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Informal Payments for Healthcare Services in Lithuania and Ukraine

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Informal payments for healthcare services

The healthcare systems of many European post-communist and post-Soviet countries have been considerably affected by informal patient payments (also known as 'under-the-table' or 'envelope' payments) (Chawla et al., 1998; Gaal et al., 2006; Stepurko et al., 2010). The definition of informal patient payments usually includes a cash or in-kind supplement to the official payment for healthcare services (Belli, 2002; Gaal et al., 2010) as well as payments for commodities, such as pharmaceuticals (Lewis, 2000). Additionally, informal payments take place outside the official payment channels (Lewis, 2007), and payers may not even know that they are making an informal payment if they are not well informed about official fees (Thompson and Witter, 2000). 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 behaviour. As a result, informal patient payments are typically not prosecuted. Besides, the healthcare sector is not unique in such behaviour. Informal payments are also seen in other areas, for example in education, police, court and customs offices (Miller et al., 1998; Polese, 2008). Thus, general moral dispositions in society such as 'everything that is not forbidden is allowed' may well predispose to the existence of informal payments in the healthcare sector.

Informal payments for healthcare services are of an unregistered and hidden nature, and comprise all unofficial patient payments for publicly funded healthcare services. They are examined as a type of out-of-pocket

payments. However, two other types of out-of-pocket payments – formal and quasi-formal payments – refer to official patient charges for public and private healthcare services that may accompany informal patient payments (Belli, 2002; Thompson and Witter, 2000). In particular, formal payments are regulated by national legislation, while quasi-formal payments are set by the healthcare provider in the absence of clear government regulations. Compared with formal and quasi-formal charges, informal patient payments claim more attention, as ignoring these payments causes an underestimation of total healthcare expenditure and their hidden nature imposes a great challenge to provision in terms of accessibility, accountability and transparency.

This chapter describes the features of informal patient payments in post-Soviet countries, with empirical evidence on cash and in-kind informal payments for health services from Lithuania and Ukraine. In the next section, background information on the consequences of informal patient payments and the prevalence and escalation of the problem is presented. This is followed by a section that outlines the context of the two post-Soviet countries – Lithuania and Ukraine – and provides recent empirical evidence on the scope and scale of informal patient payments in these countries as well as on the public attitudes towards informal payments. The final section concludes the chapter by discussing the key challenges in post-Soviet countries and strategies for the elimination of informal patient payments.

The impact of informal patient payments on the healthcare system

The impact of informal patient payments on healthcare provision is revealed at the macro (system) level as they impede reforms, and at the micro (service) level by creating barriers to adequate care. Indeed, informal patient payments distort policies aiming to improve the efficiency and quality of healthcare services. Although informal payments may help individual patients to obtain services with better quality (Mæstad and Mwisongo, 2011), there is no evidence that these payments significantly contribute to the improvement of clinical quality in the healthcare sector in general (Gaal and McKee, 2005). Moreover, informal payments may affect physicians' decisions on what services to provide and to whom. Parallel to the informal payment, however, physicians or the healthcare facilities receive a formal reimbursement (public funds) for services provided. Thus, the allocation of public resources is affected

by individual willingness to pay informally, not just by the social value of the use of these resources. In addition to allocative efficiency, the cost-effectiveness of provision can be also undermined if patients are willing to receive and pay informally for less cost-effective services (e.g. caesarean section vs. natural birth).

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 who 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 (Tambor et al., 2014). 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 and Culyer, 2006).

Therefore, informal patient payments are a threat to public health, since they jeopardize the efficiency and equity of healthcare provision (Gaal et al., 2010; Szende and Culyer, 2006). Most importantly, those who cannot afford to pay informally might receive inadequate care, or even delay seeking treatment (Burak and Vian, 2007; Tambor et al., 2014).

Studies show that informal patient payments are not unique to post-Soviet countries. They are a well-known phenomenon around the world. The practice of small gifts (flowers, chocolates, wine) given by the thankful patient to healthcare staff after service provision exists in many countries (Abbasi and Gadit, 2008; 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 healthcare provision (Dodge, 1978; Greenberg, 1990) as long as patients who do not give gifts are not deprived of adequate services. Rubin (2012) even argues that such small gifts to physicians should not be forbidden, since gift refusal may hurt the feelings 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 for better or quicker services become a common practice, and when informal cash payments appear, concerns about equity in access to adequate healthcare start to emerge (Allin et al., 2006; Barber et al., 2004).

