focused on health care services. We have analyzed the unregulated (quasi-informal) purchasing of pharmaceuticals only in case of hospitalization. Unregulated spending on pharmaceuticals in case of out-patient services is not covered. In case of out-patient services, out-of-pocket patient payments may also be related to a wide-spread self-treatment practice in the CEE region (Balabanova et al., 2004; Falkingham, 2004; Whitehead et al., 2001). In particular, patients can avoid visiting a physician because of the lack of transparency in the attainment of physician services, because service is not accessible or because self-treatment is possible. In view of this, unregulated spending on out-patient pharmaceuticals should be examined in future studies.

Nevertheless, informal patient payments (as one of many other social problems) can be brought to nothing when civil society – public participation in policy-making – is developed. When the government does not provide a satisfactory level of quality and quantity of health care services, patients should have a way to influence the actual policy instead of resorting to ‘do-it-yourself’ actions, e.g. to pay informally for desired attributes of the service. Further research may well focus on the opportunities of creating a civil society to influence policy-making in the CEE countries, which can be an important factor in the elimination of informal patient payments as well as other problems in health care delivery.

7.4 Discussion of the policy implications

7.4.1 Application of PRECEDE – PROCEED model³

As discussed earlier in this chapter, informal patient payments are a multifaceted phenomenon. They are connected to the performance of the health care system as well as to the social culture, overall economic development and governance in the country. In Chapter 1 (see Table 1.1 and Figure 1.2, SPACE matrix analysis), we have outlined four dimensions that can jointly explain the existence of informal payment practice: (1) the health care system, (2) socio-cultural environment, (3) economic-labor environment and (4) political-regulatory environment. These four dimensions can be placed in a PRECEDE – PROCEED model (see Figure 7.1) for developing a comprehensive policy agenda for the elimination of informal patient payments. PRECEDE – PROCEED models are broadly used in the health promotion field (Green & Kreuter, 2005). The core of such model explains a given behavior (e.g. smoking) by indicating its environment, determinants (predisposing, enabling and reinforcing factors) and outcomes (e.g. impact on health). Based on this, the model outlines a framework for the development of interventions (e.g. health programs), which includes the four phases of PRECEDE evaluation. At the final phase, a set of interventions is proposed. Also, the model suggests a framework for the evaluation of the intervention implementation, which includes the four phases of the PROCEED evaluation. The PROCEED evaluation is completed by analyzing the post-implementation outcomes. The strength of the PRECEDE – PROCEED models compared to other behavior models, is in their focus on outcomes rather than inputs as well as in their comprehensive character. In particular, these models give the possibility to bring together all constructs relevant to the understanding of a behavior and thus, to consider broad interventions related to juridical, economic, structural and communicative provisions which should be implemented to achieve the desired behavior change. We apply the PRECEDE – PROCEED model only as a framework to systemize the factors that are associated with informal payments as well as possible measures for their elimination.

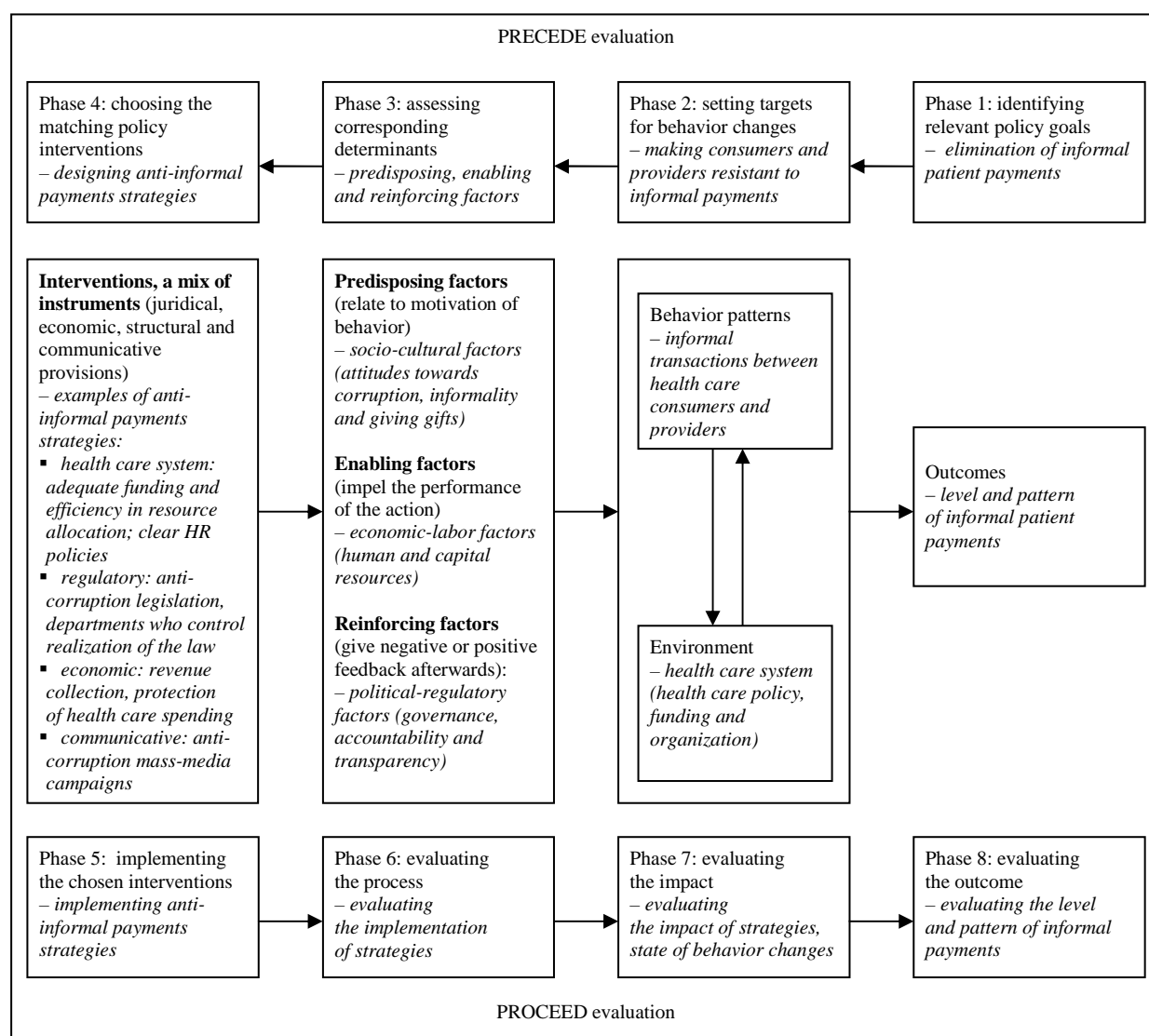
In our PRECEDE – PROCEED model for the elimination of informal patient payments (see Figure 7.1), behavior refers to informal transactions between health care consumers and providers, and the outcomes are the level and pattern of informal patient payments in a country. We apply the model at society level, not at an individual level as it is

³ PRECEDE is an acronym for **P**redisposing, **R**einforcing and **E**nabling Constructs in Educational **D**iagnosis and **E**valuation) and PROCEED is an acronym for **P**olicy, **R**egulatory, and **O**rganizational Constructs in Educational and **E**nvironmental **D**evelopment.

often done in the health promotion field. The four dimensions of the existence of informal patient payments (see Chapter 1, Table 1.1 and Figure 1.2, SPACE matrix analysis) are included in the model as behavior determinants:

- The health care system dimension represents the environment where the informal transactions between health care consumers and providers take place. It contains factors related to the policy, funding and organization aspects of health care. Weak health policy, inadequate funding of the public health care sector and low moral of health care providers create a need and favorable environment for informal transactions in the patient-physician relations. Health care reforms that aim to deal with such pitfalls should be the primary concern of policy-makers who wish to deal with informal payments.
- The socio-cultural dimension (e.g. attitudes towards corruption, informality and giving gifts) includes predisposing factors. By definition, predisposing factors are cognitive-level factors such as attitude and beliefs that motivate behavior (Crosby & Noar, 2011; Glanz et al., 2008). When corruption, informality and giving gifts are generally accepted by society, informal transactions between consumers and providers appear in the health care sector as well. The creation of an overall negative social disposition towards corruption and bribery, will be essential for the elimination of informal patient payments.
- The economic-labor dimension is linked in our model to the enabling factors. These factors are seen as conditions that impel the behavior adoption (Crosby & Noar, 2011; Glanz et al., 2008). Poor economic development in a country that results in a low-paid workforce and lack of resources for the adequate provision of public services, pushes patients and physicians to resort to informal transactions (for the patient to obtain better services and for the physician to obtain a better salary). Thus, economic and labor advancements will enable the elimination of informal patient payments by reducing the need of such payments.
- The political-regulatory dimension refers to the reinforcing factors. Reinforcing factors shape the behavior adoption by giving negative or positive feedback (Crosby & Noar, 2011; Glanz et al., 2008). Poor governance incapable to deal with corruption in general, facilitates informality in the patient-physician relation as well. Improved regulations, accountability and transparency will reinforce the elimination of informal payments in the health care sector as well as in other sectors.

Predisposing, enabling and reinforcing factors influence not only the behavior (informal transactions between health care consumers and providers) but also the environment (the health care system) where the behavior takes place (see Chapter 1, section 1.2). Thus, a

Figure 7.1. PRECEDE – PROCEED model for the elimination of informal patient payments

mixture of strategies for changing the predisposing, enabling and reinforcing factors, as well as the health care environment is necessary to diminish the informality in the patient-physician relation and eliminating the informal patient payments in a country. Figure 7.1 shows some examples of such strategies. In this policy discussion section, we outline a comprehensive set of strategies related to each of the four dimensions. At the end, we also outline several country-specific strategies.

7.4.2 The health care system

The first surrounding of informal patient payments is the health care system since these payments are embedded in the physician-patient relations. Five key health care system layers can be identified to develop anti-informal patient payments policies as well as to increase

accountability and transparency in the health care sector: (1) assuring an adequate remuneration of the health care staff and adequate reimbursement of the health care facilities; (2) defining clear professional rules (e.g. staff performance assessment and punitive measures for underperformance) as well as standardized provision of health care services (clinical, informational and service aspects); (3) assuring adequate investment in, and an efficient use of health care resources; (4) introducing clear patient payments policies (e.g. presence of formal fee together with relevant exemptions) and raising patient awareness about their rights and payment obligations; and (5) developing the private health care sector.

The low **level of salary** of health care personnel is typically considered as the most important factor that explains the spread of informal patient payments (Belli, 2001; Healy & McKee, 1997; van Lerberghe et al., 2008; Rechel & McKee, 2009). Lower physicians' salaries compared to the country average or to the industrial sector average, coupled with quality and access problems in health care, provide a motive for consumers and providers to go into informal payment arrangements. We observe in our study a high acceptance of patients in CEE countries to pay informally and a low morale of the medical profession (e.g. the case of maternity care in Ukraine). From a macro-level perspective, adequate remuneration of health care providers is crucial for strengthening capacities of the sector. In particular, Romania as well as Lithuania report some increase in physicians' salaries with a consequent light decrease in the informal payments (Glinos et al., 2011; Vlădescu et al., 2008). However, only few CEE countries (e.g. the Czech Republic and Slovenia) have not neglected the opportunity (among other achievements) to introduce an adequate remuneration of medical staff despite the difficult economic circumstances (Vepřek et al., 1995). As a result, these countries show a negligible level of informal patient payments (Belli, 2002; Masopust, 1989 in Gaal and McKee, 2005). However, at present, the Czech Republic faces the problem of resigning medical staff within the public health care system because of being 'under-evaluated and underpaid' (Holt, 2010a). When work conditions in the public health care sector are not attractive, physicians search for alternative and better-paid jobs in other sectors or other countries. This undermines the intellectual capacities of the public health care sector (Ensor & Duran-Moreno, 2002). Informal payments can provide a motive for physicians to stay in practice. Therefore, policy-makers (who are unable to raise the physicians' remuneration) neglect and tolerate the informal payments practice. From a micro-level perspective, the inconsistency in the socio-economic status of medical staff (i.e. when education and work responsibilities do not correspond to salary) lead to a display of apathy and aggressive attitudes (Cockcroft et al., 2011; Geschwender, 1967; Lewis, 2000).

Therefore, as suggested by our results, patients pay informally in order to assure responsiveness of the staff and better quality.

However, the increase of health care staff remuneration will not be a panacea for the problem of informal patient payments. The literature suggests that well-known medical specialists are able to generate a much higher (unofficial) income via patients' 'bribes,' 'tips' and 'gifts' compared to their less prestigious colleagues (Ensor and Savelyeva, 1998; Kornai, 2000). Thus, except for the level of salary in the health care sector, a performance-based **provider payment mechanism** may play an important role in stimulating the provision of sufficient quality and quantity of services. A uniform central payment scale does not count quality of services and professional skills of the personnel and therefore, efficiency in health care becomes less feasible. Similar to Western European countries, many CEE countries apply capitation payment systems for GPs. However, in-patient personnel is usually paid salaries (Groenewegen et al., 2002; Kutzin, 2010). Because incentives can distort policy goals, a case-based provider payment mechanism reflecting the nature and quality of care should be implemented. An adequate funding per case should be assured.

Except for the monetary stimuli for providers to improved performance, clear **quality standards** should be defined. When such standards are absent or when their application is not monitored, in a context of underfunding providers themselves may choose the attributes of the service to be offered to the patient. Sometimes, standards of health care can be lowered by the provider in order to make the patient pay informally for better service quality. A similar effect is observed in case of a negative attitude of medical staff to patients. Taking into account the market power of health care providers as well as the issue of information asymmetry, patients appear in a vulnerable position. Therefore, the role of the state as well as professional bodies is to introduce and monitor clinical and related standards of care provided. These policies should be supported by **informational campaigns** because patients should be informed about their rights and responsibilities. On-line guidelines for patients or telephone support will be essential supplements in these campaigns.

Additionally, when physicians earn on average more than the 'typical patient' and at the same time continue to accept expensive gifts or require cash payments, **assessment and punitive measures** should be applied aiming to create a negative staff disposition towards informal payments. This can include the implementation of strict morale and ethical standards (Code of Ethics), penalties and sanctions for underperformance (such as the acceptance of informal payments), bonuses for good practices, staff trainings, as well as participation of professional committees (Lewis, 2006). As Rowe et al. (2005) suggest, joined interventions

will be required to achieve the desired result. In particular, even if a patient offers a gift, the health care professional should feel obliged to refuse it politely (Abbasi & Gadit, 2008). At the same time, a patient-friendly system of filing complaints by patients who are asked to pay informally, should be created and promoted among the public. As our results show, health care consumers in the CEE countries are not well informed about the existence of such system. To make such system useful, patients' complaints should be taken into account in the personnel appraisal system.

Parallel to the above strategies, the government should continue to invest in the public health care sector. The lack of suitable **investments** leads to outdated equipment and an improper state of facilities' buildings. Also, shortages in medical supplies are seen as a direct result of underfunding but also of an inefficient **management of health care resources**. Informal patient payments (both pure informal payments and quasi-informal payments) as well as quasi-formal payment may well fill gaps in health care funding (Lewis, 2000; Gaal, 2010). Still, the increase in health care funding is a matter of political interests and the overall economic situation. However, the government can play an important role in assuring an efficient allocation of the scant resources. A clearly defined and well-sized basic package of services that fit the available resources will be important for the elimination of informal payments for these services.

Also, a **system of formal patient charges** for health care services can be introduced although these charges cannot actually provide a significant portion of overall funding (Gaal, 2010). In addition to this, formal charges cannot replace the informal ones because in practice, the two types of payments serve different purposes. Retrieving funds from the shadow sector will only be possible if the purpose of informal payments (e.g. adequate income of physicians and options for better quality) can be transferred into the official charges. Otherwise, preferences to pay unofficially will remain (Baji et al., 2011, 2012). This may lead to a mixture of formal and informal patient payments, as it is in Bulgaria (Atanasova et al., 2011). When providers are adequately remunerated and when public health care services are provided with an adequate quality and access, the need of informal payments can be reduced and patients can be stimulated to use exclusively the official channels. The concern that official fees increase the burden for vulnerable population groups can be partly diminished by the introduction of exemption categories and charge reductions. Such mechanisms are actually lacking in so-called quasi-formal patient payments initiated by the facility level management. This means that quasi-formal charges are also not a suitable substitute for informal patient payments.

If official patient charges for health care services are introduced, health care consumers should be well informed about the fee sizes and exemptions. The findings of our study indicate that this is still a problem in the CEE region, which supports the policy recommendation to ensure adequate access to information on formal service prices. The service consumption mechanisms should be clear for any patient (Belli et al., 2004). Complicated schemes and regulations regarding health care provision can become a barrier to health care use and can lead to informal payments. Thus, **raising patient awareness** about their right to health care services with adequate quality and access with no informal charges or gratitude payments, as well as empowering the patient to object to pay informally are essential policy strategies for the elimination of informal patient payments (Pavlova et al., 2010; Vian, 2008; Vian & Burak, 2006).

