

13 Informal Payments in Health Care

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ABSTRACT

Informal payments in health care exist in many countries around the world. However, the prevalence of informal payments varies between countries. A distinction between illegal or unethical informal payments like bribes and corruption, and legal and ethical forms of informal payment like giving gifts is not always easy to make. Illegal and unethical practices include, for example, buying medical certificates, bid rigging during procurements, or selecting service-providers for a hospital based on personal connections. A conceptual global definition of informal payments in health care is not feasible because informality depends on local regulations, values, and traditions. In this chapter, we provide an up-to-date understanding of informal payments in health care (including corruption, fraud etc.) by distinguishing micro, meso, and macro levels of informal payments. We argue that informal payments that occur at these levels cannot be unified under one umbrella of corruption because the various forms of informal payments in health care differ in nature, scope, and damaging effects.

Key words: Informal patient payments; informal provider payments; gifts; bribes; corruption; code of conduct

What are Informal Payments in Health Care?

Patients who show their appreciation to medical doctors for successful treatment outcomes through gifts of different natures, medical doctors who buy their positions at health care facilities, tender committees that receive kickbacks for procurements, families of medical students who resort to exchange of favors with medical university staff, to get a diploma (with honors) – all these and more are examples of informal practices in health care reported in many countries around the world. Informal payments are informal practices with a clear connotation of exchange of monetary or nonmonetary resources for personal benefits.

As in many other sectors – not only in health care – informal payments are sometimes labelled as fraud, corruption, bribery, kickbacks, and payoffs (European Commission, 2013; Grødeland & Aasland, 2007; Lewis & Pettersson, 2009). Hussain (2014, p. 21) defines fraud as “... any act or omission, including a misrepresentation, that knowingly or recklessly misleads, or attempts to mislead, a party to obtain a financial or other benefit or to avoid an obligation.” A well-known definition of corruption as “the use of a public function for a private gain” (The World Bank, 1997, p. 8) is reformulated by Rose-Ackerman (1998 cited by De Dios and Ferrer, 2001, p. 2) as “an illegal payment to a public agent to obtain a benefit that may or may not be deserved in the absence of pay-offs.” The key features of corruptive actions are that they are illegal, unethical, and inefficient (i.e., waste funds): “corruption is bad thing” and “concrete steps should be taken to curb it” (Bukanovsky, 2002, p. 2), therefore anticorruption policies and measures are on the global and countries political agenda.

There are also informal payments that are more difficult to label as corruption. An example is gift-giving (Abbasi & Gadit, 2008; Morris & Polese, 2014; Spence, 2005; Stepurko, Pavlova, Gryga, & Groot, 2013), which is typically seen as ingrained in social or professional culture norms or traditions. Gifts are perceived as more positive than bribes and kickbacks. For example, while kickbacks for public procurements or bribes for obtaining a medical license are a form of corruption, a food basket given by a thankful patient to the medical doctor after a successful treatment is seen as a gift, and is therefore socially acceptable. However, the distinction between corruption and a culture of

gift-giving is sometime quite ambiguous especially when gifts are given on request of the care provider or are expected by the provider. This implies that there is a gray area in between the two poles of informal payments (Morris & Polese, 2014), corruption and gift-giving. Compiling a conceptual global definition of informal payments in health care is difficult because informality is constructed by local regulations, values, and traditions (Werner, 2002). The lack of regulation (including poor sector-specific policies or weak rule of law) and a moral disposition in society like “everything that is not forbidden is allowed,” may facilitate the existence of informal payments in general and more particularly in the health care sector. Thus, the patterns of informal payments in one country partly reflect gaps in the governance structures or in the system of public service provision.

There is a variety of definitions of informal payments for health care services collected by Cherecheș, Ungureanu, Sandu, and Rus (2013) – they occur in patient–physician relations and the subject of these payments is treatment, diagnostics, or even health care goods provided. Informal payments in other subareas of the health care domain (at the level of institutional and individual providers, e.g., “buying” job positing; at the level of purchaser and non-clinical service provision) are rarely defined and studied.