A huge variety in the nature and patterns of informal patient payments is reported across countries. Studies provide evidence on the variation of payment types (cash or in-kind gifts given by patients or

their families), timing (before, after or during service provision), subject (out-patient or in-patient service), purpose (obtaining better quality or access) and motivation (physician's request or patient's initiative) (Balabanova and McKee, 2002; Belli et al., 2004; Shishkin et al., 2003; Thompson and Witter, 2000). 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 'gift' exchange as a means to maintain the underfunded healthcare system (Allin et al., 2006). Overall, the boundaries between informal payments and true gifts are blurred and not easy to determine (Polese, 2008; Wanner, 2005).

Furthermore, a variety of interrelated factors are associated with informal payments. Different authors (Gaal and McKee, 2005; Tambor et al., 2012; Thompson and Witter, 2000; Tomini and Maarse, 2011) argue that the presence of informal patient payments can be explained by the tradition of giving gifts, as mentioned above, as well as by other cultural, social and ethical factors that do not directly affect the healthcare system. In contrast to Western countries that moved towards objectivity and fairness (Scott, 1994) aimed at ensuring social welfare, the post-Soviet approach relies more on private bonds and informal relations in a context of weak institutions and poor governance. Indeed, the term 'multiple moralities' (Wanner, 2005: 530) emerged during the transition period. Political and economic changes in the countries (especially those related to the accountability and transparency of public services provision) are seen as a key factor in resorting to informal exchanges. The latter serves as a means for individuals to achieve at least individual welfare when the state fails to ensure social welfare (Wanner, 2005). In particular, payments requested by healthcare providers do not exclusively reflect unethical behaviour by providers. Still, these solicited payments are more widespread in situations of chronic underfunding – poorly paid personnel and lack of medical supplies, commodities and sanitary aids. It appears that provision is conditioned by unavoidable informal payments when the need for healthcare is high. In other words, when certain goods or services have to be accessed, consumed or provided, it is not only morality or inherited values that rule human actions. Economic factors, such as low funding and low physician salaries, as well as managerial and legal aspects and poor governance, also matter (Ensor, 2004; Gaal and McKee, 2005; Tambor et al., 2012; Tomini et al., 2012).

Overall, four basic dimensions are noted (Gaal and McKee, 2005; Mossialos et al., 2002; Tomini et al., 2012) – socio-cultural factors,

economic and labour factors, political and regulatory factors, and healthcare systems in particular – that can be used to classify the factors and shed light on the causes of informal payments. Table 9.1 presents the key factors and their possible indicators by 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 9.1 are rather interwoven, leading jointly to the existence of a specific pattern of informal payments in a country. For example, the existence of informal payments is associated with insufficient healthcare system funding and low physician salaries (healthcare system dimension in Table 9.1). This offers an explanation for why healthcare providers request informal payments, and emphasizes the providers' role in the informal payment chain.

Nevertheless, insufficient healthcare system funding is largely a result of poor economic circumstances (economic and labour dimension in Table 9.1). Low earnings in the country imply low general tax revenues and low social insurance contributions, which, in turn, limit the resources available for public healthcare provision. Thus, the two dimensions, the healthcare sector and the economic and labour environment, are interrelated, and it might be difficult to distinguish their intertwined influence in practice.

Similarly, socio-cultural factors (including indicators such as public opinion and attitudes in Table 9.1) indicate the role of society, but also the role of the patient, as a key element of the informal payment chain (healthcare system dimension in Table 9.1). Thus, even when the informal payment is requested, the patient makes the final decision on whether or not to resort to an informal transaction with the provider. In other words, the patient is able to pour oil on the fire 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 behaviour 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 fulfil healthcare needs. Therefore, theoretical discussions (Gaal and McKee, 2004) and empirically tested theories (Burak and Vian, 2007) offer a deeper look at individual motives for informal payments.