It is also important to support alternatives to public health care provision, i.e. the development of the **private health care sector** (Ensor, 2004). The data from our survey show that there is little inclination in Hungary, Romania and Ukraine to use private services as a response to informal payments than in the other countries. This may reflect different levels of private sector development, the spread of corruption, lack of stability and transparency, specificity of regulations, monitoring measures and quality mechanisms applied in the countries (Lewis, 2006; Ensor & Witter, 2001). Overall, a public-private mix in health care funding and provision can create a competitive climate and this can bring improvements in public health care service provision as well (Ensor & Witter, 2001; Thompson & Witter, 2000; Preker & Feachem, 1996). Although charges for private health care services are associated with barriers to access, it should be kept in mind that informal patient payments are found to be an even more regressive form of service funding than formal charges (Baji et al., 2012a). Thus, the elimination of informal patient payments will be an important step towards access improvements. However, as in case of Poland and Bulgaria (Atanasova et al., 2011; Golinowska, 2010; McMenamin & Timonen, 2002), physicians work in both sectors results in recruiting patients from the public sector to part-time private practice (which can even take place in the same cabinet of public institution). This overlap of the two sectors prevents the improvement of transparency. However, it can increase the overall income of providers and can diminish the requests of informal patient payments for health care services.

7.4.3 The external environment – socio-cultural, economic-labor and political-regulatory factors

The second element surrounding informal patient payments is the external environment. In Chapter 1 (see Table 1.1 and Figure 1.2, SPACE matrix analysis), this environment is divided

into a socio-cultural, economic-labor and political-regulatory environment (referring to the predisposing, enabling and reinforcing factors in Figure 7.1). Within each environment, different anti-informal patient payments policies can be defined.

Socio-cultural environment: People express their gratitude in the form of gifts. The gift-giving culture is deeply rooted in Asia (Killingsworth, 2002), but also in the CEE region, while it appears in a lesser extent in Western European societies (Spence, 2005). The practice of giving gifts is wide-spread not only in the health care sector but also in other public and business sectors (Miller et al., 1998; Miller et al., 2000). Thus, gratitude payments for health care services could be seen as part of the overall social culture. However, informal patient payments are gratitude payments as long as they are in-kind gifts with negligible monetary value and are given after the service provision by the thankful patient without any expectation of patient to improve the service as well as without any request or hint by the staff. The literature suggests that giving gifts is part of human interaction that helps strengthen bonds (Schwartz, 1967). However, strong social relations can be also coupled with bribery (Grodeland et al., 1998; Rosen, 2011). Typically, a change of generation is supposed to bring new cultural and behavioral patterns, whereas nowadays, informational technologies allow creating or changing consumer perception and behavior in a shorter period of time.

Overall, the elimination of informal payments would require general anti-corruption campaigns with involvements of efforts of a variety of sectors. Indeed, Golinowska (2010) reports on a reduction of informal payments in Poland after public anti-corruption campaigns. Mass communication media could help to **inform the public about the overall negative effects** that informal payments bring to public services provision since consumers may be able to consider only perceived personal benefits. Also, mass-media are supposed to provide information about the terms of provision of public services. When citizens are aware of their right to public services (health care specifically) with adequate quality and access with no informal charges, the realization of policy goals such as transparency and accountability can be ensured. There is also a need for mechanisms to object to paying informally such as systems of complaints and sanctions. Additionally, anti-corruption campaigns can facilitate the creation of public opposition towards bribery and other informal transactions. For policy-makers, it is highly important to focus on **changing consumer perceptions** (predisposing factors) about making informal payments to be able to deal with these payments on the consumer side. Anti-corruption actions of the government in all sectors, supported by mass-media, are expected to work effectively against informal payments.

Meanwhile, **raising social awareness** in this direction is an important remedy for informal payments. Citizens should not only be aware about their rights and obligations but should also be able to influence or participate in policy-making. When society is dissatisfied with the existing public service delivery, citizens should be able to use their power to direct policy-making agenda ('do-it-together') instead of resorting to the 'do-it-yourself' approach. At least, advocacy offices that serve to file complaints, appeals and other consultations on legislation (Karklins, 2005 in Radin, 2006) can be helpful for those who are ready to follow the rules (Grimes, 2008; Radin, 2006). An active civil society and free media are essential to analyze the performance of government and highlight shortcomings in terms of quality improvements (Primatarova, 2010; Rechel et al., 2011). By and large, **public interests represented in a civil society** have an impact on the level of corruption (Grimes, 2011). In other words, civil society can play the role of 'anti-corruption watchdog' (Grodland & Aasland, 2011). However, the presence of civil society is a political regime attribute. There is much to be desired in the CEE countries in this direction.

Political-regulatory environment: We have already discussed a variety of possibilities to solve the problem of informal payments for health care through improvements in health care provision and straitening the role of the public in policy-making. However, a key obstacle for activating social policy in the direction of eliminating informal payments is the lack of **motivation of policy-makers** for such actions. Policy-making in most CEE countries frequently serves the interests of top-business. Moreover, political and business elites are often similar or connected (Radin, 2006). The medical elite is not actually interested in reforms aiming to eliminate informal payments (Gaal & McKee, 2005). Political culture inherited from the communist past, such as passivity of the public and non-involvement of citizens in the political life, has remained common also in the transition period. Public expectations of a paternalistic welfare state are also observed (Radin, 2006). Therefore, the lack of **adequate regulation** allows citizens (e.g. public service consumers or patients) to apply a variety of behavioral patterns leading to informal payments. Thus, informal patient payments mostly prevail in poor governed countries where well-designed and respectable rules that reflect performance, are absent (Fiszbein et al., 2011). However, the concentration of problems inherited from the communist system varies between countries. If we consider the experience of other post-communist countries, Poland shows one of the best governance indicators in the region (The Worldwide Governance Indicators 2010), presenting a case of "season of corruption" in contrast to deep-rooted "climate of corruption" in other post-communist countries (Miller et al. 2001). The administrative skills and political will in Poland

provide an example of a governance practice to follow. Possibly, anti-communist public moods, lack of nostalgia as well as the intention to join the EU facilitated reforms in virtually all sectors (Leven, 2005). Indeed, rule of law, an anti-corruption legislation (realized in a cooperation between related sectors) have been developed and ensured in Poland (Golinowska, 2010). Only after such institutional anti-corruption basis was established, mass-media have been engaged. Thus, quality of governance (reinforcing factors) is crucial for diminishing the extent of informal patient payments and of the shadow sector in general.

Economic-labor environment: While governance is considered as essential for economic development (Lewis, 2006), economic development is tightly related to the fiscal revenues allocated to ‘non-profit’ sectors. Insufficiency of resources is often attributed to the incapability of the government to ensure an adequate level of public services provision. Indeed, two decades ago, virtually all CEE countries experienced an economic recession, difficulties in revenue collection as a result public spending on health, education was decreased proportionally especially in the countries where such reduction was not protected. Later, the majority of the countries in the region showed a **stable economic growth** except for the Community of Independent States due to the slow privatization process, the large extent of corruption and the distance from European markets. Informal payments (e.g. for health care services) are more deep-rooted in the countries where the government tolerates and relies on informal payments as an additional source of funding. This misuse of informal payments brings a mismatch in the health care sector goals and in the measures applied to achieve the goals. Therefore, chronic underfunding of the health care sector should be avoided and sufficient resources for health care service provision should be ensured (enabling factors).

7.4.4 Country-specific implementations

A mixture of strategies discussed above, will be necessary in a country to eliminate informal patient payments. However, the specific mix will depend on the country context. In Chapter 1, we have presented country profiles (Figure 1.2, SPACE matrix analysis) that highlight differences in economic, political and social environments of the six countries studied, as well as in funding and organization of their health care service systems. Additionally, in Chapters 3–6, we have shown that attitudes and patterns of informal patient payments differ considerably among the countries. Overall, we have observed that informal patient payments are most spread in Romania and Ukraine where the environment is relatively most conducive to informal payments (as shown in Figure 2.1), and relatively least spread in Poland, where

the environment is relatively least conducive to informal payments. Below, we discuss problematic areas in the countries to suggest priority measures aimed at the elimination of informal patient payment.

Hungary and Poland have a similar general context and are usually grouped together as belonging to the advanced CEE countries (the Visegrad group). The similarities in their context goes back to their abortive attempt to quit the soviet invasion virtually half a century ago, as well as to their fast socio-economic reforms in the 1990s, which brought them to the group of high-income countries. Nevertheless, policy makers in Hungary face a greater challenge with regard to informal patient payments than those in Poland. As shown by our results, informal patient payments are more spread in Hungary than in Poland. This can be attributed to some essential differences between the two countries. As suggested by Figure 1.2, the graphic profile of Hungary has a slightly larger area than that of Poland, which suggests a more conducive environment to informal patient payments. Also, our survey results demonstrate rather positive and indifferent attitudes towards informal patient payments among the Hungarian public compared to that in Poland. In Hungary, informal payments initiated by patients are more frequent than informal payments requested by medical staff. Hungarian patients mostly use informal payments to access better quality of services. Hence, two key directions for improvements should be considered by Hungarian policy-makers in their attempts to deal with informal patient payments. First, patients should have an institutionalized option for better care (e.g. private health care services) and second, opposition towards informal patient payments should be created on the basis of anti-corruption legislation and the support of mass-media, as it has been done in Poland. The experience of Poland in introducing reforms and getting positive effects in reducing informal payments (Golinowska, 2010) is an outstanding positive performance in the CEE region.

As we have already discussed in Chapter 5, there is a puzzling difference between the level of informal patient payments in Hungary and Bulgaria. In particular, traditionally better indicators in Hungary (e.g. higher health care funding and political stability) but also higher levels of informal patient payments, mismatch with relatively poorer socio-economic development but lower frequency of informal payments in Bulgaria. Possibly, in Bulgaria, the health care reforms (e.g. implementation of formal co-payments, development of the private sector and anti-informal payment campaigns) have proven their effectiveness as relatively few out-patients report making informal payments. Nevertheless, Bulgarian in-patient service provision requires more efforts from policy-makers to assure an adequate service organization and funding (Atanasova et al., 2011), as well as to deal with the widespread informal

payments in the hospital sector (as suggested by this dissertation). The fight against corruption in all public sectors should be high on the policy agenda.

Meanwhile, Lithuania demonstrates an interesting case of the spread of informal patient payments against the background of a satisfactory socio-economic development. It should be underlined however that in virtually all cross-country comparisons presented in this dissertation (including the conduciveness of the country environment to informal patient payments presented in Figure 1.2), Lithuania ranks in the middle. The primary explanation for informal patient payments in Lithuania can be found in the soviet past of the country reflected by weak health policy-making at present and perceptions of health care sector as unproductive and of low priority in funding. Indeed, the process of decentralization and privatization has not been finished effectively in Lithuania (Jakusovaite et al., 2005). Related to informal patient payments, the analyses suggest that there is an urgent need of clear regulation on out-of-pocket patient payments, which have been largely lacking in Lithuania since the start of the transition process (Murauskiene et al., 2012).

Romania and to a higher extent Ukraine show an environment that is relatively most conducive to informal patient payments (their graphic profiles in Figure 1.2 have the largest areas, several times higher compared to Poland or Hungary. This is an indication of a high number of problematic areas in these countries when it comes to informal patient payments. As suggested by the results in this dissertation, informal patient payments clearly fill funding gaps in the Romanian and Ukrainian public health care system. Since the private health care sector is under-developed in both countries, patients have no other option except to resort to informal payments in order to obtain the necessary care. It should be pointed out however that although informal patient payments in Romania and Ukraine mostly function as a remedy to the health care system failures, providers' misuse of market power is also widely observed. To diminish and eliminate the informal patient payments, Romania and Ukrainian policy-makers need to encourage the development of private health care provision with the objective to provide an alternative to patients, who are willing to use more luxury services and are able to pay extra for such services. At the same time, a reasonable basic service package should be defined and adequately to assure good quality and access for all patients. Parallel to this, improved governance and economic development will be required in both countries.

To be successful, the implementation of these priority measures should be combined with other more general strategies for the elimination of informal payments (discussed earlier). Also, only by securing political commitment and involvement of all stakeholders in the process of elimination of informal patient payments, appreciable effects can be ensured.

7.5 Concluding remarks

The research described in this dissertation suggests that attitudes and perceptions of informal patient payments and their patterns vary significantly among the CEE countries and within each country. Negative, positive and indifferent public attitudes exist simultaneously, solicited payment are present together with gratitude payments, though the proportion of these contrasting categories differ in the region. Differences in regulatory mechanisms, availability of alternatives to informal payments as a means to achieve better quality and access, and the level and sources of funding can explain the cross-country diversity. Nevertheless, the devotion to accepting, giving and relying on informal patient payments observed in the CEE region can become a great obstacle to health care reforms in any of the countries. Thus, strategies to deal with informal patient payments and their causes are urging.

Post-communist countries have been confronted with economic, political, and regulatory challenges during the transition period. Therefore, new moral principles or “multiple moralities” (Wanner, 2005, p.530) that do not support social consensus as well as a country’s development, have been established in the societies. Moreover, professional groups such as teachers, physicians, judges – whose values and beliefs are perceived as a benchmark for social morality – demonstrate quite unethical behavior like soliciting informal payments. This pattern has become rooted and has translated to new generations as well as to new professional strata. Behavior that previously was considered as “wrong”, has become an acceptable social practice. In other words, the “do-it-yourself approach” used by consumers and providers to ensure a reliable supply of essential services in an informal manner (when the government fails to assure such supply) has not been restricted by the overall negative social attitudes to such approach. Overall, the so-called gift-giving culture in the post-communist countries has undergone substantial changes when restraining factors, e.g. legislative or social borders for allowable behavior, are lacking. Thus, unhealthy moral principles of wealth distribution, of goods or services access, consumption and provision persist in new shapes using old labels of “gifts” or “gratitude money”. Indeed, Polese (2008) and Morris and Polese (2013) suggest the term “bripts” or “grafts” for describing the hybrid nature of giving “gifts” or “bribes”. In other words, a very extensive grey zone appears when a typical differentiation between corruption and gratitude is applied. Informal patient payments are gratitude payments as long as they are in kind gifts with negligible monetary value and are given after the service provision by the thankful patient.

In contrast to the countries that are aware of the undesirable consequences of “corruption” (its stigmatizing effect as well as legal consequences), the post-communist societies have adopted this concept and the stigmatization connotation has been lost (Polese, 2008). Practically, from the providers’ point of view, “using public office for private purpose” is seen as an option to survive. For health care users informal payments can help to fulfill their needs in health care even when the state fails to do provide an adequate quantity and quality of these services. Changes of governments and international organization interventions may give a stimulus to improve governance and the management culture in all public sectors. Overall, the ability of the government to ensure the good-performance of the public sector in general and of the health care sector in particular, is seen as a key factor to avoid shadowed practices. However, so far, political decision-making in the CEE region has been mostly based on the interests of business (the medical elites in case of health care) without considering evidence-based strategies and public opinions (Rechel & McKee, 2009). This impedes actual positive changes in public service provision regardless of the policy goals stated by the CEE governments. In the absence of good governance, consumers (patients in particular) apply alternative politics following the “do-it-yourself” approach despite the disgrace that they need to experience. The ultimate challenge for CEE policy-makers is to realize that when such failure (“do-it-yourself” approach) appears in health care, it also aggravates the health and wealth of the nation.

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APPENDIX A.