The health and health care domains have characteristics that distinguish the nature of informal payments there. In contrast to other goods and services, health care consumers do not directly buy health as they buy cars or the services of a hairdresser or even choose a university to study in. Indeed, health care services are mostly used when the person feels ill, when time and the pressure of other resources (information, finances) do not allow the individual to make an independent decision. The health care sector differs from other sectors firstly because physicians have information about the disease and treatment, which the patient lacks (asymmetric information), and secondly this professional information is linked to the amount of services recommended to the patient, for example, tests, drugs, specialist consultations, or interventions where the patient cannot take independent decisions (lack of consumer sovereignty). Also, in most health care systems, physicians control the access to care and patients cannot access (highly) specialized health care services without a referral. These peculiarities of health and health care may lead to an (unintended) exploitation of users and payers by health care providers, especially when the policies, codes of conduct, and its

monitoring do not adequately regulate the provision of health care services.

Health care services are frequently publicly financed and the system of their provision as well as governance play a crucial role in ensuring the welfare of the citizens (Gupta, Davoodi, & Tiongson, 2000; Lewis & Pettersson, 2009). Health care service provision involves not only consumers (patients) and providers, but also a number of additional actors, for example, the government, (quasi-governmental) regulators, suppliers of supplementary services and health care goods (devices, equipment, drugs), third-party payers (e.g., insurance funds, users, and their families; Savedoff, 2007). The various parties involved in health care service provision facilitate the multifaceted informal payments woven into their relations.

Among the illegal and unethical practices in informal payments in health care, that is, corruption, a sequence of negative effects on health and health care service provision can be noted (European Commission, 2013; Vian, 2008): inefficient use of health care budgets (higher prices for equipment and constructions, and purchases irrelevant to urgent patient needs), inequality in access to and low-quality of care received, impoverishment because of informal out-of-pocket expenditures, higher morbidity, and mortality rates. Vian (2008) classifies the types of informalities and corruption in health care as related to: (a) health care service provision, (b) medical research, (c) medical education, (d) procurement of health care goods and equipment, (e) the distribution of pharmaceuticals and medical devices etc. The Transparency International (TI) Global Corruption Report – Focus on Health, TI (2006, p. xviii) described several forms of corruption: (a) embezzlement and theft which refer to stealing health care goods or equipment, (b) corruption in procurement, (c) corruption in health payment systems, (d) corruption in the pharmaceutical supply chain, and (e) corruption at the point of health care delivery that includes payments made by either consumer or provider. We go beyond these classifications and approaches which are linked to a normative perspective to extend the area of informal payments investigation.

Often the functional side of informal payments in health care is ignored, for example, some people's needs are being met through informalities, we look into these functional aspects as well. For example, on the one hand, patients in a poorly governed system still seek adequate health care services and expect respectful behavior and good bedside manners, adequate

qualifications of health care providers, and the availability of adequate equipment. Frequently, goods have to be bought by informal payments. On the other hand, there are low-paid physicians who strive for additional sources of income and therefore demand and accept patients' "donations," provide private consultations on an informal payment basis, engage in unlawful collaboration with the pharmaceutical industry etc.

In this chapter, we provide an understanding of informal payments in health care (including corruption, fraud etc.), and discuss the available evidence, and the responses to informal payments in a specific context. We identify several levels of informal payments in health care: micro, meso, and macro levels. We argue that informal payments that occur at these levels, cannot be unified under one umbrella of corruption because informal payments in health care differ in nature, scope, and damaging effects. In order to illustrate this statement, the nature of informal payments at different levels of the health care systems is presented in the subsequent sections.

Informal Patient Payments – Microlevel

The micro level refers to the interactions between the patient and the health care provider. Here, gifts and bribes that health care consumers give to health care providers for better treatment and health care goods as well as for improved conditions of hospitalization are looked into.

The practice of small gifts (flowers, chocolates, wine) given by the thankful patient to the health care staff after service provision exists in many countries (Lewis, 2007). Such gifts are not typically expected by providers. Although it is recognized that 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 of adequate health care services (Dodge, 1978; Greenberg, 1990; Orentlicher, 1994). At first sight, both providers and informal payers benefit from the informal exchange. However, when giving expensive in-kind gifts to physicians in exchange for better or quicker services becomes a common practice and when informal cash payments appear, ethic and legal concerns and concerns about access to adequate health care start to emerge, that is, patients who cannot afford to pay informally might be deprived of adequate health care (Allin,

Davaki, & Mossialos, 2006; Barber, Bonnet, & Bekedam, 2004; Ensor & San, 1996).