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 healthcare services,

Table 9.1 Dimensions, factors and indicators that explain the presence of informal patient payments

Dimensions	Factors	Example indicators	Explanation
Healthcare system	Healthcare funding and policy	Total/government expenditure on health	Inadequate levels of healthcare funding, efficiency, equity and quality of service provision provide incentives to 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 lineitem budgets lack incentives to increase productivity and satisfy patients' needs.
		Level and structure of user charges	
		Allocation and management of funds	
	Healthcare organization and provision	Range and reach of services	
		GP practice functioning	
		Range of competing health facilities	
	Healthcare 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	Widespread 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 (e.g., age structure).
		Dependency ratio	
	Social factors	Level of education and literacy	
		Civil society functioning	
	Social psychology and morals	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 labour environment	Labour	Employment opportunities Levels of unionization Level of capital mobility	Economic growth reduces the need for a grey economy and informal transactions. Well-functioning labour 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 unions, e.g. 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 to informal payments.
	Governance	Stability of political institutions Control, accountability, transparency Levels of corruption Political will to combat corruption	
	Ethics	Clear professional and ethics codes	

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

informal payments also provide a means for patients in post-Soviet countries to receive services with quicker access and better quality, as well as for healthcare providers to obtain adequate reimbursement for services provided (Belli, 2002; Chawla et al., 1998; Cockcroft et al., 2008; Tatar et al., 2007). Governments that are unable to effectively reform and fund their healthcare sectors often ignore the problematic side of informal payments (Lewis, 2006; Shahriari et al., 2001; Thompson and Witter, 2000). Hence, when the government policies and promises on

the amount of service provision do not correspond to the organization and funding of the services, patients and providers resort to informal payments (Cohen, 2012).

Given the above, informal payments are considered to be a great concern 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 decreasing the negative impact of informal payments on the attributes of healthcare service provision (Vian, 2008; Vian et al., 2006).

Healthcare systems and the socio-political context of post-Soviet European countries: Lithuania and Ukraine

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 former Soviet republics (Deppe and Oreskovic, 1996). 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 post-Soviet countries (Gaal, 2004; Kuszewski and Gericke, 2005; Lekhan et al., 2010). Although Lithuania and Ukraine have much in common, they also show some diversity in terms of economic development, demographic patterns and health indicators, and the extent of the abovementioned problems also differs between the countries. More specifically, the characteristic features of these two post-Soviet countries are briefly described in this section.

In order to compare the context of Lithuania and Ukraine, we draw upon the SPACE-matrix (Strategic Position and Action Evaluation Matrix) analysis, which is a management tool for determining the competitiveness of an organization in the market place. It uses a set of pre-selected indicators of four key dimensions, and the exact indicators per dimension depend on the type of organization and its industry (Swayne et al., 2008). The matrix method can be also applied for healthcare and other sectors at the country level (Country Assessments and Performance Measures, 2007).

We apply this tool to determine the conduciveness of the environment in Lithuania and Ukraine to informal payments. To select the indicators, we use the four dimensions of the presence of informal patient payments described in Table 9.1: economic and labour factors,

socio-cultural factors, political and regulatory factors, and healthcare system factors. For each dimension, we select five key quantitative indicators whose values are readily available for the two countries from a single source. This means that important context-related indicators (such as average physicians' salary per country) are omitted, because their values are either not available or come from different sources.

The indicators and their values per country are presented in Table 9.2. The values of the indicators are used to calculate standardized scores per indicator per country. In particular, for each indicator, we sum up the two country values and then 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. When high original values of an indicator indicate low conduciveness to informal payments (e.g. in case of GDP, expenditure on health, etc.), the new rescaled values are reversed. Thus, a high standardized score per country per indicator in Table 9.2 indicates a relatively high conduciveness to informal payments, that is, a relatively problematic area in the country. The sum of all country standardized scores per indicator equals 1. Thus, the standardized scores allow a comparison across countries and across indicators. An average standardized score per country per group of indicators (dimension) is also calculated, that is, four average standardized scores per country.

The average standardized scores (see Table 9.2) indicate differences in economic, regulatory and healthcare systems and perhaps, to a lesser extent, differences in the cultural environment in the countries. Based on the average standardized scores per country, the country graphic profile is drawn (see Figure 9.1). 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. Thus, Figure 9.1 shows that the environment in Ukraine is relatively more conducive to informal payments compared with that in Lithuania. Changes in the set of indicators do not change this main conclusion, which suggests robustness of the results. Based on the SPACE-matrix analysis, informal payments in Ukraine can be expected to be higher and more widespread than in Lithuania.