INFORMATION ABOUT THE COUNTRIES INCLUDED IN THE STUDY

Appendix A. Information about the countries included in the study (adopted from Pavlova et al., 2012)

		Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine
Health care context							
Health policy	Types of constitutional provision	Universal right to “free-of charge” health care, but entitlement defined by the law	Universal right to health	Universal right to “free-of charge” health care, but entitlement defined by the law	Universal right to “free-of charge” health care, but entitlement defined by the law	Universal right to “free-of charge” health care, but entitlement defined by the law	Universal right to “free-of charge” health care provided in state facilities
	Patient rights and information [weighted score], 2009	84	136	136	117	91	no data
	Government expenditure on health [% total government expenditure]	9.1%	10.2%	12.8%	10.9%	11.8%	8.6%
	Social health insurance [year of introduction]	1999	1989	1992	1999	1998	Semashko system
	Patient cost-sharing for health care services	Yes. The levels are adjusted to the minimum wage	Introduced in 2007 but abolished in 2008 after a referendum	Fees for GPs’ home visits, specialist without referral, and some diagnostics	No fees for services used, discussion only	No fees for services used, discussion only	Free-of-charge is guaranteed by the Constitution, except for some luxury services ⁹
Health care funding	Social health insurance [year of introduction]	Since 1999	Since 1989	Since 1992	Since 1999	Since 1998	Semashko system
	Total expenditure on health [% GDP]	7.4%	8.2%	7.8%	7.1%	5.4%	7.0%
	Per capita total expenditure on health at average exchange rate [\$US], 2009	475	938	730	804	408	180
	Government expenditure on health [% total expenditure on health]	55.4%	69.9%	68.3%	68.2%	78.9%	54.7%
	Per capita government expenditure on health at average exchange rate [\$US], 2009	280	653	499	548	322	98
Health care organization and capacity	Type of provider payment mechanisms (output versus input based mechanism)	Partly output based	Partly output based	Partly output based	Partly output based	Partly output based	Input based
	Existence of GPs gate-keeping function	Fully existent	Partly existent	Partly existent	Partly existent	Fully existent	Does not function
	E-health score [weighted], 2009	42	46	38	38	25	no data
	Physicians density [physicians per 10 000 population]	3,73	3,03	3,61	2,16	2,27	3,25
Health care indicators	Maternal mortality [deaths per 100 000 live births]	11	21	8	5	27	32
	Adults aged ≥20 years who are obese (% , male)	22.0	26.2	23.9	22.9	16.3	15.5
	Adults aged ≥20 years who are obese (% , female)	20.4	22.9	24.7	22.9	19.0	23.6

Appendix A. Information about the countries included in the study (continued)

		Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine
Socio-cultural and demographic context							
Demographic: population size and country territory	Territory [sq.km]	110 994	93 030	65 200	312 685	238 391	603 700
	Population [million]	7.4	10.2	3.5	38.2	21.7	48.5
	Population growth rate	-0.781%	-0.170%	-0.276%	-0.062%	-0.252%	-0.622%
	Age structure:						
	0-14 years	13.9%	14.9%	13.8%	14.7%	14.8%	13.7%
	15-64 years	67.9%	68.2%	69.7%	71.6%	70.4%	70.8%
	65 years and over	18.2%	16.9%	16.5%	13.7%	14.8%	15.5%
Culture: norms and values	The 2010 Corruption Perception Index	73	50	46	41	69	134
	Survival-self-expression values	-1.52	-1.22	-1.00	-0.14	-1.60	-1.72
Educability	Human development index [rank, lower value = higher level]	55	38	40	39	50	76
	Education index [score, higher value = higher level]	0.802	0.886	0.883	0.882	0.831	0.858
Political and regulatory context							
Political: quality of governance, political stability	Political stability [rank]	58	71	69	84	55	42
	Government effectiveness [rank]	55	72	74	73	50	25
	Control of corruption [rank]	52	67	66	70	54	17
	Rule of law ²	53	73	72	69	56	25
	Democracy index	6.78	7.04	7.24	7.12	6.54	5.94
Transition indicators: reform development	Governance and enterprise restructuring [units; 1-little or no change; 4- standards of industrialized market economies]	2,7	3,7	3,0	3,7	2,7	2,3
	Large scale privatization [unit]	4,0	4,0	4,0	3,7	3,7	3,0
	Competition policy [unit]	3,0	3,7	3,7	3,7	3,3	2,3
External environment: international organization membership							
	EU member	Since 2007	Since 2004	Since 2004	Since 2004	Since 2007	Not member

Appendix A. Information about the countries included in the study (continued)

		Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine
Economic-labor context							
Economic: wealth and its distribution	GDP [PPP per capita; \$US, billion]	13 563	18 738	12 323	19 752	11 860	6 656
	GDP real growth rate	0.2%	1.2%	1.3%	3.8%	-1.3%	4.2%
	Minimum wage defined by the government [Euro]	122.59	277.36	231.70	356.71	163.41	88.56
	Population below poverty line	21.8%	13.9%	4.0%	17.0%	25.0%	35.0%
	Gini index	45.30	24.96	36.00	34.5.00	32.00	31.00
	Black market [US\$, billion]	4.741	4.6	0.044	0.919	1.536	4.310

Sources of information:

- European Bank of Reconstruction and Development, 2011: www.ebrd.com/pages/research/economics/data/macro.shtml
- Federation of European employers: <http://www.fedee.com/minwage.html>
- Gotsadze, G. and P. Gaál (2010). Coverage decisions: benefit entitlements and patient cost sharing. Implementing Health Financing Reform Lessons from countries in transition.
- International Average Salary Income Database <http://www.worldsalaries.org/professionalnurse.shtml>
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- World Health Organization 2011. World Health Statistics 2011.

APPENDIX B.

DESCRIPTION OF THE QUANTITATIVE DATA COLLECTION

Appendix B. Description of the quantitative data collection (adopted technical report)

DATA COLLECTION

Quantitative data collection in the FP7 Project ASSPRO CEE 2007, took a form of household survey carried out in July 2010 in the six partners' countries - Bulgaria, Lithuania, Hungary, Poland, Romania and Ukraine during a first wave and in July 2011 in the three partners' countries – Bulgaria, Hungary and Ukraine. The data collection was sub-contracted to Gallup International. The sub-contractor used the survey questionnaire developed by the project team. The questionnaire and its translations were adjusted based on recommendations by the sub-contractor. The sub-contractor was responsible for the preparation of the data collection, the data-collection and the creation of the database.

The objective of the survey was to provide quantitative data on past payments for health care services, data on preferences and willingness to pay for health care improvements. Also, the objective was to provide data comparable across the countries. For this purpose, the questionnaire for all countries was identical, and the data collection process took place simultaneously in all six countries in a compact period of time – about one month. In all countries, the survey was conducted based on face-to-face individual interviews. The respondents were identified using an identical sampling methodology for all countries. The aim was to have 1000 and 800 effective interviews within the first and second wave of data collection respectively per country that present samples representative for the countries. The sampling methodology was developed by the sub-contractor and the coordinator. It was based on a multi-staged random probability method:

- *Stage 1: Distribution of sampling points.* The sampling points in each country were distributed proportionally to regional, urban/rural and ethnic characteristics of the population. Within each region, the cities and towns belonging to the same group were put in an alphabetical order. The cities and towns included in the survey, were selected at random from that list. The number of sampling points in the rural areas was calculated based on the ratio urban/rural population in a country. In total, there were ca. 150 sampling points per country within the first wave and ca. 80-100 sampling points per country within the second wave of data collection.

- *Stage 2: Selection of addresses/ households.* The objective was to identify, 8-10 (6-8 within the second wave) respondents per sampling point. To select addresses/households of potential respondents, the random route method was used. For each sampling point, a starting point and direction were determined. The household selected for the survey, was every fourth address on the left-hand side of the street in urban areas, turning left at intersections and, after reaching a dead end, going back to the last crossing and further proceeding at random. In a block-of-flats of up to four floors, every fifth apartment household was selected, counting from the first apartment on the left of the ground floor. In cases of unsuitable household, the interviewers approached the apartment next-door and continued doing this until reaching a suitable household. At that point, the interviews resume

the standard step of every fifth apartment. In a block-of-flats of 5 floors and more, the selection is every tenth apartment. In rural areas, every fourth inhabitable house on both sides of the interviewer's route was selected. In compounds of several houses behind a common fence, the interviewer had to select the fourth one from the left (counting from the gate), or if there were less than four houses behind a common fence, then the interviewer went out of the common yard, counting the houses as if they were along the street.

▪ *Stage 3: Selection of the respondent within the household selected.* The selection of the respondent within the selected household was done using the “last birthday” principle. In this procedure, the interviewer asked to speak to the adult member of the household who had the last birthday. The last-birthday method is based on the assumption that the assignment of birthdates is a random process and also every household member has an equal chance of being selected. Only one individual per household was interviewed.

▪ *Stage 4: Replacement of the respondent/household.* If the respondent determined on stage 3 refused or was unavailable to participate after two call backs recorded in the fieldwork report, a replacing respondent was identified following stage 2-3.

The sampling procedure described above, is known as an efficient method for selecting a sample representative for the population of a particular country. It is proven by practice that the sample produced by this method does not differ significantly from the official statistical data on age, gender and other demographic parameters.

The sub-contractor organized and managed the interviewers' training to clarify the fieldwork standards and the specificities of the questionnaire. A high number of interviewers were involved in the survey to avoid the interviewer bias that might occur when one interviewer carries out many interviews. The total number of the interviewers and the number of interviews per interviewer for each country are presented in the table below:

	First wave (2010)						Second wave (2011)		
	Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine	Bulgaria	Hungary	Ukraine
Total number of interviewers	108	130	84	70	100	111	91	80	108
Number of interviews per interviewer (min-max)	1 - 29	6 - 8	6 - 26	1 - 50	1 - 27	1 - 25	7 - 16	6 - 31	2 - 14
Total number of sampling points	129	132	121	100	126	63*	103	80	117
Number of sampling points in rural areas	39	43	38	37	55	17	30	15	38
Number of interviews per sampling point (min-max)	1 - 10	7 - 8	6 - 10	10 - 10	4 - 11	5 - 63*	7 - 8	6 - 31	4 - 10
Number of interviews per geographical region (min-max)	63 - 290	104-285	38 - 254	30 - 120	89 - 170	41 - 157	64 - 240	80 - 223	35 - 121

The duration of the interviews was as expected – on average 30-35 min per interview. The average duration of the interviews per country was as follows:

	Duration of the interviews in minutes								
	First wave (2010)						Second wave (2011)		
	Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine	Bulgaria	Hungary	Ukraine
Mean	35.88	35.28	33.63	29.15	31.70	22.78	21.00	23.63	34.48
Median	35.00	35.00	33.00	27.00	30.00	20.00	20.00	23.00	32.00
Std. Deviation	10.473	9.928	7.637	11.491	9.378	8.655	8.214	7.247	9.500
Minimum	10	15	15	10	10	5	6	9	15
Maximum	100	95	75	98	60	60	57	42	65

About 10% of all interviews per country were verified (re-contacted) either by telephone or in person by the sub-contractor. The verifications of the interviews confirmed that the interviews were carried out in reality.

The sub-contractor entered the data collected according to the preliminary data entry mask agreed with the coordinator. The final dataset contains the following number of respondents per country:

	First wave (2010)						Second wave (2011)		
	Bulgaria	Hungary	Lithuania	Poland	Romania	Ukraine	Bulgaria	Hungary	Ukraine
Number of effective interviews (respondents)	1003	1037	1012	1000	1000	1000	817	805	800

The sub-contractor also performed the standard data clean-up and logical checks procedures. The coordinator checked the representativeness of the sample and the overall quality of the dataset. The sample characteristics related to age, gender, place of residence and household income are overall comparable to the countries' national statistics.

QUESTIONNAIRE DEVELOPMENT

The questionnaire was developed by the team of the FP7 Project ASSPRO CEE 2007. All partners were involved in the development of the questionnaire, namely in formulating questions, discussing content, translating and pre-testing early drafts of the questionnaire. The coordinator managed the overall process and based on the recommendations of the partners, set up the final English version partly presented in Appendix D. The partners finalized the translations.

The questionnaire is developed with the objective to collect data and to answer the following research question: What is the magnitude of patient payments for out-patient physician's services and in-patient hospital services in the six Central and Eastern European countries included in the project (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine), and what is the willingness and ability of consumers in these countries to pay for these services? The questionnaire is uniform for all countries. It contains 6 main components:

- Past experience with the use of and payments for health care services (Part 1 and 2)
- Attitudes towards informal patient payments (Part 3)
- Preferences for physician and hospital services (Part 5, 6, 7 and 8)
- Willingness to pay for physician and hospital services (Part 9)
- Socio-demographic and health-related characteristics (Part 10)
- Household characteristics (Part 11)

The process of the development of the questionnaire consisted of the following steps:

- First draft: The first draft of the questionnaire was set up by the junior researchers and the coordinators. Then, it was discussed with partners in two subsequent project meetings.
- First pre-test: Each junior researcher translated and pre-tested one part of the questionnaire. The main objective of this pre-test was to check the content validity of the questions. This first pre-test resulted in several modifications.
- Second draft: The second draft of the questionnaire was distributed among partners for comments and suggestions for improvements. This resulted in several major modifications.
- Discussion with experts: The second draft of the questionnaire was discussed with two experts on informal payments involved in the project.
- Third draft: Based on the comments of the experts and the suggestions of the partners during the subsequent project meeting, the third draft of the questionnaire was finalized.
- Second pre-test: The third draft of the questionnaire was translated and pre-tested in all countries to check the face-validity of the questions and the overall length of the interviews. This pre-test indicated that the questionnaire is very long and need to be reduced substantially.
- Fourth draft: The coordinator prepared the fourth (reduced) draft of the questionnaire.
- Third pre-test: The fourth (reduced) draft of the questionnaire was pre-tested once again in one country to assure that its length is suitable.
- Backward translation: Partners translated this reduced draft. These new translations were translated backward into English by a person who was not involved in the project. The backward translations were used by the coordinator to check the uniformity of the translations.
- Final version: The final version of the questionnaire was prepared by the coordinator and the final translations were prepared by the partners.

APPENDIX C.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE SAMPLES AND RESPONSE RATE

APPENDIX C. Socio-demographic characteristics of the samples and response rate

			Bulgaria		Hungary		Lithuania	Poland	Romania	Ukraine	
			2010	2011	2010	2011	2010	2010	2010	2010	2011
Age	Years	Median	52.0	51.0	47.0	47.0	45.0	43.0	49.0	49.0	49.0
		Mean (SD)	50.5 (17.0)	50.2 (16.9)	46.3 (17.6)	46.9 (17.8)	46.4 (16.8)	44.1 (16.5)	48.5 (17.2)	48.6 (17.6)	48.7 (18.3)
		Valid N	1003	817	1037	805	1012	1000	1000	1000	800
Gender	Male [0]	N (%)	470 (46.9)	350 (42.8)	481 (46.4)	369 (45.8)	437 (43.2)	470 (47.0)	417 (41.7)	415 (41.5)	338 (42.3)
	Female [1]	N (%)	533 (53.1)	467 (57.2)	556 (53.6)	436 (54.2)	575 (56.8)	530 (53.0)	583 (58.3)	585 (58.5)	462 (57.8)
		Valid N	1003	817	1037	805	1012	1000	1000	1000	800
Place of residence	Village [0]	N (%)	299 (29.8)	238 (29.1)	303 (29.2)	226 (28.1)	340 (33.6)	370 (37.0)	438 (43.8)	315 (31.5)	248 (31.0)
	Town (< 200000) [1]	N (%)	445 (44.4)	364 (44.6)	528 (50.9)	406 (50.4)	396 (39.1)	400 (40.0)	337 (33.7)	328 (32.8)	285 (35.6)
	City (> 200000) [2]	N (%)	101 (10.1)	71 (8.7)	24 (2.3)	31 (3.9)	112 (11.1)	190 (19.0)	136 (13.6)	142 (14.2)	89 (11.1)
	The capital [3]	N (%)	158 (15.8)	144 (17.6)	182 (17.6)	142 (17.6)	164 (16.2)	40 (4.0)	89 (8.9)	156 (15.6)	130 (16.3)
		Valid N	1003	817	1037	805	1012	1000	1000	1000	800
Education ISCED ^a	ISCED 0	N (%)	4 (0.4)	10 (1.2)	2 (0.2)	9 (1.1)	5 (0.5)	5 (0.5)	7 (0.7)	3 (0.3)	2 (0.3)
	ISCED 1	N (%)	50 (5.0)	28 (3.4)	203 (19.6)	128 (15.9)	43 (4.2)	83 (8.3)	77 (7.7)	16 (1.6)	21 (2.6)
	ISCED 2	N (%)	176 (17.5)	169 (20.7)	324 (31.2)	39 (4.8)	80 (7.9)	162 (16.2)	147 (14.7)	54 (5.4)	48 (6.0)
	ISCED 3	N (%)	540 (53.8)	434 (53.1)	337 (32.5)	384 (47.7)	434 (42.9)	611 (61.1)	507 (50.7)	624 (62.4)	502 (62.8)
	ISCED 4	N (%)	48 (4.8)	28 (3.4)	34 (3.3)	129 (16.0)	239 (23.6)	30 (3.0)	77 (7.7)	60 (6.0)	49 (6.1)
	ISCED 5+6	N (%)	185 (18.4)	148 (18.1)	137 (13.2)	116 (14.4)	211 (20.8)	107 (10.7)	185 (18.5)	234 (24.3)	178 (22.3)
		Valid N	1003	817	1037	805	1012	1000	1000	1000	800
Chronic health problems	No [0]	N (%)	524 (52.3)	421 (51.5)	569 (54.9)	466 (57.9)	533 (52.7)	645 (64.5)	574 (57.4)	540 (54.0)	448 (56.0)
	One or more [1]	N (%)	477 (47.7)	396 (48.5)	468 (45.1)	339 (42.1)	479 (47.3)	355 (35.5)	426 (42.6)	460 (46.0)	352 (44.0)
		Valid N	1001	817	1037	805	1012	1000	1000	1000	800
Persons in the household	Number of persons	Median	3.0	3.0	2.0	3.0	2.0	3.0	2.0	3.0	3.0
		Mean (SD)	2.9 (1.4)	2.9 (1.4)	2.7 (1.3)	2.8 (1.3)	2.6 (1.3)	3.1 (1.4)	2.6 (1.4)	2.8 (1.4)	2.7 (1.3)
		Valid N	1002	817	1037	805	1012	996	1000	1000	800