Patient payments (or so-called “out-of-pocket payments”) can be a major source of health care funding. They take different forms, for example, formal copayments, quasiformal charges, and informal patient payments. Formal copayments are regulated by national legislation and quasiformal charges are set by the health care provider in the absence of clear government regulation. Informal payments (also known as “under-the-table” or “envelope” payments) comprise all unregistered patient payments for publicly funded health care services. A huge variety in the nature and patterns of informal patient payments exists across countries. Studies provide evidence for 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, Gotsadze, & Shahriari, 2004; Cockcroft et al., 2008; Delcheva, Balabanova, & McKee, 1997; Gaal & McKee, 2005; Lewis, 2002; Shishkin et al., 2003; Stepurko, Pavlova, Gryga, Gaal, & Groot, 2017; Thompson & Witter, 2000). High informal payments are observed in all patient groups irrespective of socioeconomic status (Belli, 2002; Falkingham, Akkazieva, & Baschieri, 2010; Tomini, Groot, & Pavlova, 2011).

In the past, patients in many countries brought in-kind donations for family doctors on a regular basis in order to show gratitude for their work (Gaal & McKee, 2005; Levene & Sireling, 1980). As Winslow noticed over 60 years ago, “the tribute from one ‘g.p.’ (the grateful patient) to another ‘g.p.’ (the general practitioner (GP)) is a supplement to – not a substitute for – an assured income” (Winslow, 1946, p. 316). Most obvious, in Western settings, 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, 2002; Williams, 2005). Health care reforms, most notably the introduction of universal and generous health insurance systems, which ensured a stable and adequate income for physicians, have also contributed to the elimination of informalities 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

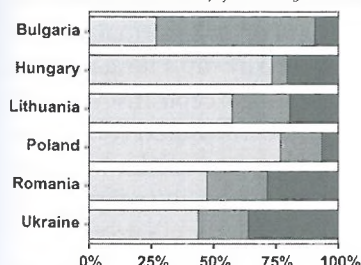
(Bass & Wolfson, 1980; Greenberg, 1990; Orentlicher, 1994). At the same time, informal patient payments flourished in some other regions (Lewis, 2007): Central and Eastern Europe (Lithuania, Moldova, Ukraine, Georgia), Central Asia (Kyrgyz Republic, Tajikistan), Eastern and Southern Asia (China, Pakistan, Bangladesh, Shri Lanka, Cambodia, Vietnam), Africa (Tanzania, Ghana), and South America (Colombia, Bolivia).

In 2010 a cross-country study on patient payments was conducted (Atanasova, Pavlova, Moutafova, Rechel, & Groot, 2013; Baji, Pavlova, Gulácsi, & Groot, 2011; Pavlova, Tambor, Stepurko, Merode, & Groot, 2012; Stepurko et al., 2013; 2017, Tambor, Pavlova, Woch, & Groot, 2011) in Central and Eastern European countries: Bulgaria, Hungary, Lithuania, Poland, Romania (EU countries), and Ukraine (non-EU country). Specifically, the level, scope, and consumer perceptions of informal patient payments were compared. These six countries are at different stages of social and economic development. In the past, they had similar health care sectors established during the communist period, while the last decades of transformation have resulted in health care reforms that are progressing at different paces.

The graphs below show the percentage of service users per country who paid for health care services within the preceding 12 months, as reported in the study. The highest share of service users who reported informal payments for out-patient service is observed in Ukraine and in Romania and much lower shares of informal payers are reported in Poland and in Bulgaria. In Hungary, a quite substantial share of out-patient service users who paid informally is found, however in contrast to other countries only 5.6% of them reported an inability to pay.