Nonetheless, the country profiles in Figure 9.1 lack some qualitative indicators. Two decades ago, virtually all post-Soviet European countries experienced economic recession and difficulties in revenue collection. Later, the majority of the countries in the region experienced economic growth, but not the countries from the Community of Independent

States (e.g. Ukraine). This was due to the slow privatization process, widespread corruption and the greater distance from European markets. In particular, it is worth underlining an important change that occurred in Lithuania, which joined the EU in 2004. EU membership provided a frame and stimulus to improve regulations and to achieve

Table 9.2 Indicators of the four dimensions of the presence of informal patient payments applied in the SPACE-matrix analysis

Economic and labour factors	Lithuania	Ukraine	Socio-cultural factors	Lithuania	Ukraine
GDP (PPP per capita, US$ billion)	12,323	6,656	Human development index (rank, lower value = higher level)	40	76
Standardized score	0.35	0.65	Standardized score	0.35	0.65
GDP real growth rate (%)	1.30	4.20	Education index (score, higher value = higher level)	0.883	0.858
Standardized value	0.76	0.24	Standardized score	0.49	0.51
GNI (PPP per capita, US$ billion)	16,234	6,175	Survival self-expression values (score, higher value = higher level)	−1.00	−1.72
Standardized score	0.28	0.72	Standardized score	0.37	0.63
Black market (US$ billion)	0.044	4.310	Corruption perception index (rank, higher value = higher level)	46	134
Standardized score	0.01	0.99	Standardized score	0.26	0.74
Average standardized score	0.35	0.65	Average standardized score	0.37	0.63

Healthcare system factors	Lithuania	Ukraine	Political and regulatory factors	Lithuania	Ukraine
Total expenditure on health (%GDP)	7.8	7.0	Political stability index (rank, higher value = higher level)	69	42
Standardized score	0.47	0.53	Standardized score	0.37	0.62
Total expenditure on health (per capita, US$)	730	180	Government effectiveness index (rank, higher value = higher level)	74	25
Standardized score	0.20	0.80	Standardized score	0.25	0.75
Government expenditure on health (per capita, US$)	499	98	Control of corruption index (rank higher value = higher level)	66	17
Standardized score	0.16	0.84	Standardized score	0.20	0.80
Maternal mortality (deaths per 100,000 live births)	8	32	Rule of law index (rank, higher value = higher level)	72	25
Standardized score	0.20	0.80	Standardized score	0.26	0.74
Physicians density (physicians per 10,000 population)	3.61	3.25	Democracy index (score, higher value = higher level)	7.24	5.94
Standardized score	0.47	0.53	Standardized score	0.45	0.55
Average standardized score	0.30	0.70	Average standardized score	0.31	0.69

Note: 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, Trans-

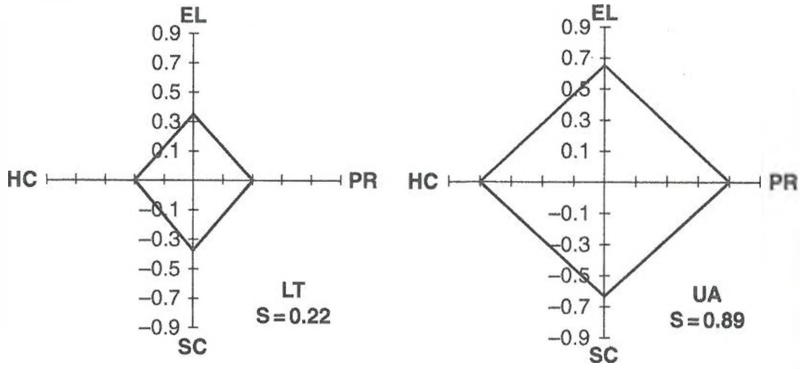

Figure 9.1 Country profiles of Lithuania and Ukraine based on the average standardized scores from the SPACE-matrix analysis (see Table 9.2)
EL = economic–labour factors; SC = socio-cultural factors; PR = political–regulatory factors; HC = healthcare system; S = area size.

better living standards, more transparency and accountability. It also required the eradication of corruption. Meanwhile, Ukraine is a non-EU member and, until recently, the chance of the country achieving membership has been doubtful. Its disadvantaged situation is also visible in our SPACE-matrix analysis.