APPENDIX C. Socio-demographic characteristics of the samples and response rate (continued)

			Bulgaria		Hungary		Lithuania	Poland	Romania	Ukraine	
			2010	2011	2010	2011	2010	2010	2010	2010	2011
Net average household income per month [Euro]	Less than 50 Euro	N	11	10	6	0	18	1	34	12	9
		(%)	(1.2)	(1.4)	(0.6)	(0.0)	(1.8)	(0.1)	(3.7)	(1.3)	(1.2)
	51 to 75 Euro	N	20	17	5	0	7	1	19	23	18
		(%)	(2.2)	(2.3)	(0.5)	(0.0)	(0.7)	(0.1)	(2.1)	(2.5)	(2.4)
	76 to 100 Euro	N	56	35	2	6	22	1	29	103	76
		(%)	(6.2)	(4.8)	(0.2)	(0.8)	(2.2)	(0.1)	(3.2)	(11.1)	(10.1)
	101 to 150 Euro	N	98	78	9	6	27	11	82	128	100
		(%)	(10.8)	(10.6)	(0.9)	(0.8)	(2.7)	(1.3)	(8.9)	(13.7)	(13.2)
	151 to 200 Euro	N	98	79	22	10	71	17	101	149	108
		(%)	(10.8)	(10.7)	(2.2)	(1.3)	(7.2)	(2.0)	(11.0)	(16.0)	(14.3)
	201 to 250 Euro	N	83	82	43	17	103	31	94	125	88
		(%)	(9.1)	(11.2)	(4.3)	(2.2)	(10.5)	(3.6)	(10.2)	(13.4)	(11.6)
	251 to 300 Euro	N	73	71	85	40	96	37	107	95	98
		(%)	(8.0)	(9.7)	(8.5)	(5.2)	(9.8)	(4.3)	(11.6)	(10.2)	(13.0)
	301 to 350 Euro	N	88	68	61	43	71	38	99	110	95
		(%)	(9.7)	(9.3)	(6.1)	(5.6)	(7.2)	(4.5)	(10.8)	(11.8)	(12.6)
	351 to 400 Euro	N	62	55	66	65	64	41	87	54	45
		(%)	(6.8)	(7.5)	(6.6)	(8.5)	(6.5)	(4.8)	(9.5)	(5.8)	(6.0)
	401 to 450 Euro	N	52	49	68	32	78	36	49	45	43
		(%)	(5.7)	(6.7)	(6.8)	(4.2)	(7.9)	(4.2)	(5.3)	(4.8)	(5.7)
	451 to 500 Euro	N	72	58	84	69	44	79	65	26	17
		(%)	(7.9)	(7.9)	(8.4)	(9.0)	(4.5)	(9.3)	(7.1)	(2.8)	(2.2)
	501 to 600 Euro	N	77	52	162	94	91	87	54	33	26
		(%)	(8.5)	(7.1)	(16.2)	(12.3)	(9.3)	(10.2)	(5.9)	(3.5)	(3.4)
	601 to 750 Euro	N	60	43	159	135	95	144	47	18	23
		(%)	(6.6)	(5.9)	(15.9)	(17.6)	(9.7)	(16.9)	(5.1)	(1.9)	(3.0)
	751 to 1000 Euro	N	46	30	145	128	95	165	28	7	6
		(%)	(5.1)	(4.1)	(14.5)	(16.7)	(9.7)	(19.4)	(3.0)	(0.8)	(0.8)
	1001 to 1500 Euro	N	7	6	65	83	67	115	16	2	3
		(%)	(0.8)	(0.8)	(6.5)	(10.8)	(6.8)	(13.5)	(1.7)	(0.2)	(0.4)
	1501 to 2000 Euro	N	4	1	13	32	20	41	3	1	1
		(%)	(0.4)	(0.1)	(1.3)	(4.2)	(2.0)	(4.8)	(0.3)	(0.1)	(0.1)
	2001 to 3000 Euro	N	0	1	1	5	12	7	3	0	0
		(%)	(0.0)	(0.1)	(0.1)	(0.7)	(1.2)	(0.8)	(0.3)	(0.0)	(0.0)
	More than 3000 Euro	N	1	0	1	0	2	0	3	0	0
		(%)	(0.1)	(0.0)	(0.1)	(0.0)	(0.2)	(0.0)	(0.3)	(0.0)	(0.0)
Valid N			908	735	997	765	983	852	931	931	756
Number of contacted persons	Outright refusal "at the door step"	N	214	143	312	203	579	878	353	850	790
		(%)	(13.9)	(10.7)	(22.7)	(19.9)	(29.7)	(33.4)	(18.8)	(34.5)	(36.2)
	Outright refusal by the target respondent	N	185	256	8	5	233	488	354	409	353
		(%)	(12.0)	(19.1)	(0.6)	(0.5)	(11.6)	(18.6)	(18.8)	(16.6)	(16.2)
	Refusal after informed consent	N	104	117	9	4	124	260	121	154	158
		(%)	(6.7)	(8.7)	(0.6)	(0.4)	(6.2)	(9.9)	(6.4)	(6.3)	(7.2)
Terminated interviews		N	5	2	1	0	5	3	6	11	34
		(%)	(0.3)	(0.1)	(0.1)	(0.0)	(0.3)	(0.1)	(0.3)	(0.4)	(1.6)
Completed interviews		N	1034	824	1046	810	1049	1002	1049	1040	847
		(%)	(67.1)	(61.4)	(76.0)	(79.2)	(52.2)	(38.1)	(55.7)	(42.2)	(38.8)

Note: The preliminary analysis showed that the socio-demographic characteristics of the samples are overall comparable to the official statistics in the countries for adults (age 18+ years).

^a ISCED - international standard classification of education, UNESCO

APPENDIX D.

ENGLISH WORDING OF THE QUESTIONS USED IN THE STUDY

APPENDIX D. English wording of the questions used in the study

Before interviewers started asking questions, they have got a preliminary agreement of respondent to participate in the research and the following information was given to the respondent.

- The aim of this survey is to collect data on citizens' opinion about the quality, access and price of medical services they use.
- The survey is not commissioned by the government or a health insurer.
- This survey is part of an international research project funded by the European Commission.
- The same survey is carried out in several European countries.
- The data collected during the survey will be used for research purposes, namely for statistic analyses and reports.
- Your answers will not be related to your personal details (address, etc.) and will be completely confidential.
- Answers to all questions are highly important to the project, so we hope that you will share your opinions and thoughts by answering all questions in the questionnaire.

PART 1	USE AND PAYMENTS FOR PHYSICIAN AND HOSPITAL SERVICES USED BY THE RESPONDENT
---------------	--

The first set of questions concerns medical services that YOU used during the last 12 months

(June 2009 – May 2010 OR June 2010 – May 2011), and the money that you paid out-of-pocket (or your family members paid on your behalf) for YOU receiving these services.

Out-of-pocket payments include OFFICIAL payments, for which one may usually receive a receipt or other document, INFORMAL cash payments (such as gratitude cash payments or under-the-table cash payments), or gifts in kind for receiving medical services.

Out-of-pocket payments EXCLUDE monthly payments for health insurance (or voluntary health accounts), as well as payments that the patient receives back from the state or a health insurer.

Consumption and expenditures on out-patient services last 12 month

- | | | |
|-----------|--|---|
| A1 | During the last 12 months, how many times did you personally visit a physician or a physician visited you personally at your home, including any physician in both the public and private system? (Homeopaths and traditional healers who are not physicians, and also dentists are excluded.) | <ul style="list-style-type: none"> • Number of times • 0 – None • [Don't know] <p>If none, go to next part</p> |
| A2 | Considering all types of official and informal cash payments, and in-kind gifts, how much in total did you spend (out-of-pocket) on these visits excluding payments for travelling, transportation by ambulance and pharmaceuticals? | <ul style="list-style-type: none"> • Amount 0 – None |
| A3 | How much of this amount approximately was for INFORMAL cash payments and in-kind gifts? | <ul style="list-style-type: none"> • Amount 0 – None |

Consumption and expenditures on last physician visit[applied in 2nd wave of data collection only]

- B1** When was your last visit to/by a physician? Homeopaths and traditional healers who are not physicians, and also dentists are excluded. Please indicate the month and the year only.
- Date
 - 0 – None
- If none, go to next part
- B2** What type of physician - GP (personal doctor, family doctor) or medical specialist?
- 1 – Medical specialist
 - 0 – GP
- B3** What type of medical specialist – what specialty?
- 5 – Anaesthesiologist
 - 4 – neurologist
 - 3 – dermatologist
 - 2 – internist
 - 1 - obstetrician – gynaecologist
 - 0 - other specialist
- B4** Considering all types of official and informal cash payments, and gifts in kind, how much in total did you (or your family members) pay for this last visit to/by a physician excluding payments for travelling, transportation by ambulance and pharmaceuticals?
- Amount
 - 0 – None
- B5** How much of this amount approximately was for informal cash payments and gifts in kind?
- Amount
 - 0 – None
- B6** What was the main purpose of these informal payments?
- 4 - Quicker access
 - 3 - Better quality
 - 2 - Skilled physician
 - 1 - Better attention
 - 0 - Other reason
- B7** Did you make these informal payments because you were asked/expected by the physician (or other staff) to pay informally or because you (or your family members) consider necessary/appropriate to pay informally, or both?
- 2-Both
 - 1-Asked to pay
 - 0-Considered necessary/appropriate to pay

Consumption and expenditures on in-patient services last 12 month

- C1** During the last 12 months, how many times were you hospitalized (placed in a hospital), including day surgeries or day treatments? (Re-hospitalization, i.e. repeated hospitalization for the same health problem, should be counted separately as a different hospitalization.)
- Number of times
 - 0 – None
- If none, go to next part
- C2** Considering all types of official and informal cash payments, and in-kind gifts, how much in total did you spend (out-of-pocket) on these hospitalizations excluding payments for travelling, transportation by ambulance and pharmaceuticals?
- Amount
 - 0 – None
- C3** How much of this amount approximately was for informal cash payments and in-kind gifts?
- Amount
 - 0 – None

Consumption and expenditures on last hospitalization[applied in 2nd wave of data collection]

- D1** When was your last hospitalization (including day surgeries or day treatments)? Please indicate only the month and the year when the hospitalization started.
- Date
 - 0 – None
- If none, go to next part

D2	Which of the following categories would best describe this hospitalization?	<ul style="list-style-type: none"> • 3 - Planned procedure • 2 - Planned surgery • 1 -Emergency procedure • 0 - Emergency surgery
D3	How many nights did you spent in the hospital during this last hospitalization?	<ul style="list-style-type: none"> • Number of nights • 0 – None
D4	Was this hospitalization due to delivery or complications during pregnancy? (Due to both, yes, due to pregnancy, yes, due to delivery)	<ul style="list-style-type: none"> • 3 – Yes, due to both • 2-Yes, due to pregnancy • 1-Yes, due to delivery • 0-No
D5	Considering all types of official and informal cash payments, and gifts in kind, how much in total did you (or your family members) pay for this last hospitalization excluding payments for travelling, transportation by ambulance and pharmaceuticals?	<ul style="list-style-type: none"> • Amount • 0 – None
D6	How much of this amount approximately was for informal cash payments and gifts in kind?	<ul style="list-style-type: none"> • Amount • 0 – None
D7	What was the main purpose of these informal payments	<ul style="list-style-type: none"> • 4 - Quicker access • 3 - Better quality • 2 - Skilled physician • 1 - Better attention • 0 - Other reason
D8	Did you make these informal payments because you were asked/expected by the physician (or other staff) to pay informally or because you (or your family members) consider necessary to pay informally, or both?	<ul style="list-style-type: none"> • 2-Both • 1-Asked to pay • 0-Considered necessary/appropriate to pay
D9	Were you asked to bring pharmaceuticals (medicines) for this hospitalization?	<ul style="list-style-type: none"> • 1-Yes • 0 - No
D10	What was the total monetary value of these pharmaceuticals that you (or your family members) brought for this hospitalization?	<ul style="list-style-type: none"> • Amount
D11	Were you asked to bring medical supplies (consumables) and/or appliances (for example prosthetics, blood-sugar meters) for this hospitalization? Please include also less expensive items such as bandages, catheters, syringes, thermometer, etc.	<ul style="list-style-type: none"> • 1-Yes • 0 - No
D12	What was the total monetary value of these medical supplies and/or appliances that you (or your family members) brought for this hospitalization	<ul style="list-style-type: none"> • Amount
D13	Did you bring with you bed linen, blankets and/or food for this hospitalization (excluding additional food items such as fruits, chocolate, juices etc.)?	<ul style="list-style-type: none"> • 1-Yes • 0 - No

PART 2 ATTITUDE TOWARDS INFORMAL PATIENT PAYMENTS

E1	What is your attitude towards informal cash payments to physicians, medical staff or other personnel in health care facilities – positive, negative or indifferent?	<ul style="list-style-type: none"> • 2-Positive • 1-Indifferent • 1-Negative
E2	What is your attitude towards giving gifts in kind to physicians, medical staff or other personnel in health care facilities - positive, negative or indifferent?	<ul style="list-style-type: none"> • 2-Positive • 1-Indifferent • 1-Negative

Do you agree with the following statements?

- | | | |
|-----------|---|---|
| E3 | Informal cash payments to physicians and medical staff are similar to corruption. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E4 | Gifts in kind to physicians and medical staff are similar to corruption. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E5 | Informal cash payments to physicians and medical staff are an expression of gratitude. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E6 | Gifts in kind to physicians and medical staff are an expression of gratitude. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E7 | Informal cash payments and gifts in kind to physicians and medical staff are inevitable because of the low funding of the health care sector. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E8 | Cash or gifts in kind, given informally to physicians and medical staff, should be eradicated. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |

Individual perception and attitude towards informal patient payments

Do the following statements apply to you personally?

- | | | |
|------------|--|---|
| E9 | I will feel uncomfortable if I leave the physician's office without a gratitude cash payment or gift in kind. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E10 | I would recognize the hint of physicians or medical staff for an informal cash payment or a gift in kind. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E11 | I will refuse to pay if a physician or medical staff asks me to pay informally for a medical service. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E12 | I will prefer to use private medical services if I have to pay informally for public medical services. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |
| E13 | If I have serious problems with my health, I will be ready to pay as much as I have in order to get better medical services. | <ul style="list-style-type: none"> • 2-Yes • 1-Somewhat • 0 - No |

Experience of ever giving informal patient payments in cash or in-kind gifts

- | | | |
|------------|--|---|
| E14 | Have you been ever personally asked by physicians, medical staff or other personnel in health care facilities to pay informally in cash or to give a gift in kind? | <ul style="list-style-type: none"> • 1-Yes • 0 - No |
| E15 | Have you ever personally paid informally in cash to physicians, medical staff or other personnel in health care facilities? | <ul style="list-style-type: none"> • 1-Yes • 0 - No |
| E16 | Have you ever personally given any gift in kind to physicians, medical staff or other personnel in health care facilities? | <ul style="list-style-type: none"> • 1-Yes • 0 - No |

Fee awareness and knowledge where to complain

- | | | |
|------------|---|--|
| E17 | Do you know the size of the official fees for medical services of physicians (including any kind of specialists) before you use such services – always, sometimes, never? | <ul style="list-style-type: none"> • 2-Always • 1-Sometimes • 0 - Never |
| E18 | Do you know the size of the official fees for hospital services related to hospital admissions (staying in hospital) before you use such services – always, sometimes, never? | <ul style="list-style-type: none"> • 2-Always • 1-Sometimes • 0 - Never |
| E19 | Do you know where to complain if physicians, medical staff or other personnel in health care facilities ask you to pay informally for a medical service? | <ul style="list-style-type: none"> • 2-Always • 1-Sometimes • 0 - Never |

PART 3 SOCIO-DEMOGRAPHIC OF RESPONDENT AND HOUSEHOLD CHARACTERISTICS

Next questions concern your social and demographic characteristics. The information that is required will not be related to your identity. The data are only necessary in order to analyze the results of this survey in a statistical way.