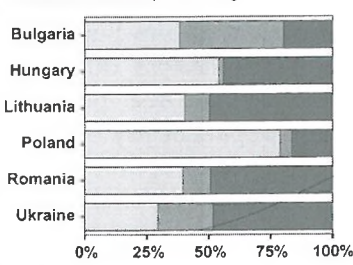
Payments for physician visits

Bars show % of those who visited a physician during the last 12 months



Payments for hospitalizations

Bars show % of those hospitalized during the last 12 months



- Did not pay
- Paid only formal charges
- Paid also informally

- Did not pay
- Paid only formal charges
- Paid also informally

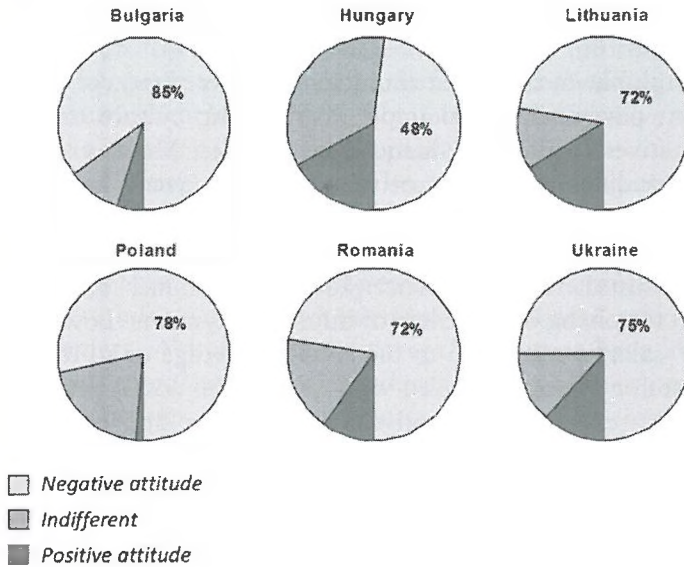
Concerning in-patient hospital services during the preceding 12 months, about half of inpatient service users paid informally for hospitalization in Lithuania, Ukraine, and Romania. However, 36.9% of in-patient service users in Romania and 44.3% in Ukraine were unable to pay for hospitalization in contrast to 23.7% in Lithuania. Poland has the lowest share of inpatient service users who paid informally whereas Hungary has quite a high share of service users who paid informally for inpatient care. The inability to pay is only minor (11.7%) in Hungary, which corresponds to the out-patient payment pattern (Tambor et al., 2014).

Informal payments are more widespread 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. The probability and the size of the informal payment are to a great extent determined by the type of service consumed (GP or specialist, out-patient or inpatient care). The trend of a higher number of users who make more expensive informal payments to specialist services compared to GP services is noticeable across the countries. Also informal patient payments for surgery and childbirth are higher compared to other hospital interventions.

Informal cash payments are generally perceived as corruption, which is evident of their social undesirability. In contrast, attitudes towards in-kind gifts are less negative and more mixed, and are more often perceived as signs of gratitude than informal cash payments are. More positive perceptions of informal payments in general are observed among those who have themselves given in-kind gifts rather than among those who have paid informally in cash. Furthermore, cross-country differences are observed: 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 anticorruption policies supported by mass-media and relatively better governance in the country than in neighboring countries. In general people in Central and Eastern Europe want a solution to the problem of informal patient payments, but failing that, often accepts these payments as a means to receive more attention, better quality, and quicker access when using health care services.

Attitudes towards informal cash payments for health care

Pies show % of actual and potential health care users



Systems of formal patient charges for health care services have been introduced in many countries (Barber et al., 2004; Tambor et al., 2011). However, formal charges do not replace 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) is accounted for in the design of the policies on official charges. Otherwise, preferences to pay unofficially continue to exist alongside formal patient payments (Baji et al., 2011; Baji, Pavlova, Gulácsi, & Groot, 2012). This may lead to a mixture of formal and informal patient payments, as is the case in Bulgaria (Atanasova et al., 2013). When providers are adequately remunerated and when public health care services are provided with adequate quality and access, the need for informal payments is reduced and patients are stimulated to use exclusively the official channels. The concern that official fees increase the burden for vulnerable population groups can only partly be diminished by exemption categories and charge reductions. Such mechanisms are actually lacking in so-called quasiformal patient payments

(“obligatory” charitable contributions, or other payments initiated by the facility level management which do not correspond with national user charge policies). This means that quasiformal charges are also not a suitable substitute for informal patient payments.