In addition to this, more than one decade ago, almost all post-Soviet European countries, including Lithuania but not Ukraine, switched from the system of central planning and free-of-charge healthcare to a decentralized system with a health insurance fund. While Ukraine largely preserved the tax-based healthcare system established during communism, Lithuania established a social health insurance system as early as the 1990s. In Lithuania, access to healthcare is assured for the vast majority of residents, while the working population are obliged to join the state health insurance scheme, and the state increasingly contributes for the 60% of the total population who are not economically active (Murauskiene et al., 2013). Lithuania has achieved more in the field of reducing hospital capacity and extending primary healthcare (general practitioners (GPs) play a gatekeeping role and are paid per capita), as well as in improving quality and equity in provision and cost-effectiveness. Emergency care remains free for everyone in need.

Although in both countries there is little discussion of the introduction of user fees for publicly funded services, the systems of patient

payments are unclear in Ukraine, where a list of 'paid services' has been introduced. In Lithuania, payment regulations seem to be more grounded: Lithuanians who are non-residents, non-insured and non-registered are charged for using non-vital services (Murauskiene et al., 2010, 2012). In addition, a price list has been developed in case of consumption of services from the negative list of (mostly auxiliary) services. Quasi-formal payments and informal patient payments are considered to be widespread, but they are not the subject of consistent policy debates, and are not always recognized by policy-makers as essentially problematic. Recently, the Lithuanian government has attempted to regulate the quasi-formal payments for healthcare services that were introduced by public facilities.

Thus, healthcare reforms in the two post-Soviet republics have an uneven character. The countries experienced numerous appointments of ministers of health during the last decade (17 in Lithuania and 18 in Ukraine, with an average length of stay of 1–1.5 years). The general political and social situation in the countries has also not been very stable in recent years. While Wanner (2005) suggests that 'the "Europeanness" of Ukraine is more questioned than that of the Baltic or other former-socialist Eastern European countries' (517), in both Ukraine and Lithuania political and economic changes have also entailed new combinations of individual–social interests (skewed towards individual ones) as well as new consumer values. However, during transition, most post-Soviet societies, including Lithuania and Ukraine, are characterized by a low level of expectation of and trust in authorities because of the political intention to ensure private wealth instead of maintaining the principles of social welfare (Dobryninas, 2005; Polese, 2008; Wanner, 2005). In particular, the overall situation in Ukraine till 2014 has been characterized by monopolization of political and economic power by political forces for self-enrichment, as well as by the lack of public trust in state institutions coupled with non-fulfilment of political and economic obligations (Kuzio, 2012). As has been noted (EU Neighbourhood Barometer, 2012), the level of trust in the national government and parliament was about 18% and 13%, respectively, in 2012 (the lowest in the region). Apart from the negative effect of corruption on trust (Life in Transition, 2011), lower levels of trust are observed in poorer countries as well as in societies with an unequal distribution of income (Morrone et al., 2009). At the same time, Lithuania is enduring a demographic crisis, with one of the highest emigration rates in Europe.

Despite these qualitative aspects, the country profiles in Figure 9.1 highlight the strengths and weaknesses of the environment in each country with regard to informal patient payments. These profiles can also be used to elaborate a single-country strategy for solving the problem of informal patient payments.

Empirical evidence on informal patient payments in Lithuania and Ukraine

Based on a cross-country survey conducted in 2010 (multi-staged probability representative sample designed for each country and face-to-face structured interviews), we present data on the scope and level of informal patient payments in Lithuania and Ukraine.[1] Widespread informal practices in healthcare provision in Ukraine, and to a lesser extent in Lithuania, are noted. In particular, there is a variety of patterns of informal patient payments as well as a mixture of patient payment policies that accompany informal payments.