Socio-demographic characteristics		
F1	In which year were you born?	<ul style="list-style-type: none"> • Year
F2	<i>Fill in the respondent's gender</i>	<ul style="list-style-type: none"> • Female • Male
F3	<i>Fill in the type of respondent's residence place</i>	<ul style="list-style-type: none"> • Capital • City (more than 500,000 inhabitants) • City (200,000 – 500,000 inhabitants) • Town (up to 200,000 inhabitants) • Village
F4	What is the level of your current education or current study?	From not completed primary education (ISCED 0) TO Tertiary education (ISCED 5+6)
F5	What is your primary occupation (activities) at present?	E.g. soldier, pensioner, unemployed, not employed, student, own business.
F6	During the last 12 months, did you need to use medical services frequently due to a chronic disease or a major health problem?	<ul style="list-style-type: none"> • 1-Yes • 0 - No
	Have a physician told you that you have any of the following health problems?	
F7	Diabetes (increased sugar in the blood)	<ul style="list-style-type: none"> • 1-Yes • 0 - No
F8	Chronic heart disease or high arterial blood pressure	<ul style="list-style-type: none"> • 1-Yes • 0 - No
F9	Chronic lung, liver or kidney disease	<ul style="list-style-type: none"> • 1-Yes • 0 - No
F10	Stroke	<ul style="list-style-type: none"> • 1-Yes • 0 - No
F11	Infarct	<ul style="list-style-type: none"> • 1-Yes • 0 - No
F12	Other chronic or major health problems	<ul style="list-style-type: none"> • 1-Yes • 0 - No
Household characteristics		
F13	How many persons are there in your household (incl. You)?	<ul style="list-style-type: none"> • Number
F14	How many children under the age of 18 are there in your household?	<ul style="list-style-type: none"> • Number
F15	Please take a look at this card. Could you tell me which of the following categories corresponds to the net average household income per month (i.e. after tax income) – considering all household members and all sources - wages, social welfare, pensions, rents, fees, etc?	From A – less than 50 Euro TO R – more than 3000 Euro

APPENDIX E.

INDEX OF PUBLICATIONS INCLUDED IN THE REVIEW

APPENDIX E. Index of publications included in the review

1. Özgen, H., Sahin, B., Belli, P., Tatar, M., & Berman, P. (2010). Predictors of informal health payments: The example from Turkey. *Journal of Medical Systems*, 34(3), 387-396.
2. Cockcroft, A., Andersson, N., Paredes-Solis, S., Caldwell, D., Mitchell, S., Milne, D., et al. (2008). An inter-country comparison of unofficial payments: Results of a health sector social audit in the Baltic States. *BMC Health Services Research*, 8, 15.
3. Liaropoulos, L., Siskou, O., Kaitelidou, D., Theodorou, M., & Katostaras, T. (2008). Informal payments in public hospitals in Greece. *Health Policy*, 87, 72-81.
4. Siskou, O., Kaitelidou, D., Papakonstantinou, V., & Liaropoulos, L. (2008). Private health expenditure in the Greek health care system: Where truth ends and the myth begins. *Health Policy*, 88, 282-293.
5. Tediosi, F., Aye, R., Ibodova, S., Thompson, R., & Wyss, K. (2008). Access to medicines and out of pocket payments for primary care: Evidence from family medicine users in rural Tajikistan. *BMC Health Services Research*, 8, 109.
6. Dabalen, A., & Wane, W. (2008). *Informal payments and moonlighting in Tajikistan's health sector*. Washington, D.C.: The World Bank and Development Research Group.
7. Burak, L., & Vian, T. (2007). Examining and predicting under-the-table payments for health care in Albania: An application of the theory of planned behavior. *Journal of Applied Social Psychology*, 37(5), 1060-1076.
8. Chiu, Y.C., Smith, K.C., Morlock, L., & Wissow, L. (2007). Gifts, bribes and solicitations: Print media and the social construction of informal payments to doctors in Taiwan. *Social Science & Medicine*, 64, 521-530.
9. Hunt, J. *Bribery in Health Care in Peru and Uganda*. NBER Working Paper. Cambridge: NBER. [<http://www.nber.org/papers/w13034>]
10. Tatar, M., Özgen, H., Sahin, B., Belli, P., Berman, P. (2007). Informal payments in the health sector: A case study from Turkey. *Health Affairs*, 26, 1029-39.
11. Baschieri, A., & Falkingham, J. (2006). Formalizing informal payments: The progress of health reform in Kyrgyzstan. *Central Asian Survey*, 25(4), 441-460.
12. Szende, A., & Culyer, A.J. (2006). The inequity of informal payments for health care: The case of Hungary. *Health Policy*, 75, 262-71.
13. Vian, T., Grybosk, K., Sinoimeri, Z., & Hall, R. (2006). Informal payments in government health facilities in Albania: results of a qualitative study. *Social Science & Medicine*, 62, 877-887.
14. Gotsadze, G. Bennett, S., Ranson, K., & Gzirishvili, D. (2005). Health care-seeking behaviour and out-of-pocket payments in Tbilisi, Georgia. *Health Policy and Planning*, 20, 232-242.
15. Hotchkiss, D.R., Hutchinson, P.L., Malaj, A., & Berruti A.A. (2005). Out-of-pocket payments and utilization of health care services in Albania: Evidence from three districts. *Health Policy*, 75, 18-39.
16. Balabanova, D., McKee, M., Pomerleau, J., Rose, R., & Haerpfer, C. (2004). Health service utilization in the Former Soviet Union: evidence from eight countries. *Health Services Research*, 39(6), 1927-1950.

17. Belli, P., Gotsadze, G., & Shahriari, H. (2004). Out-of-pocket and informal payments in health sector: Evidence from Georgia. *Health Policy*, 70, 109-123.
18. Falkingham, J. (2004). Poverty, out-of-pocket payments and access to health care: Evidence from Tajikistan. *Social Science & Medicine*, 58, 247-258.
19. Shishkin, S., Bogatova, T., Potapchik, Y., Chernets, V., Chirikova, A, Shilova, L. (2003). *Informal out-of-pocket payments for healthcare in Russia*. Independent Institute for Social Policy, Moscow.
20. Balabanova, D., & McKee, M. (2002). Understanding informal payments for health care: The example of Bulgaria. *Health Policy*, 62, 243-73.
21. Belli, P. (2002). *Formal and informal household spending on health: A multi-country study in Central and Eastern Europe*. Cambridge, MA, Harvard School of Public Health.
22. Litvak, A., Pogorilyi, V., & Tyschuk, M. (2001). *Underground Economy in Health Care in Contemporary Ukraine*. Odesa: TEC.
23. Shahriari, H., Belli, P., & Lewis, M. (2001). *Institutional issues in informal health payments in Poland*. HNP Discussion Paper. Washington,D.C., The World Bank.
24. Anderson, J. (2000). *Corruption in Slovakia: Results of diagnostic surveys*. Washington,D.C.: The World Bank and USAID.
25. Miller, W.L., Grødeland, A.B., & Koshechkina, T.Y. (2000). 'If you pay, we'll operate immediately'. *Journal of Medical Ethics*, 26, 305-311.
26. Killingsworth, J.R. (1999). Unofficial fees in Bangladesh: Price, equity and institutional issues. *Health Policy and Planning*, 14, 152-163.
27. Mastilica, M., & Božikov, J. (1999). Out-of-pocket payments for health care in Croatia: implications for equity. *Croatian medical journal*, 40(2), 152–159.
28. McPake, B., Asiimwe, D., Mwesigye, F., Ofumbi, M., Orteublad, L., & Stree, P. (1999). Informal economic activities of public health workers in Uganda: Implications for quality and accessibility of care. *Social Science & Medicine*, 49, 849–865.
29. Chawla, M., Berman, P., & Kawiorska, D. (1998). Financing health services in Poland: New evidence on private expenditures. *Health Economics*, 7, 337-346.
30. Delcheva, E., Balabanova, D., & McKee, M. (1997). Under-the-counter payments for health care: Evidence from Bulgaria. *Health Policy*, 42, 89-100.
31. Barr, D.A. (1996). The ethics of Soviet medical practice: Behaviours and attitudes of physicians in Soviet Estonia. *Journal of Medical Ethics*, 22, 33-40.

SUMMARY

IN ENGLISH, DUTCH, UKRAINIAN AND RUSSIAN

Informal Patient Payments in Central and Eastern European Countries

SUMMARY

Out-of-pocket patient payments are a major source of health care funding in Central and Eastern European (CEE) countries. They take different forms, e.g. formal co-payments, quasi-formal charges and informal patient payments. Formal co-payments are regulated by national legislation and quasi-formal charges are set by the health care provider in the absence of clear government regulations. Informal payments (also known as “under-the-table” or “envelope” payments) comprise all unregistered patient payments for publicly-funded health care services. Informal patient payments claim more attention as ignoring these payments causes underestimation of total health expenditure and their hidden nature imposes a great challenge to health care provision in terms of accessibility as well as accountability and transparency. Overall, a huge variety in the nature and patterns of informal patient payments is reported across countries. Studies provide evidence on the variation in informal payment type (cash or in-kind gifts given by patients or their families), timing (before, after or during service provision), subject (out- or in-patient service), purpose (obtaining better quality or access), and motivation (physician’s request or patient’s initiative). As recent cross-country studies on informal patient payments are lacking, this dissertation enhances our understanding of informal patient payments by comparing their scale and pattern across CEE.

The general background of the dissertation presented in **Chapter 1** describes the escalation of the phenomenon of informal patient payment, its effects on health care provision and the reasons for its existence. In particular, empirical evidence suggests that informal patient payments affect the health care system in a complex and interrelated manner. Their impact on health care provision is revealed at the macro (system) level as they impede health care reforms, and at the micro (service) level by creating barriers to adequate care. Indeed, informal patient payments can distort policies that aim to improve efficiency and equity in the health care sector. At first sight both providers and informal payers benefit from the informal exchange. However, the allocation of public resources is also affected by the individual willingness to pay informally, not just the social value of the use of these resources. Most important however, informal patient payments distort equity since patients who cannot afford to pay informally might be deprived from adequate health care.

A few decades ago, informal patient payments were considered as mostly a socio-cultural phenomenon ('gratitude money'). Currently, multi-dimensional explanations, such as insufficient resources (low income of physicians) and inadequate governance (poor political-regulatory context) combined with the socio-cultural reasoning, prevail in the literature. These three dimensions are rather interwoven leading jointly to the existence of a specific pattern of informal patient payments in a country.

Previous studies suggest that informal patient payments are a key characteristic of nearly all CEE health care systems. Although empirical studies underline the need to eradicate informal patient payments due to their negative effects, these studies mostly focus on single countries and mainly on the scale and determinants of these payments. Consumer perceptions are rarely considered even in single-country studies. Therefore, this dissertation aims to study informal payments for health care services in CEE countries and to compare the level, scope and consumer's perceptions of informal patient payments in the region. The focus of the thesis is placed on six CEE countries at different stage of social and economic development - Bulgaria, Hungary, Lithuania, Poland, Romania, and Ukraine. These countries present an interesting context for a cross-country comparison given the past similarities in their health care sectors during the communist period, as well as the different pace of health care reforms during the transition.

With the objective to provide a base for the empirical analyses in this dissertation, **Chapter 2** systematically reviews previous studies on informal patient payments. The review has been carried out in 2010 and included English-language publications that report on empirical studies measuring informal patient payments. In total, 31 publications have been identified as relevant. The content of the publications is analyzed qualitatively to identify methodological difficulties in studying informal patient payments.

From a methodological perspective, the review suggests that informal payments for health care services are most often investigated in studies involving patients or the general public, but providers and officials are also sample units in some studies. The majority of the studies apply a single mode of data collection that involves either face-to-face individual interviews or group discussions. Overall, self-administrated questionnaires are seldom used as a research instrument. However, this mode is usually preferred when the subject matter is sensitive. Still, face-to-face interviews are considered the most adequate approach in obtaining a high response rate and do not require strong cognitive efforts of respondents to answer the questions.

One of the main methodological difficulties reported in the publications, concerns the inability of some respondents to distinguish between formal and informal payments. Therefore it is not surprising that we observe a variety of operational definitions of informal patient payments used in the studies. Most studies refer to the unique feature of informal patient payments of being unregistered (no official receipt of payment) and taking place outside the official payment channels. However, two opposite concepts of these payments emerge in the literature: “bribe” and “gratitude” or “fee-for-service” and “donation”. To distinguish truly gratitude informal payments that have practically no impact on health care service provision, from other types of informal payments (bribes) that undermine the functioning of the health care system, an operational definition of informal patient payments that reflect the key characteristics of these payments, is required. In our review, we outline these key characteristics and argue that they should be considered in cross-country comparisons instead of a universal definition. In particular, we suggest that researchers should not only aim to study the amount of the informal patient payment, but should also answer the question who is the initiator of the payment (consumer or provider), who pays (patient or family), and who is the beneficiary (individual provider, team of providers or institution). Also, the nature (monetary or not), moment (ex- or post-ante), purpose (obtaining better quality or access), and subject (out-patient or in-patient, surgery or laboratory tests) of the informal payment should be considered.

Last but not least, the key characteristics of informal patient payments studied, should also include the perceptions and attitudes towards these payments, which may vary within and across countries. Evidence on perceptions and attitudes towards informal patient payments may play an essential role in developing and implementing adequate strategies for dealing with these payments. In view of this, Chapter 3 and Chapter 4 focus on this issue.

In **Chapter 3**, we compare public attitudes, perceptions and opinions on informal patient payments in the six CEE countries mentioned above. The data for the analysis were collected in July 2010 in identical household surveys conducted simultaneously in Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine. A national representative multi-staged stratified random sample was drawn in each country. The objective was to have 1000 completed face-to-face interviews based on a standardized questionnaire per country. In Chapter 3, we analyze the data on public attitudes, perceptions and opinions collected in the country surveys. We apply cluster analysis to identify meaningful groups of respondents. Three cluster analyses are carried out each using one group of perception variables: (1) attitudes towards cash informal payments and in-kind gifts; (2) perceptions of informal

payments as corruption or gratuity; (3) opinions about the acceptability of informal patient payments. Based on the three cluster analyses, three variables indicating cluster membership per respondent are created and regressed in ordinal regression analysis to investigate the association between the cluster membership variables and a set of independent variables such as country variables, individual and household socio-demographic characteristics, and past experience with informal payments.

Irrespective of the country, we observe consistent negative attitudes towards informal cash payments. Also, informal cash payments are overall perceived as corruption, which is evidence of their social undesirability. The attitudes towards in-kind gifts are less negative and more mixed. These payments are more often perceived as gratitude than informal cash payments. More positive perceptions of informal payments in general are observed among those who have ever given in-kind gifts rather than those who have ever paid informally in cash. This difference in perceptions regarding informal cash and in-kind payments is reported in previous studies as well, and it confirms the importance of distinguishing between the two types of payments in policy analysis and research.

Furthermore, we observe cross-country differences. In particular, public perceptions in some countries (especially in Poland but also in Bulgaria) are less in favor of informal patient payments than in other countries (especially in Hungary and Ukraine). The less positive attitudes and perceptions towards informal patient payments in Poland can be attributed to the successful anti-corruption policies supported by mass-media and relatively better governance in the country than in neighboring countries.

In **Chapter 4**, we examine the association between informal payments for health care services (actual behavior) and perceptions of health care consumers about paying informally (perceived behavior statements) as well as socio-demographic characteristics. The chapter analyzes data collected in the same country surveys described for Chapter 3. In particular, respondents are asked to confirm, deny, or express ambiguity about five perception statements that indicate individual acceptance or willingness to pay informally for health care (e.g. feeling uncomfortable when leaving the physician's office without a gratitude payment, or being unable to refuse to pay informally if asked). In addition to data on respondents' perceptions about making informal patient payments and socio-demographic data, informal patient payments for health care services by users during the last 12 months are also reported. Both in-kind gifts and cash payments are included in the wording of the question when respondents are asked about the size of informal payments during the last 12 month. We carry out binary regression analysis where the actual behavior of making informal patient payments

is the dependent variable while individual perceptions about making informal payments and socio-demographic features are taken as independent variables.