Multiple factors contribute to a higher share of informal patient payments, for example a gift-giving culture or lack of alternatives to publicly financed health care. However, chronic underfunding of health care and the subsequent low level of salary of personnel are typically seen as the most important challenge (Belli, 2001; Healy & McKee, 1997; Rechel & McKee, 2009; van Lerberghe, Conceição, Van Damme, & Ferrinho, 2002) to solving the problem of informal payments. 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 engage in informal payment arrangements.

Informal Payments at Health Care Facilities — Meso Level

The meso level refers to the level of the health care organization, and includes relations between different providers, providers and facility administration, as well as suppliers at the level of facility. At the meso level, we focus on the competences of health care managers and providers, the extent to which they promote good practices within the facility (organizational human resource policies, codes of conduct, etc.), as well as how they define organizational goals and assure their implementation. In practice, meso level issues, practices, matters are concerned with the performance and therefore the governance at the facility level.

In low-income settings, the quality of governance is of particular importance due to the scant resources and the need for their adequate allocation. Meanwhile, facility performance in a low-income setting is typically characterized by poorly paid medical personnel, improper state of buildings, and outdated equipment (Jain, Nundy, & Abbasi, 2014). Also, shortages in medical supplies are seen both as a direct result of underfunding and of the waste of funds during corruptive procurement procedures and inefficient management of resources. Therefore, various strategies for generating and investing informal income are observed

among physicians, for example, private consultations outside of the facilities, “private” practice at the public facility, collaboration with the pharmaceutical industry, etc. (Belli, Dzygyr, & Maynzyuk, 2015). These physicians’ revenues also appear to be a means for professional advancement, including informal purchase of job positions in prestigious hospitals (avoiding rural areas), ensuring career growth, obtaining administrative positions, and access to participation in paid training.

Informal provider payments also take place in generously financed and the “least corrupt” settings (Heidenheimer, 1996). Indeed, Godlee (2015) describes cases of medical embezzlement in the United States that are linked to the health insurance system as well as to informal provider payments for patients’ referral to private centers. Although “least corrupt” countries have implemented strict moral and ethical standards (Code of Ethics), penalties and sanctions for underperformance, bonuses for good practices, staff training, as well as participation in professional committees (Lewis, 2006), still, intended and unintended practices that affect health care efficiency and quality can have a systematic nature. The practice of inappropriate billing and inappropriate care is a good example of the ambiguous border between unintended mistakes in the billing and purposive fraudulent activity.

Inappropriate care and inappropriate billing in health care can be interpreted as a result of moral hazard. For instance, for a patient it could be relatively easy to simulate disease-like symptoms with the purpose of obtaining a prescription to sell drugs afterwards. In many cases, health professionals trust their patients and accept their claims. As a result, the insurance company is faced with increased costs. This is a typical example of a moral hazard, as the behavior is the result of the fact that the costs are shifted to others and neither the patient nor the provider suffers any direct financial risk and instead the insurance company takes the financial burden. For the case of the physician, patients trust that he or she will act on behalf of their interest and welfare. However, conflicts could occur when a medical doctor prescribes a service to the patient, while at the same time being the supplier of that service. Thus, the same person determines both demand and supply of services. For instance, the medical doctor might be driven by the profit motive to prescribe more services than medically necessary – one form of a fraudulent activity. Consequently, this results in an inefficiently high level of service utilization.

Evidence shows that patients are involved in fraudulent activities. Misrepresenting enrolment in insurance plans by using the insurance card of another person in order to access medical care, services, and treatment is one example. Other cases include claiming false exemptions from prescription copayments and other health care costs, trying to achieve refunds for service costs which were never incurred, selling prescriptions, drug trafficking, or registering with a range of physicians in order to receive prescriptions from each. The identification of such fraudulent activities engaged in by patients is difficult, as it concerns a rather small amount of money per case. However, the use of electronic health records and other databases have increased the chance of spotting outliers and potential fraudulent activities among patients.