The results of the cross-country comparison in Chapter 4 suggest that health care users in Bulgaria and Poland are less inclined to make informal payments, while health care users in Romania and Ukraine most often report such payments. The informal payment rates for Hungary and Lithuania fall between these two groups. In all six countries, individuals who feel uncomfortable when leaving the physician's office without a gratuity and who feel unable to refuse the request of medical staff to pay informally, more often make informal payments. Also, it should be pointed out that the statistical significance of the relations reported in regression analyses in Chapter 4 varies among the countries, which indicates a dissimilar explanatory power of the consumer perceptions depending on the country. This underlines the importance of country-specific strategies for dealing with informal patient payments

When we compare the association of perceived behavior statements and socio-demographic features with actual behavior of making informal payments to health care providers, we find a lower relevance of socio-demographic characteristics compared to perceived behavior. Indeed, the behavioral pattern of making informal patient payments is mostly associated with patient's perception statements while socio-demographic features play minor role in explaining this pattern. Specifically, we observe that those who feel uncomfortable to leave without a gratitude payment and who feel unable to refuse to pay informally if asked, more often report making informal payments than the rest of the respondents. Hence, policy-makers should develop strategies on informal patient payments elimination taking into account the importance of these personal constructions

With the objective to examine the level and patterns of informal patient payments in CEE, **Chapter 5** studies informal patient payments in Bulgaria, Hungary and Ukraine. The chapter examines in detail the variation in informal patient payments with regards to the country and year of occurrence, type of service used, the purpose and initiator of the payment. The data are collected based on national representative samples. The data collection is finalized after having about 1000 and 800 effective interviews per country in 2010 and 2011 respectively. In 2010 and 2011, respondents are asked about their consumption and expenditure (total and informal) on out- and in-patient health care services during the preceding 12 months. For informal patient payments, respondents are asked to include both cash payment and the value of in-kind gifts. Socio-demographic data are surveyed as well in both years. In 2011, more detailed information is collected on payments for the last visit to a physician and last hospitalization, including type of care, size of formal and informal

payments, purpose and mechanism of the informal payment, as well as payments for other goods (e.g. medical supplies, pharmaceuticals, bed linen, food) that the patient brought for the treatment.

The results of the cross-country comparison suggest a relatively higher prevalence of informal patient payments in Hungary and Ukraine than in Bulgaria, where patients also meet formal service charges in the public sector. More than 35% of health care users in Ukraine report informal payments for physician visits during the preceding 12 months in addition to widespread quasi-formal payments. In Hungary, this share is more than 20% while in Bulgaria it is less than 10%. Regarding hospitalizations, the percentage of service users who report informal payments is also higher in Hungary and Ukraine (more than 40%) and lower in Bulgaria (10-20%). We do not observe major differences in the magnitude of the annual informal payments across the two years.

Informal payments are more spread and higher when they are solicited or expected by providers. However the relatively high prevalence of informal patient payments in Hungary does not follow this logic since informal payments in Hungary are mostly initiated by the consumers. A considerable number of informal payers (also in Hungary) report ‘better attention’ and ‘better quality’ as the main reasons of informal payment. Furthermore, the probability and the size of the informal payment is to a great extent determined by the type of service consumed (GP or specialist, out-patient or in-patient care). The trend of a higher number of users who make more expensive informal payments to specialists when compared to GPs remains noticeable. It is similar for surgery and childbirth compared to other hospital interventions.

The quantitative results presented in Chapter 5 also suggest that the number of payers and the amounts paid (including informal payers) are highest for hospitalizations related to childbirth or pregnancy. For example, in Hungary and Ukraine, about half of the in-patients report informal payments for pregnancy or delivery, although the median value of these payments is about 70 – 100 euro while total payment is about two – three times higher.

Given the peculiarities of obstetric services and taking into account the UN millennium development goals, we had a deeper look on the informal payments and its behavioral patterns related to childbirth. Therefore, **Chapter 6** provides results on a qualitative study on maternity care conducted in the capital of Ukraine that explores the experience of consumers and providers with informal payment for childbirth. Insufficient data on maternity care provision in CEE countries (also in Ukraine) have drawn our attention to the qualitative aspects of the process of informal payments. We have applied the method of

ethnographic study that enables us to learn more about local specificity of human behavior related to the process and nature of informal patient payments for childbirth. The data on informal patient payments for this study were collected in Kiev, in the period of December 2008 - April 2009. We relied on qualitative research methods, namely face-to-face semi-structured interviews. Three groups of respondents were included: key informants (experts), young mothers and obstetricians. The method of convenience sampling was used in case of key informants and mothers, while obstetricians were included based on the snow-ball sampling method. In total, twenty respondents participated in the study: eleven women who gave birth during the last two years; six obstetricians who worked in Kiev maternity hospitals; and three key-informants.

The results suggest there are two groups of patients in the Ukrainian maternity care ward: “individual patients” who have found a “personal obstetrician” before the childbirth and agreed with the obstetrician the childbirth services and related payments, and “emergency room patients” who do not have a “personal obstetrician” though they may still pay a variety of charges. We have also found two push-factors that lead to a search for a “personal obstetrician” in Ukraine: the need for twenty-four-hours access to reliable information and the need for psychological comfort during the childbirth. Thus, gaining better “service wrapping” (reliable information, better attention, responsiveness) against the background of feelings of anxiety is seen by patients as a strategy to avoid “substandard care”.

The obstetricians in our qualitative study were quite open about the redistribution of the informal payments among medical staff as well as the use of money to buy pharmaceuticals and to maintain physicians’ wards. As a result, informal payments not only add to the salary of the obstetricians but also to the salary of other staff and to the budget of the hospital facility. In fact, the low salary of medical staff was indicated by both obstetricians and mothers in our study as the main cause for the existence of informal payments. Thus, informal payments remain an unregulated tool that ensures extra payments to health care providers when adequate reimbursement policies are lacking.

Finally, **Chapter 7** summarizes the main findings of the studies presented in the dissertation, discussion on limitations of the methods and results, its policy implications as well as concluding remarks. The research described in this dissertation suggests that attitudes and perceptions of informal patient payments and their patterns vary significantly among the CEE countries. Negative, positive and indifferent public attitudes exist simultaneously, solicited payments are present together with gratitude payments, though the proportion of these contrasting categories differs in the region. Variations in regulatory mechanisms,

availability of alternatives to informal payments as a means for achieving better quality and access, and level and sources of funding can explain the cross-country diversity. It presents key added value of the dissertation.

Meanwhile, the devotion to accepting, giving and relying on informal patient payments observed in the CEE region can become a great obstacle in introducing health care reforms in any of the countries. Thus, strategies for dealing with informal patient payments and their causes are urging. As was indicated in Chapter 1, informal patient payments can be jointly explained by the performance of the health care system as well as by the social culture, overall economic development and governance in the country. These four dimensions are placed in a PRECEDE – PROCEED model for developing a comprehensive policy agenda for the elimination of informal patient payments. Indeed, the model provides the possibility to bring together all constructs relevant to the understanding of a behavior and to evaluate the implementation of the intervention. The application of the model for the elimination of informal patient payments is suggested.

Overall, the ability of the government to ensure a good performance of the public sector in general and of the health care sector in particular, is seen as a key factor for avoiding shadow practices. However, so far, political decision-making in the CEE region has been mostly based on the interests of business (the medical elites in case of health care) without considering evidence-based strategies and public opinions. This impedes real positive changes in public service provision regardless of the policy goals stated by the CEE governments. Therefore, changes in governments and international organization interventions may give a stimulus to improve governance and the culture of management of all public sectors. The ultimate challenge for CEE policy-makers is to realize that when informal patient payments appear in health care, it also aggravates the health and wealth of the nation.

Informele betalingen van patiënten aan de gezondheidszorg in Centraal- en Oost-Europese landen

Samenvatting

Eigen betalingen (out-of-pocket payments) van patiënten aan de gezondheidszorg dragen aanzienlijk bij aan de financiering van de gezondheidszorg in Centraal- en Oost-Europese landen. Er zijn verschillende vormen van eigen betalingen te onderscheiden, zoals een formele eigen bijdrage die is vastgesteld door de overheid, schijnbaar formele kosten die bepaald worden door de zorgverlenende instelling bij gebrek aan nationale wetgeving op dat gebied en de informele betalingen van patiënten aan een de zorginstelling. Onder deze informele betalingen worden alle ongeregistreerde betalingen van patiënten aan door de overheid gefinancierde diensten in de zorgsector verstaan. Het buiten beschouwing laten van deze informele en verborgen betalingen leidt tot een onderschatting van de totale uitgaven in de gezondheidszorg en brengt de toegang tot, het afleggen van rekenschap en de transparantie van de gezondheidszorg in het geding.

In hoofdstuk 1 wordt besproken hoe de informele betalingen zijn geëscaleerd, wat de effecten van informele betalingen zijn op het leveren van diensten in de gezondheidszorg en waarom deze informele betalingen bestaan. Enkele decennia geleden werden informele betalingen nog gezien als een sociaal-cultureel fenomeen (een uiting van dankbaarheid). Vandaag de dag duiken er in de literatuur multi-dimensionale verklaringen op zoals financieringstekorten en slecht bestuur in combinatie met sociaal-culturele factoren. Deze drie dimensies zijn nauw verweven en leiden gezamenlijk tot een specifiek patroon van informele betalingen van patiënten aan de gezondheidszorg in een land.

Voorgaande studies suggereren dat informele betalingen karakteristiek zijn voor bijna alle Centraal- en Oost-Europese (COE) zorgsystemen. Empirische studies richten zich vooral op de schaal en de determinanten van de informele betalingen in afzonderlijke landen terwijl de percepties van de zorgconsumenten nauwelijks worden meegenomen.

Dit proefschrift bestudeert informele betalingen aan de gezondheidszorg in verschillende Centraal- en Oost-Europese landen, en vergelijkt de reikwijdte, het niveau, en de percepties van de zorgconsumenten over deze betalingen in de regio. De focus van het proefschrift ligt op zes COE landen in verschillende stadia van sociale en economische ontwikkeling – Bulgarije, Hongarije, Litouwen, Polen, Roemenië en Oekraïne. Het feit dat

deze landen een vergelijkbaar socialistisch verleden hebben en tegelijkertijd een verschillende ontwikkeling hebben doorgemaakt in de gezondheidszorghervormingen in de post-Sovjet periode, maakt de vergelijking tussen de verschillende landen interessant.

Hoofdstuk 2 legt een basis voor de empirische analyses in dit proefschrift en evalueert systematisch voorgaande studies over informele betalingen van patiënten. In totaal zijn 31 Engelstalige publicaties gebaseerd op empirisch onderzoek geïdentificeerd als zijnde relevant. De inhoud van de publicaties is geanalyseerd om de methodologische moeilijkheden waar het de studie van informele betalingen betreft te identificeren. De evaluatie van de bestaande literatuur laat zien dat het fenomeen informele betalingen het meest aan bod komt in studies over patiënten of het brede publiek, alhoewel er ook studies zijn waar zorgverleners en zorgfunctionarissen aan bod komen. De meerderheid van de studies maakt gebruik van een unieke set van data die gegenereerd zijn door persoonlijke interviews of groepsdiscussies. Schriftelijke enquêtes worden zelden gebruikt terwijl dit een gebruikelijke methode is wanneer het onderzoek gevoelig ligt bij de doelgroep. Persoonlijke interviews waarborgen een hoge respons en vragen weinig cognitieve competenties van de geïnterviewden om de vragen te kunnen beantwoorden, met name als het gaat om onderzoek dat moeilijk in te kaderen is.

Om betalingen die uitingen van dankbaarheid zijn (die nauwelijks invloed hebben op het zorgsysteem) te kunnen onderscheiden van andere vormen van informele betalingen (zoals steekpenningen die het functioneren van de gezondheidszorgsector ondermijnen) is een operationele definitie van informele betalingen vereist. Deze definitie moet de belangrijkste karakteristieken van informele betalingen weerspiegelen. Onderzoekers zouden niet alleen oog moeten hebben voor het aantal informele betalingen, maar zouden ook antwoord moeten vinden op de vraag wie het initiatief tot betalen neemt (de consument of de zorgverlener), wie er betaalt (de patiënt of zijn familie), en wie de begunstigde is (de individuele zorgverlener, een team van zorgverleners of een instituut). Ook moet er rekening gehouden worden met het soort betaling (in cash of niet), het moment van betaling (voor of na de verlening van zorg), het doel van de betaling (om toegang tot zorg of een betere kwaliteit van zorg te krijgen), en het onderwerp van de betaling (een poliklinische patiënt of een interne patiënt, voor een operationele ingreep of laboratorium testen). Als laatstgenoemde, maar daarom niet minder belangrijk, moeten de percepties van en opvattingen over deze informele betalingen die binnen en tussen landen kunnen verschillen, in ogenschouw worden genomen. Bewijsbare kennis van percepties en opvattingen kunnen een essentiële rol spelen in de ontwikkeling en

implementatie van adequate strategieën om deze betalingen het hoofd te kunnen bieden. Hoofdstuk 3 en 4 zullen hier over gaan.

In hoofdstuk 3 worden de standpunten, opvattingen en meningen ten aanzien van informele betalingen in de bovengenoemde Centraal- en Oost-Europese landen met elkaar vergeleken. De data zijn verzameld in juli 2010 door middel van identieke onderzoeken onder huishoudens die gelijktijdig uitgevoerd werden in Bulgarije, Hongarije, Litouwen, Polen, Roemenië en Oekraïne. In ieder land werd een nationaal representatieve getrapte en gestratificeerde steekproef genomen. Het doel was 1000 volledige individuele interviews te verkrijgen op basis van een gestandaardiseerde enquête per land. In hoofdstuk 3 worden de data betreffende standpunten (positief of negatief), opvattingen (betaling in cash of in natura wordt gezien als corruptie of dankbaarheid), en meningen over de redenen en behoefte om informele betalingen stop te zetten, geanalyseerd in een clusteranalyse om zinvolle respondentengroepen te identificeren. Vervolgens worden drie variabelen, die bepalen tot welk cluster een respondent behoort, door middel van een ordinale regressieanalyse gerelateerd aan een set van onafhankelijke variabelen zoals land, sociaal-demografische karakteristieken van individuen en huishoudens en eerdere ervaringen met informele betalingen. Ongeacht het land worden de consistente negatieve standpunten en opvattingen dat informele betalingen een vorm van corruptie zijn geïnterpreteerd als een bewijs van de sociale onwenselijkheid van informele betalingen.

De verschillen die er tussen landen bestaan suggereren dat de publieke opinie in sommige landen (vooral in Polen maar ook in Bulgarije) minder positief is over informele betalingen dan andere landen (zoals Hongarije en Oekraïne). Meer positieve opvattingen over informele betalingen worden vaker geobserveerd bij degenen die ooit een betaling in natura hebben gedaan dan bij diegenen die ooit een betaling in cash hebben gedaan. Dit verschil in opvattingen wat betreft informele betalingen in natura en in cash komt ook in andere studies naar voren en het bevestigt het belang om een onderscheid te maken tussen deze twee soorten van informele betalingen in beleidsanalyses en –onderzoek.

In hoofdstuk 4 worden de link tussen informele betalingen aan de gezondheidszorg en de opvattingen van zorgconsumenten over deze betalingen (waargenomen verklaringen van gedrag) alsmede sociaal-demografische karakteristieken, onderzocht. In het hoofdstuk worden dezelfde data geanalyseerd die uit de onderzoeken beschreven in hoofdstuk 3 voortgekomen zijn. Aan de respondenten wordt gevraagd om vijf verschillende opvattingen te bevestigen dan wel te ontkennen, of neutraal te antwoorden, die de bereidheid tot het doen van een informele betaling aanduiden (bijv. zich ongemakkelijk voelen wanneer er na een

doktersbezoek geen betaling uit dankbaarheid wordt gedaan of niet in staat zijn een verzoek tot een informele betaling te weigeren). De resultaten van de vergelijking tussen de verschillende landen laat zien dat zorgconsumenten in Bulgarije en Polen minder geneigd zijn informele betalingen te doen, terwijl zorgconsumenten in Roemenië en Oekraïne het vaakst dergelijke betalingen melden. In alle zes landen doen zorgconsumenten die zich ongemakkelijk voelen als ze na een doktersbezoek geen informele betaling doen of als ze niet in staat zijn een verzoek tot een informele betaling te weigeren, vaker informele betalingen. Ook moet worden genoemd dat de statistische significantie van de relaties die aangetoond worden in de regressieanalyses in hoofdstuk 4 tussen de landen varieert. Dit onderstreept het belang van landenspecifieke strategieën om de informele betalingen aan te pakken.