Health care providers (physicians, nurses, and pharmacists) also may have different motives and opportunities to commit fraud, error, and abuse. Fraud on the providers' side can be divided into two main categories: inappropriate billing and inappropriate care. Whereas the first category is easily detectable and does not require medical proficiency for investigation, the second requires medical knowledge of efficient and effective medical practice and guidelines. Inappropriate billing can be further divided into two subcategories. The first subcategory includes billing or coding that is not in compliance with rules, such as up coding patients into a more complex case associated with a higher reimbursement. The second subcategory includes billing for services when health care was actually not provided, such as the creation of "phantom" patients for additional payments, and absentee providers claiming a salary (Wieninger, 2013).

Apart from the monetary stimuli for providers to improve performance, clear professional ethics standards are often defined in the Codes of Conduct in order to minimize the purposive abuse of the system. Since clinical standards do not protect patients adequately, organizational ethics is considered as sufficient to assure expedient behavior and relations at health care facilities (Silverman, 2000). The recent organizational culture has moved from "what you cannot do" to "what you should do" (Silverman, 2000, p. 203). Thus, in addition to laws and regulations, Codes of Ethics and Codes of Conducts are designed and implemented to regulate providers' behavior in many countries (Seedhouse, 2008). However, the monitoring and audit of performance and adherence to the standards are one of the most challenging issues in this context.

In the Netherlands health care fraud and abuse has long been ignored or downplayed. Increased media attention has put the issue more on the agenda. Examples of (suspected) fraud in health care in the Netherlands are diverse. Some examples illustrate this. In 2011, a dental clinic called Beperfect Clinics was found to have billed patients and health insurers several hundreds of thousands of euros for care that was not delivered (Zorgvisie, 2011). Almost a year later, the dental Eurosmile clinic was fined because of incorrect billing of treatment (Zorgvisie, 2012a). In June 2013 a large health insurer warned 1,100 patients from two dental practices about high billing practices by their dentist (Zorgvisie, 2013). In 2010 it was found that 15 dentists had falsely claimed the title orthodontist. They were registered as dentists, but recruited patients claiming to be an orthodontist because orthodontists are able to charge higher rates for their treatment than a dentist (Zorgvisie, 2010).

Besides dental fraud, dentists also cheat with the personalized budgets for long-term care. In 2012, three executives from a home care organization in Almere were arrested by the Dutch antifraud agency on suspicion of fraud with personalized budgets. The home care organization was suspected of fiddling with applications for personalized budgets and invoices (Zorgvisie, 2012b). In January 2014 the magazine *Skipr* reported that the police administration of a company in Maastricht which managed personalized budgets for clients had been confiscated. The company was suspected of large-scale financial fraud, forgery, and money laundering (Skipr, 2014a). On March 17, 2014 the same magazine reported that the care office in Zwolle suspected care organization Pivot of fraud and forgery with personalized budgets (Skipr, 2014b). Pivot was said to have forged signatures of clients and included these in their billing to the care office. Pivot had billed a lot more care than was actually delivered. Two days later – on March 19, 2014 – the same magazine reported two arrests in Dordrecht on suspicion of fraud with personalized budgets (Skipr, 2014c).

Fraud in home care also regularly makes the news. In June 2013, the former director of the home care organization Gooizorg was arrested on suspicion of fraud. He was said to have sent billed home care services to the health insurer that had never been delivered. In addition he billed at a higher rate than allowed (Trouw, 2013). In 2014 the Dutch Care Authority (Nza) fined the St. Antonius Hospital for incorrect billing for an

amount of 24.6 million euros, about 1% of annual turnover (Zorgvisie, 2014).

Thus, when clear quality standards are absent or when their application is not monitored, providers themselves may choose the attributes of the service to be offered to the patient, especially in a context of underfunding. 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 to be in a vulnerable position. Therefore, the role of regulators as well as professional bodies is to introduce and monitor clinical and related standards of care provided, where the system of compliance is one of the core elements of service improvement. These policies need to be supported by informational campaigns in order to inform the patients about their rights and responsibilities.