Hoofdstuk 5 heeft als doel het niveau en de patronen van informele betalingen aan de gezondheidszorg in Centraal- en Oost-Europa te onderzoeken. Variaties in informele betalingen met betrekking tot het land en het jaar waarin deze voorkomen, het type zorg dat is gebruikt, het doel en de initiatiefnemer van de betaling, worden uitgebreid onderzocht. De data zijn verzameld aan de hand van nationaal representatieve steekproeven in de grootte van 800-1000 interviews per land in respectievelijk 2010 en 2011. Het resultaat van de vergelijking tussen de landen laat een hogere prevalentie van informele betalingen in Hongarije (20%) en Oekraïne (35%) zien dan in Bulgarije (9%). Informele betalingen zijn hoger en wijder verspreid wanneer zij worden verzocht of verwacht door de zorgverlener. Desalniettemin verklaart dit niet de relatief hoge prevalentie van informele betalingen in Hongarije waar zij meestal het initiatief zijn van de zorgconsument. Een aanzienlijk aantal informele betalers (ook in Hongarije) geeft aan ‘meer aandacht’ en ‘betere kwaliteit’ te krijgen als reden waarom zij informele betalingen doen. Daarnaast wordt de waarschijnlijkheid en de grootte van de informele betalingen voor een groot deel bepaald door het type zorg dat geleverd wordt (huisarts of specialist, poliklinische patiënt of een interne patiënt). Er is een trend zichtbaar van een groter aantal gebruikers dat meer betaalt aan specialisten dan aan huisartsen. Dit geldt ook voor chirurgie en verloskunde in vergelijking met andere zorgdomeinen. De kwantitatieve resultaten die gepresenteerd worden in hoofdstuk 5 laten ook zien dat het aantal betalers en de hoogte van de bedragen het grootst zijn voor interventies gerelateerd aan zwangerschap en bevallingen. In Hongarije en Oekraïne bijvoorbeeld, meldt de helft van de ondervraagde interne patiënten dat zij informele betalingen hebben gedaan voor interventies gerelateerd aan zwangerschap en bevallingen. De mediaanwaarde van deze betalingen is tussen de 70 en 100 euro terwijl de totale kosten die de patiënt moet betalen 2 tot 3x hoger is.

Een nadere beschouwing van informele betalingen en bijbehorende gedragspatronen gerelateerd aan bevallingen wordt gepresenteerd in hoofdstuk 6, waar de resultaten uit eerdere hoofdstukken en de millennium ontwikkelingsdoelen besproken worden. Een kwalitatieve, etnografische studie in Kiev onder twintig respondenten (11 vrouwen die in de twee jaar voor het interview zijn bevallen, 6 verloskunde-artsen die werken in kraamklinieken in Kiev, en 3 sleutelinformanten) die persoonlijk zijn geïnterviewd door middel van semi-gestructureerde interviews, laat zien dat er een onderscheid gemaakt kan worden tussen twee verschillende groepen patiënten in de kraamkliniek. Zo zijn er ‘individuele patiënten’ en ‘patiënten op de eerste hulp’ die geen persoonlijke verloskunde-arts hebben maar mogelijk wel diverse kosten moeten betalen. Twee push-factoren leiden naar de wens voor een ‘persoonlijke verloskunde-arts’: de behoefte aan 24 uren-toegang tot betrouwbare informatie en de behoefte aan psychologisch comfort tijdens de bevalling. Tegen een achtergrond van bezorgdheid wordt het verkrijgen van een betere service (betrouwbare informatie, aandacht, ontvankelijkheid) door patiënten gezien als een strategie om ondermaatse zorg te vermijden. Daarnaast dragen informele betalingen niet alleen bij aan het salaris van de verloskunde-artsen maar ook aan de salarissen van andere medewerkers en aan het ziekenhuisbudget. Feitelijk zijn de lage salarissen van het medisch personeel voor de verloskunde-artsen en de moeders in het onderzoek de belangrijkste reden voor het bestaan van informele betalingen. Wanneer een adequaat vergoedingsbeleid ontbreekt, zijn informele betalingen een niet gereguleerd hulpmiddel van de patiënten om de zorgverlening te verbeteren.

Hoofdstuk 7 bevat de belangrijkste resultaten van de dissertatie, waaronder implicaties voor beleid, een discussie over de beperkingen, en een conclusie. Het onderzoek beschreven in deze dissertatie laat zien dat standpunten en opvattingen over informele betalingen sterk variëren tussen de COE landen. Negatieve, positieve en onverschillige publieke houdingen bestaan naast elkaar; verzoeken om betalingen en betalingen uit dankbaarheid komen gelijktijdig voor, alhoewel de proporties kunnen verschillen in de regio. Variaties in regulerende mechanismen, de aanwezigheid van alternatieven in plaats van informele betalingen om betere kwaliteit van en toegang tot zorg te verkrijgen, en het niveau en de oorsprong van de gelden verklaren de diversiteit tussen de landen. De meerwaarde van deze dissertatie ligt in het groot aantal landen dat mee wordt genomen ter vergelijking, het verduidelijken van de relaties tussen de ervaringen met informele betalingen en de standpunten van de respondenten en de karakteristieken van de verleende zorg.

Tegelijkertijd kan acceptatie van informele betalingen en het feit dat men er op rekent in de COE landen een obstakel vormen voor veranderingen in de gezondheidszorg.

Strategieën om de informele betalingen een halt toe te roepen zijn daardoor noodzakelijk. Een belangrijke factor hierin is het vermogen van de regeringen een sterke publieke sector en gezondheidszorgsector te waarborgen. Veranderingen in regeringen en interventies vanuit internationale organisaties kunnen het bestuur en de managementcultuur van alle publieke sectororen verbeteren.

Неформальні платежі пацієнтів в країнах Центральної та Східної Європи

Анотація

Платежі пацієнтів за медичну допомогу з власної кишені є основним джерелом фінансування охорони здоров'я в країнах Центральної та Східної Європи. Такі платежі пацієнтів існують в різних формах, наприклад, формальні платежі, які регулюються національним законодавством, а також квазі-формальна оплата, що встановлюється надавачами медичних послуг за відсутності виразно визначених національних норм. Доповнюють цей перелік платежів і неформальні витрати з кишені пацієнтів, які включають в себе всі незареєстровані платежі пацієнта за медичну допомогу, що фінансується державою. Такі незареєстровані сплати потребують особливої уваги, оскільки ігнорування неформальних платежів породжує недооцінку загальних витрат на систему охорону здоров'я, а їх прихований характер робить проблематичною доступність і прозорість надання медичної допомоги.

У розділі 1 дисертації подано загальну характеристику неформальних платежів пацієнтів, розвиток цього явища, причини та наслідки існування неформальних платежів. Зокрема, наголошується, що кілька десятиліть тому, неформальні платежі пацієнтів розглядали здебільшого як соціально-культурне явище. Нині ж у літературі переважає багатовимірний підхід до розуміння цього явища, а саме пояснення з позицій браку ресурсів, а також належного врядування, які поєднані з соціально-культурними особливостями. Ці три виміри неформальних платежів пацієнтів та переплетіння цих вимірів є досить унікальними для кожної окремо узятій країни та формують неповторну картину.

Попередні дослідження свідчать, що неформальні платежі пацієнтів є важливою складовою майже всіх систем охорони здоров'я країн Центральної та Східної Європи (далі – ЦСЄ). Емпіричні ж дослідження неформальних платежів пацієнтів переважно зосереджені на окремо узятих країнах і здебільшого на масштабах та детермінантах цих платежів, тоді як сприйняття споживачів вивчається вкрай рідко, навіть у дослідженнях в одній країні. Таким чином, мета цієї дисертації – вивчення неформальних платежів за медичну допомогу, співставлення рівня, масштабу таких платежів, ставлення споживачів до них у країнах ЦСЄ. Основну увагу в дисертації приділено шістьом країнам ЦСЄ, які перебувають на різних етапах соціально-економічного розвитку – Болгарії, Угорщині, Литві, Польщі, Румунії та Україні. Ці країни являють собою

цікавий приклад для порівнянь з урахуванням, з одного боку, подібності їхніх секторів охорони здоров'я в минулому, в соціалістичний період, а іншого – різних темпів реформи системи охорони здоров'я в пост-соціалістичний час.

Для обґрунтування дизайну емпіричного аналізу, здійсненого в дисертації, в розділі 2 зроблено систематичний огляд попередніх досліджень неформальних платежів пацієнтів. Загалом, 31 англomовна публікація, в якій йдеться про емпіричні дослідження, була ідентифікована як така, що відповідає умовам пошуку. Зміст публікацій проаналізовано на предмет виявлення методологічних труднощів у вивченні неформальних платежів пацієнтів. Огляд свідчить, що неформальні платежі за медичну допомогу досліджують переважно з позицій пацієнтів чи загального населення, в деяких дослідженнях одиницями вибірки стають посадові особи й надавачі послуг. Більшість досліджень звертається до одного способу збору даних – особистих чи групових інтерв'ю. Такий інструмент дослідження як самозаповнювана респондентом анкета застосовують зрідка, хоча саме такому методу мала б бути надана перевага в дослідженнях на сенситивну тематику. І все ж таки особисті інтерв'ю вважають найадекватнішим методом у разі, коли виникає потреба в отриманні малої кількості відмов від участі в дослідженні і не вимагається висока інтелектуальна діяльність респондентів при відповіді на питання, особливо за умов невизначеного явища. Для того, аби відрізнити неофіційний платіж як справжню подяку, що практично не впливає на характер наданої медичної допомоги, від інших типів неформальної оплати (хабарів), які підривають функціонування системи охорони здоров'я, варто звернутися до робочого визначення неформальних платежів пацієнтів, в якому відображено ключові характеристики. Зокрема, в дисертаційному дослідженні припускається, що дослідники повинні не лише мати на меті вивчення розміру неофіційних платежів пацієнта, а й відповісти на питання: хто є ініціатором платежу (споживач або надавач), хто саме сплачує (пацієнт або його сім'я), хто є отримувачем (індивідуальний надавач послуг, група провайдерів чи ж установа). Окрім того, мають бути враховані такі риси неформальної оплати, як природа (грошова чи ні), момент сплати (до чи після допомоги), мета (отримання кращої якості або доступу) і предмет оплати (амбулаторна або стаціонарна допомога, хірургічне втручання чи лабораторний тест). Останнім, але не менш важливим моментом вивчення характеристик неформальних платежів пацієнтів мають також бути сприйняття і ставлення до цих платежів, які можуть варіюватися залежно від країни. Сприйняття і ставлення до неофіційних платежів пацієнта може відігравати важливу роль у розробці та реалізації адекватних стратегій,

спрямованих на розв'язання цієї проблеми. З огляду на важливість суспільного ставлення та сприйняття в політичному контексті розділи 3 та 4 зосереджені на цих аспектах.

У розділі 3 суспільна думка відносно неформальних платежів, ставлення громадськості до них і сприйняття порівнюються на прикладі країн ЦСЄ, про які йшлося вище. Дані для аналізу були зібрані в липні 2010 року в ідентичних дослідженнях домогосподарств, проведених одночасно в Болгарії, Угорщині, Литві, Польщі, Румунії та Україні. Національна репрезентативна багатоступінчаста стратифікована випадкова вибірка була застосована в кожній країні з метою проведення 1000 завершених особистих інтерв'ю на основі стандартизованої анкети. У розділі 3 в кластерному аналізі по чергово застосовані дані щодо громадського ставлення (позитивного чи негативного), сприйняття (на оплату готівкою чи на подарунок в натуральній формі вішається ярлик корупції чи подяки) і наостанок громадська думка про причини явища і потребу викорінення неформальних платежів. Після виявлення змістовних груп, три змінні, в яких зазначено членство респондента в кластері, проаналізовані як залежні змінні в регресійному аналізі з тим, щоб вивчити зв'язок між кластерним членством і набором незалежних соціально-демографічних характеристик, попереднім досвідом неформальної сплати за медичну допомогу. Порівняння між досліджуваними країнами виявило, що скрізь спостерігається переважно негативне ставлення і сприйняття неформальних платежів готівкою як корупції, що свідчить про соціальну небажаність цього явища. Порівняння між країнами ЦСЄ вказують на те, що в деяких країнах (особливо в Польщі, але також і у Болгарії) сприйняття суспільством неформальних платежів є менш прихильним порівняно з іншими (особливо в Угорщині та Україні). Більш позитивне ставлення до неформальної оплати за медичну допомогу в цілому спостерігається серед тих, хто має досвід дарування подарунків, і в меншій мірі серед тих, хто має досвід неформальної оплати грошима. Така різниця в сприйнятті неформальних платежів у натуральній та грошовій формах помічена і в попередніх дослідженнях, що підтверджує важливість відокремлення цих двох форм оплати в політиці і в дослідженнях.

У розділі 4 особливу увагу приділено вивченню зв'язку між здійсненням неформальної оплати за медичну допомогу (реальна поведінка) і сприйняттям неформальної оплати пацієнтами (твердження щодо можливої уявної поведінки), з урахуванням соціально-демографічних характеристик респондентів. В цьому розділі проаналізовані дані, зібрані за тією ж методологією, про яку йшлося в розділі 3.

Респондентів просили підтвердити, спростувати або висловити невпевненість щодо п'яти тверджень, які вказують на особистісне сприйняття або готовність платити неформально за медичну допомогу (приклад твердження – пацієнт почувається некомфортно, коли виходить з кабінету лікаря без прояву вдячності; пацієнт не може відмовити на прохання персоналу сплатити неформально). Результати порівнянь між країнами ЦСЄ доводять, що болгарські та польські пацієнти виявляють меншу схильність до здійснення неофіційних платежів пацієнтів, в той час як респонденти з Румунії та України частіше звітують про такі випадки. У всіх шести країнах люди, які відчують себе ніяково, якщо лишають кабінет лікаря без «подяки», а також які вважають, що неспроможні відмовити на прохання медичного персоналу платити неформально, частіше вдаються до практики неформальної оплати. Окрім того, варто зазначити, що статистична значущість зв'язків отриманих в регресійному аналізі у Розділі 4 варіюються між країнами. Це доводить важливість розробки стратегії, спрямованої на викорінення неформальних платежів пацієнтів у конкретній країні з урахуванням важливості таких особистих установок.

Враховуючи завдання роботи – виявити рівень і особливі риси неформальних платежів пацієнтів у ЦСЄ – у розділі 5 неформальні платежі пацієнтів вивчено на прикладі Болгарії, Угорщини та України. Досліджено різноманіття неформальних платежів пацієнтів залежно від країни і років, в які здійснювалася оплата, від різновиду медичної допомоги, від мети та ініціатора оплати. Дані були зібрані в 2010 і в 2011 роках (в межах національних репрезентативних вибірок, розмір яких близько 1000 і 800 завершених інтерв'ю відповідно). Порівняння між країнами виявили відносно високу поширеність неформальних платежів пацієнтів в Угорщині (20%) і України (35%), аніж в Болгарії (9%). Неформальні платежі вищі й більш поширені, коли вони вимагаються чи очікуються надавачами послуг. Тим не менше, відносно висока поширеність неформальних платежів пацієнтів в Угорщині є виключенням з такої логіки, оскільки там неформальна сплата здебільшого ініційована пацієнтами. Значна кількість неформальних оплат (Угорщина не виняток) має на меті отримати «більше уваги» чи ж «кращу якість». Більше того, імовірність здійснення і розмір неформального платежу значною мірою визначається різновидом спожитої медичної допомоги (лікар загальної практики чи спеціаліст, амбулаторна чи стаціонарна допомога). Так, помічено більшу кількість пацієнтів, які здійснюють високі неформальні сплати за спеціалізовану медичну допомогу на відміну від допомоги, наданої лікарем загальної практики. Аналогічна ситуація спостерігається і у разі хірургічного втручання та пологів у

порівнянні з іншими втручаннями, зробленими в стаціонарі. Кількість платників і сплачені суми (зокрема неформально) є найвищими у випадках госпіталізації, пов'язаної з пологами або вагітністю. Наприклад, в Угорщині та Україні близько половини пацієнтів стаціонару повідомляють стосовно здійснення неформальної сплати під час вагітності чи пологів, і хоча середнє значення цих платежів становить близько 70 – 100 євро, загальна сума платежу є вдвічі-втричі вищою за неформальну.

Зважаючи на отримані у дисертаційному дослідженні результати та Цілі тисячоліття ООН у розділі 6 представлено детальніший погляд на неформальні платежі та поведінкові моделі, пов'язані з народженням дитини. Результати якісного етнографічного дослідження, проведеного в Києві (особисто опитано двадцять респондентів, зокрема, одинадцять жінок, які народили протягом останніх двох років, шість акушерів-гінекологів, які працюють в київських пологових будинків; і три ключових інформанти), – дають підстави виокремити дві групи пацієнтів у пологових будинках: «приватні пацієнти» та «по швидкій». Останні не мають «індивідуального акушер-гінеколога», хоч вони можуть здійснювати різноманітні платежі. Було виявлено два фактори, які мотивують майбутніх батьків до пошуку «приватного акушер-гінеколога»: потребу в цілодобовому доступі до надійного джерела інформації та необхідність психологічного комфорту під час пологів. Таким чином, спроба отримати найкращу «обгортку послуги» (перевірену інформацію, більше уваги та чуйність) на тлі почуття тривоги сприймається пацієнтами як стратегія, що дає змогу уникнути «допомоги, яка не відповідає стандартам». Крім того, неформальна оплата з кишені пацієнта не лише виступає доповненням до зарплати акушерів-гінекологів, а й до зарплат інших співробітників, так само як і до бюджету лікарняного закладу. Справді, низька заробітна плата медичного персоналу в дослідженні вказується як акушерами-гінекологами, так і матерями як основна причина існування неформальних платежів. Таким чином, за відсутності адекватної політики нарахування заробітної плати, неформальні платежі виявляються інструментом в руках деяких пацієнтів, який дозволяє впливати на «обгортку» отриманої допомоги.