Informal Payments and Health Policy Making – Macro Level

The framework for health care activities is established at the macro level, which is the level of regional or national policy-making that identifies the roles of the health care system actors and influences their behavior. For example, although informal patient payments originate at the micro level, the predisposing factors for these payments can be found at meso- and macro levels. At these levels, there is less ambiguity in defining corruption. When the relations of public officials involve monetary aspects it is often defined as corruption (as most countries regulate “public servant” behavior, including cash or gift exchange), however favoritism and nepotism (nonmonetary, less tangible exchanges) appear in the gray zone of informal payments. Still, procurement of health care goods is often considered as a “goldmine,” especially in environments where fraud and corruption are widespread, are not much stigmatized or prosecuted.

The supply of health care inputs (pharmaceuticals and medical devices for example) can be significantly affected by fraudulent activities. One major impact is on the price of such inputs. When there is a lack of a price control policy, the purchasing

price of health care inputs can be artificially increased if the parties involved can gain personal benefits from such deals (e.g., through kickbacks). If patients have to pay or co-pay for these inputs and are not able to pay the high price, their access will be blocked and they may seek low-cost alternatives. The search for cheaper alternatives may bring them in direct contact with suppliers of counterfeit drugs and substandard medical devices outside the formal health care system. This may well be the case when people choose to purchase pharmaceuticals and medical devices through unregulated online channels. In fact the development of e-commerce may simplify the spread of counterfeit products.

Fraud and corruption related to the purchasing of health care inputs may also impact the quality of health care services at a facility level if the shortcomings of the purchased products are unintentionally or intentionally overlooked. The latter can be motivated by the engagement of health care staff in fraudulent activities for private returns. In this way, counterfeit drugs and substandard medical devices may enter the health care system. Fraud and corruption in the supply of health care inputs may also impact the access to health care services. For example, the waste of scarce resources due to fraud and corruption might push health care staff to demand informal payments and thereby, people who cannot afford to pay extra might have limited or no access to care. Thus, although indirectly, as a result of fraud and corruption, the inequality in access to health care may increase and patients' health may be worsened.

At a national level, the lack of good governance in the health care sector results among other things in inadequate policy and vague regulations with regard to the supply of health care inputs. The most pronounced issue is the registration and inspection of new pharmaceuticals and medical devices entering the health care market. When the system of registration and inspection is not effective, counterfeit drugs and substandard medical devices find their way into the health care system. If the input product control is not sufficiently addressed in health policy, the supply chain processes in the health care facilities are negatively affected leading to malpractice and fraudulent behavior. Another weak point is the regulation regarding the wholesalers of pharmaceuticals and medical devices, especially if this regulation does not require transparency from wholesalers on a regular basis in terms of audits and inspections. Similarly to manufacturers of counterfeit products, wholesalers may also engage in the supply of

counterfeit products for extra profit when adequate policy and regulations are absent (Zidan, 2014).

Various forms of corruption can be associated with public procurements of medical devices and pharmaceutical products, including bribery, kickbacks, collusion, state capture, favoritism, and nepotism. Each phase of the public procurement process may offer opportunities for corruption. In the prebidding phase, the needs assessment, tendering procedure, and the tendering itself can be jeopardized due to corruption. For example, a tender can be written without an actual need, due to an agreement between the procurement official and a certain supplier/producer. It is also possible that the tender is written in a way that would only fit, or exactly fit, the offer of a certain bidder. A procurement official could have been bribed to engage in such behavior, or the official can do this as a favor for a relative (nepotism).

In the bidding phase, especially the bid evaluation can be prone to bribery and kickbacks as well as to favoritism and collusion. Procurement officials may be approached with bribes by one of the bidders, or a kickback has been prenegotiated to influence the decision-making process. It can also occur that in this phase the procurement official only has one bidder or other bids are not available or too bad, or simply too expensive, due to collusion amongst the bidders. These practices actively manipulate the procurement official's choice for contract awarding.

Even in the postbidding phase, false invoicing and changes of contract agreements may occur as a result of corruption. The corruption here may also occur in the form of bribery, where a procurement official is bribed to alter the contracts retrospectively in favor of the supplier or producer.