Розділ 7 узагальнює основні результати дослідження, представленого в дисертації, пропонує можливості використання результатів цієї роботи в політиці, а також містить обговорення обмежень і прикінцеві зауваження. Дисертаційне дослідження припускає, що ставлення і сприйняття пацієнтами неформальних платежів, а також картина платежів пацієнтів істотно різняться між країнами ЦСЄ. При цьому одночасно виявляються негативне, позитивне і байдуже громадське ставлення,

оплата на вимогу наявна разом з платежами-вдячністю, хоча частка цих контрастних категорії різниться в регіоні. Відмінності між країнами ЦСЄ можуть бути пояснені багатоманіттю регуляторних механізмів, наявністю альтернатив неофіційним платежам як засобу для отримання доступу до послуги чи її кращої якості, а також рівнем та джерелами фінансування. Основна ж цінність дисертації полягає в тому, що залучено велику кількість країн для порівняння й розуміння зв'язків між досвідом оплати і ставленням респондентів як і особливістю наданої послуги.

Тим часом, прихильність до отримування, надання та покладання на неформальні платежі пацієнтів, що спостерігається в країнах ЦСЄ, можуть стати істотною перешкодою під час реформування систем охорони здоров'я в кожній із країн. Таким чином, стратегії, спрямовані на розв'язання проблеми неформальних платежів пацієнтів та причин їхнього існування, мають бути пріоритетом в порядку денному урядів країн. Загалом, здатність уряду забезпечити належну роботу структур державного сектора в цілому і сектора охорони здоров'я, зокрема, розглядають як ключову передумову для запобігання тіньових практик. Зміни в державному управлінні та залучення міжнародних організацій можуть стати стимулами для покращення врядування та управлінської культури у всіх державних секторах.

Неформальные платежи пациентов в странах Центральной и Восточной Европы

Аннотация

Платежи пациентов за медицинскую помощь из их собственного кармана являются основным источником финансирования здравоохранения в странах Центральной и Восточной Европы. Такие платежи пациентов существуют в различных формах, например, формальные платежи, регулируемые национальным законодательством, и квази-формальная оплата, устанавливаемая поставщиками медицинских услуг при отсутствии четко установленных национальных норм. Дополняют этот список неформальные платежи пациентов, включающие в себя все незарегистрированные платежи пациента за медицинскую помощь, финансируемую государством. Такие незарегистрированные оплаты требуют особого внимания, поскольку игнорирование неформальных платежей порождает недооценку общих затрат на систему здравоохранения, а их скрытый характер делает проблематичной доступность и прозрачность предоставления медицинской помощи.

В разделе 1 диссертации подано общую характеристику феномена неформальных платежей пациентов, развитие этого явления, причины и последствия существования неформальных платежей. В частности отмечается, что несколько десятилетий назад неформальные платежи пациентов рассматривались преимущественно как социально-культурное явление. Теперь в литературе преобладает многоаспектный подход к пониманию этого явления, а именно объяснение с позиций нехватки ресурсов, а также надлежащего управления, неразрывно связанных с социально-культурными особенностями. Эти три измерения неофициальных платежей пациентов и переплетения этих измерений достаточно уникальны для каждой отдельно взятой страны и формируют неповторимую картину.

Предыдущие исследования показывают, что неформальные платежи пациентов являются важной составляющей многих систем здравоохранения стран Центральной и Восточной Европы (далее – ЦВЕ). Эмпирические же исследования неформальных платежей пациентов в основном сфокусированы на отдельно взятых странах и в основном на масштабах и детерминантах этих платежей, тогда как восприятие потребителей изучается крайне редко, даже в исследованиях в одной стране. Таким образом, цель данной диссертации – изучение неформальных платежей за медицинскую помощь, сравнение уровня, масштаба таких платежей, отношения

потребителей к ним в странах ЦВЕ. Основное внимание в диссертации уделяется шести странам ЦВЕ, находящимся на разных этапах социально-экономического развития – Болгария, Венгрия, Литва, Польша, Румыния и Украина. Эти страны представляют собой интересные примеры для сравнений с учетом, с одной стороны, сходства их секторов здравоохранения в прошлом, в социалистический период, а с другой – различных темпов реформы системы здравоохранения в пост-социалистическую эпоху.

Для обоснования эмпирического анализа, произведенного в диссертационном исследовании, в разделе 2 сделан системный обзор предыдущих исследований неформальных платежей пациентов. В целом 31 англоязычная публикация, в которой идет речь об эмпирических исследованиях, была идентифицирована как соответствующая условиям поиска. Содержание публикаций проанализировано на предмет выявления методологических трудностей в изучении неформальных платежей пациентов. Обзор показывает, что неформальные платежи за медицинскую помощь исследуются преимущественно с позиций пациентов или общего населения, в некоторых исследованиях единицами выборки становятся также должностные лица и поставщики услуг. Большинство исследований обращается к одному методу сбора данных – личным или групповым интервью. Такой инструмент исследования как самозаполняемая респондентом анкета применяется редко, хотя именно такой метод обладает преимуществом в исследованиях на чувствительную тему. И все же личные интервью считаются наиболее адекватным методом, когда есть потребность в получении малого количества отказов от участия в исследовании и не требуется высокая интеллектуальная деятельность респондентов при ответе на вопрос, особенно в условиях неопределенного явления, существующего в четких границах. Для того, чтобы отличить неофициальный платеж как настоящую благодарность, практически не влияющую на характер оказываемой медицинской помощи, от других типов неформальной оплаты (взятки), подрывающих функционирование системы здравоохранения, следует обратиться к рабочему определению неформальных платежей пациентов, в котором отображаются их ключевые характеристики. В данной диссертации предполагается, что исследователи должны не только иметь целью изучение размера неофициальных платежей пациента, но также должны ответить на следующие вопросы: кто является инициатором платежа (потребитель или провайдер), кто именно платит (пациент или его семья), кто является бенефициаром (индивидуальный провайдер, группа провайдеров или учреждение). Кроме того, такие черты неформальной оплаты как природа (денежная или нет), момент оплаты (до или

после помощи), цель (получение лучшего качества или доступа) и предмет оплаты (амбулаторная или стационарная помощь, хирургическое вмешательство или лабораторный тест) должны быть учтены. Последним, но не менее важным моментом изучения характеристик неформальных платежей пациентов должны также быть восприятие и отношение к этим платежам, которые могут варьироваться в зависимости от страны. Восприятие и отношение к неофициальным платежам пациента может играть важную роль в разработке и реализации адекватных стратегий, нацеленных на решение этой проблемы. Учитывая важность общественного отношения и восприятия в политическом контексте, раздел 3 и раздел 4 сосредоточены на этих аспектах.

В разделе 3 общественное отношение относительно неформальных платежей, восприятие общественности и мнения пациентов сравниваются на примере стран ЦВЕ, о которых говорилось выше. Данные для анализа были собраны в июле 2010 года в идентичных исследованиях домохозяйств, проведенных одновременно в Болгарии, Венгрии, Литве, Польше, Румынии и Украине. Национальная репрезентативная многоступенчатая стратифицированная случайная выборка была применена в каждой стране с целью проведения 1000 завершенных личных интервью на основе стандартизированной анкеты. В разделе 3 в кластерном анализе поочередно применены данные относительно общественного отношения (положительного или отрицательного), восприятия (на оплату наличными или на подарок в натуральной форме вешается ярлык коррупции или благодарности) и напоследок общественное мнение о причинах явления и потребность искоренения неформальных платежей. После обнаружения содержательных групп три переменные, в которых указано членство респондента в кластере, проанализированы в качестве зависимой переменной в регрессионном анализе с тем, чтобы изучить связь между кластерным членством и набором независимых как социально-демографических характеристик, так и с предыдущим опытом неформальной оплаты за медицинскую помощь. Во всех странах наблюдается преимущественно негативное отношение и восприятие неформальных платежей наличными как коррупции, что свидетельствует о социальной нежелательности этого явления. Сравнения между странами ЦВЕ указывают на то, что в некоторых странах (особенно в Польше, но и в Болгарии) восприятие обществом неформальных платежей является менее благосклонным по сравнению с другими (особенно в Венгрии и Украине). Более позитивное отношение к неформальным платежам за медицинскую помощь в целом наблюдается среди тех, кто имеет опыт дарения подарков, и в меньшей степени среди тех, кто имеет опыт неформальной

оплаты деньгами. Такая разница в восприятии неформальных платежей в натуральной и денежной формах замечена и в предыдущих исследованиях, что подтверждает важность отделения этих двух форм оплаты в политике и в исследованиях.

В разделе 4 особое внимание уделено изучению связи между осуществлением неформальной оплаты за медицинскую помощь (реальное поведение) и восприятием неформальной оплаты пациентами (утверждение о возможной мнимой поведения) с учетом социально-демографических характеристик респондентов. В этом разделе проанализированы данные, собранные по той же методологии, о которой говорилось в разделе 3. Респондентов просили подтвердить, опровергнуть или выразить неуверенность в пяти утверждениях, указывающих на личностное восприятие или готовность платить неформально за медицинскую помощь (пример утверждения – пациент чувствует некомфортно, когда выходит из кабинета врача без проявления благодарности или же пациент не может отклонения просьбы персонала оплатить неформально). Результаты сравнений между странами ЦВЕ сравнений показывают, что болгарские и польские пациенты проявляют меньшую склонность к совершению неофициальных платежей пациентов, в то время как респонденты из Румынии и Украины чаще отчитываются о таких случаях. Во всех шести странах люди, чувствующие себя неловко, если оставляют кабинет врача без «благодарности», а также считающие, что могут отказать в просьбе медицинского персонала платить неформально, чаще прибегают к практике неформальной оплаты. Кроме того, следует отметить, что статистическая значимость связей, полученных в регрессионном анализе в разделе 4, варьируется между странами. Это подчеркивает важность разработки стратегии, нацеленной на искоренение неформальных платежей пациентов в конкретной стране с учетом важности таких личных установок.

Учитывая задачи работы – выявить уровень и особые черты неформальных платежей пациентов в ЦВЕ – в разделе 5 неформальные платежи пациентов изучаются на примере Болгарии, Венгрии и Украины. Исследовалось многообразие неформальных платежей пациентов в зависимости от страны и года, в которые производилась оплата, от типа медицинской помощи, от цели и инициатора оплаты. Данные были собраны в 2010 и в 2011 годах (рамках национальных репрезентативных выборок, размер которых составляет около 1000 и 800 завершённых интервью соответственно). Сравнения между странами выявили относительно высокую распространенность неформальных платежей пациентов в Венгрии (20%) и Украине (35%), чем в Болгарии (9%). Неформальные платежи выше и более распространены, когда они требуются и

ожидаются поставщиками услуг. Тем не менее, относительно высокая распространенность неформальных платежей пациентов в Венгрии является исключением из такой логики, поскольку там неформальная оплата в основном инициируется пациентами. Значительное количество неформальных оплат (Венгрия не исключение) имеет целью получить «больше внимания» или же «лучшее качество». Более того, вероятность осуществления и размер неформального платежа в значительной степени определяется типом потребленной медицинской помощи (врач общей практики или же специалист, амбулаторная или стационарная помощь). Так, замечено большее количество пациентов, осуществляющих высокие неформальные оплаты за специализированную медицинскую помощь в отличие от помощи, предоставленной врачом общей практики. Аналогичная ситуация замечена и в случаях хирургического вмешательства и при родах по сравнению с другими вмешательствами, сделанными в стационаре. Количество плательщиков и уплаченной суммы (в том числе неформально) являются самыми высокими в случаях госпитализации, связанной с родами или беременностью. Например, в Венгрии и Украине, около половины пациентов стационара сообщают об осуществлении неформальной уплаты во время беременности или родов, и хотя среднее значение этих платежей составляет около 70 - 100 евро, общая сумма платежа является в два - три раза выше неформальной.

Учитывая полученные результаты и Цели тысячелетия ООН, в разделе 6 представлено более глубокое изучение неформальных платежей и поведенческих моделей, связанных с рождением ребенка. Результаты качественного этнографического исследования, проведенного в Киеве (лично опрошено двадцать респондентов, в частности, одиннадцать женщин, родивших в течение последних двух лет, шесть акушеров-гинекологов, работающих в киевских роддомов, и три ключевых информанта), позволяют выделить две группы пациентов в родильных домах: «частные пациенты» и «по скорой». Последние не имеют «индивидуального акушера-гинеколога», хотя они могут осуществлять различные платежи. Было выявлено два фактора, мотивирующие будущих родителей к поиску «частного акушера-гинеколога»: потребность в круглосуточном доступе к надежному источнику информации и необходимость психологического комфорта во время родов. Таким образом, попытка получить лучшую «обертку услуги» (проверенную информацию, больше внимания и отзывчивость) на фоне чувства тревоги воспринимается пациентами как стратегия, позволяющая избежать «помощи, не отвечающей установленным стандартам». Кроме того, неформальная оплата из кармана пациента не только выступает дополнением к

зарплате акушеров-гинекологов, но и к зарплатам других сотрудников, так же как и в бюджет лечебного учреждения. Действительно, низкая заработная плата медицинского персонала в исследовании указывается как акушерами-гинекологами, так и матерями как основная причина существования неформальных платежей. Таким образом, при отсутствии адекватной политики начисления заработной платы, неформальные платежи являются инструментом в руках некоторых пациентов, который позволяет влиять на «обертку» получаемой помощи. .

В завершение раздел 7 обобщает основные результаты исследования, представленного в диссертации, предлагает возможности использования результатов данной работы в политике, а также содержит обсуждение ограничений и заключительные замечания. Диссертационное исследование предполагает, что отношение и восприятие пациентами неформальных платежей, а также картина платежей пациентов существенно отличаются между странами ЦВЕ. При этом одновременно проявляются отрицательное, положительное и безразличное общественное отношение, оплата по требованию сосуществует вместе с платежами–благодарностью, хотя доля этих контрастных категорий различается в регионе. Различия между странами ЦВЕ могут быть объяснимы многообразием регуляторных механизмов, наличием альтернатив неофициальным платежам как средства для получения доступа к услуге или ее лучшего качества, а также уровнем и источниками финансирования помощи. Основной ценностью диссертации является привлечение большого количества стран для сравнения, понимания взаимоотношений между опытом оплаты и отношением респондентов как и особенностью предоставляемой услуги.

Между тем приверженность к получению, предоставлению и опора на неформальные платежи пациентов, что наблюдается в странах ЦВЕ, могут стать существенными препятствиями в ходе реформирования систем здравоохранения в каждой из стран. Таким образом, стратегии, направленные на решение проблемы неформальных платежей пациентов и причин их существования, должны быть приоритетом в повестке дня правительств стран. В общем, способность правительства обеспечить надлежащую работу структур государственного сектора в целом и сектора здравоохранения, в частности, рассматривается как ключевая предпосылка для предотвращения теневых практик. Изменения в государственном управлении и привлечение международных организаций могут стать стимулами для улучшения менеджмента и управленческой культуры во всех государственных секторах.

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CURRICULUM VITAE

Tetiana Stepurko (maiden name Chernysh) was born on March 13th, 1984, in Vinnitsa, Ukraine. After graduating from secondary school at Vinnitsa Technical Lyceum in 2000, she moved to Kiev and started her studies in Sociology at the National University of Kyiv-Mohyla Academy (NaUKMA) in the same year. In 2004 and 2006, she finished her bachelor and master studies respectively at the Department of Sociology, Faculty of Social Science and Social Technology, NaUKMA. In parallel to this, she worked as a program and project manager at the School of Public Health (SPH), NaUKMA since 2004 till 2008. She has been a teacher in the Research Methods course since 2006 and supervisor of master theses at SPH. Later, the course of Social Structure and Social Dynamics has become taught by her as well. Tetiana joined the FP7 ASSPRO CEE 2007 project in 2008 by becoming a PhD student at the Department of Health Services Research, Maastricht University as well as at SPH, NaUKMA. She had been also involved in research projects of School of Public Health, e.g. Gender Assessment of Health Care Services in Ukraine funded by Swiss Cooperation Office in Ukraine. As well as she participated in the projects of the Kiev International Institute of Sociology, e.g. 'Evaluation of Stop TB in Ukraine Programme' and 'TB Social Mobilization and Community Involvement in Ukraine' funded by WHO as well as 'Governance in Health Care in Ukraine' funded by World Bank.

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