In public procurements especially, it is important to first carry out a needs assessment. Also, a check whether the procurement process is properly regulated and follows specific, predetermined and verifiable protocols, and whether the conditions for fair competition are being met, is advisable. The chance of corruption may increase if a tender is not publicized or has a very short deadline to ensure that only those who know of it are able to bid. In addition, lack of transparency and unified guidelines enables unjustified contract awarding and contract changes in hindsight. These corruptive activities abuse public resources allocated to procurements, as a part of these resources are used for personal gains. In some instances, such practices may have far-reaching consequences. Those consequences are usually financial losses and damage to social welfare, but can also affect patients'

health. This could be the case, for example, with poorly tested or unsafe drugs, procured and prescribed by bribed health professionals, affecting the health of patients of all age groups, including infants and children (Schipperges, 2014).

Moreover, the macro level is sensitive to institutional corruption, which is defined as systemic and strategic influences that distort institutions' effectiveness and performance through diverting it from its purpose and therefore jeopardizing expected system outcomes, "including, to the extent relevant to its purpose, weakening either the public's trust in that institution or the institution's inherent trustworthiness" (Lessig, 2013, p. 553). Numerous suggestions how to improve transparency in health care (anticorruption policies and actions) are available, for example, e-procurement system, monitoring of spending of funds and sanctioning improper practices, increase penalties for bribery, involving third parties (civil society) to the controlling bodies, implementation of country-level anticorruption policies, etc. (European Commission, 2013). The major obstacle to eliminating corruption is the lack of political will, or institutional corruption. Countries often start combating corruption after a change of political and governmental elites, that is, after parliamentary elections or new government appointment. However, international organizations can also foster anticorruption policies or at least can limit the areas for abuse while providing aid to low-income economies. Indeed, efficiency in health care funding as well as clear policies on service provision (e.g., basic package) or the development of standards cannot take place when political interest is lacking.

Conclusions

Informal payments in health care exist in many countries around the world. However the prevalence of certain types of informal payments varies between countries. Informal payments are the result of a multitude of factors, for instance the peculiarities of the health care system, its regulations and financial incentives play a part, as do the characteristics of the wider socio-political context, such as economic capacity, rule of law, culture of policy-making, traditions, and values. Indeed, informal patient payments are a key feature of the health care systems of Central and Eastern European countries as well as Eastern and Southern Asian countries. At the same time, while informal payments in

Western settings are less noticeable for citizens, cases of fraud in insurance systems and informal provider payments do in fact happen – even though their existence is sometimes ignored or not recognized. Informal payments in procurement (kickbacks and favoritism) seem to be present in most countries.

Corruption, widely stigmatized, and with a highly negative connotation is often taken out of the context by the media and is discussed from a normative perspective. For example, the Guardian offers titles like “Bribes for basic care in Romania” (The Guardian, 2008), or “Welcome to Ukraine, the most corrupt nation in Europe” (The Guardian, 2015). Western and often national media highlight cases of informal payments, or bribery, in developing countries suggesting punitive measures for illegal actions. However, the role of poverty and other socioeconomic circumstances are often disregarded. In this respect, “corruption” in the patient–provider relation in a context of scarce resources and “corruption” in procurement procedures differs in terms of scope of damage, illegality, and alternative solutions.

Informal payments can serve either as a means for individuals to increase individual welfare in low-income countries or as an additional source of goods or higher status in higher income countries. Informal practices can flourish with the political and economic changes in the country (especially those related to public services provision (e.g., in Hungary after introduction and then abolishment of formal patient payments), its accountability, and transparency) and with the collapse of restraints as, for instance, in the case of post-Soviet countries.

A variety of responses to informal payments in health care exist ranging from improvements in health care provision and financing to strengthening the role of the public in policy-making. However, a key obstacle to designing and implementing policies which would decrease undesirable behavior and effects of informal payments is the lack of motivation of policy-makers for such actions, which are frequently interwoven with other interests due to the fact that political, business, and medical elites are often connected (Radin, 2006). In political cultures where the passivity of the public is high there is low awareness of the complex negative effects of informal payments in health care and involvement of citizens in political life is at a minimum. This public inertia impedes actual positive changes in public service provision, regardless of the policy goals stated by governments. In the absence of good governance, patients in particular apply the

alternative politics of the “do-it-yourself” approach despite the difficulties that they experience in making informal payments.

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