The scope and level of informal patient payments in Lithuania and Ukraine

Table 9.3 shows the valid percentage of respondents and the number of those who report that they have ever paid informally in cash or in the form of in-kind gifts. In Lithuania and Ukraine, the percentage of those who have ever given cash to medical staff is almost the same (48% and 53%, respectively). A higher percentage of respondents report that they have ever made informal payments to medical staff in the form of in-kind gifts compared with cash payments. Moreover, every third respondent in the Ukrainian sample, in contrast to every eighth respondent in the Lithuanian sample, has ever been asked to pay informally for healthcare services. Generally, informal payments are more widespread when they are solicited or expected by providers, and also higher amounts of informal payments are given at the medical staff's request, as suggested by previous studies (e.g. Tomini et al., 2012). According to Cohen (2012), solicited informal payments can be seen as an indicator of major financial troubles in the healthcare system, while patient-initiated informal payments can be related to patients' unmet expectations of better service quality.

Furthermore, the probability and the size of the informal payment are to a great extent determined by the type of service consumed (out-patient or in-patient care). Our study results presented in Table 9.3 suggest a higher number of users as well as higher amounts that are

paid for hospitalization. The literature also provides evidence on more expensive payments paid by a higher share of patients during hospitalization (Kornai, 2000; Shahriari et al., 2001; Szende and Culyer, 2006; Tomini and Maarse, 2011; Vian et al., 2006). In detail, when the annual proportion of informal payers is examined, it appears that about 23% of Lithuanian and about 37% of Ukrainian out-patients, and about half of the in-patients in both countries, pay informally. However, with respect to the average amounts paid informally, Ukrainians report a median value of about 14 euro in informal payments per respondent per year, while this is about 44 euro in Lithuania. When the means of the informal patient payments per respondent per year are compared with the minimum wages in the countries (see Eurostat, 2010), it appears to be virtually equal to one monthly minimum wage in Ukraine and to half of this in Lithuania. This indicates a considerable burden on households caused by informal patient payments (especially for lower-income households, and especially in Ukraine).

It is worth mentioning 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 payment obligations. For example, we observe that informal payments are a widespread supplement to also widespread quasi-formal payments in both countries. Meanwhile, patients in these two post-Soviet countries are poorly informed about the size of the formal fees, as indicated in Table 9.3. Therefore, similar practices of informal payments constitute a behavioural pattern in healthcare consumption. Perhaps a common social past provides many similarities; however, the more modest nature of the phenomenon in Lithuania can be stipulated by higher levels of economic development and governance practice (also illustrated by the SPACE-matrix analysis in Table 9.2 and Figure 9.1).

Attitudes towards informal patient payments: Empirical evidence

The existence of informal patient payments in Lithuania and Ukraine indicates that the public fails to oppose payments. Indeed, public opinion, though rarely considered in policy-making, can play an essential role in dealing with informal payments (Ensor, 2004), since it reflects culture, social norms and historical developments. The acceptance of informal patient payments enables the existence of these payments and may hinder measures for their elimination. Moreover, public opinion towards a social phenomenon may affect individual patients' and

Table 9.3 Healthcare services consumption and payments during the last 12 months

			Lithuania	Ukraine
Ever				
Have you ever personally paid informally in cash to physicians, medical staff or other personnel in healthcare facilities?	No	N (%)	525 (52.0)	467 (47.0)
	Yes	N (%)	484 (48.0)	527 (53.0)
Have you ever personally given any gift in kind to physicians, medical staff or other personnel in healthcare facilities?	No	N (%)	472 (46.7)	417 (42.0)
	Yes	N (%)	539 (53.3)	576 (58.0)
Number of respondents who have ever been personally asked to pay informally	No	N (%)	887 (87.9)	689 (69.5)
	Yes	N (%)	122 (12.1)	303 (30.5)
Last year				
Use of out-patient (physician) services during the last 12 months	No	N (%)	272 (26.9)	426 (42.7)
	Yes	N (%)	739 (73.1)	572 (57.3)
	Number of visits	Median	3.00	2.00
		Mean (SD)	5.02 (5.32)	3.45 (4.25)
Payments for out-patient (physician) services by users	No	N (%)	414 (56.0)	246 (43.3)
	Yes	N (%)	325 (44.0)	322 (56.7)
	Total payments	Median	28.9	19.2
		Mean (SD)	85.4 (159.3)	60.8 (123.5)
Informal payments for out-patient (physician) services by users	No	N (%)	569 (77.0)	359 (63.3)
	Yes	N (%)	170 (23.0)	208 (36.7)
	Total informal payments	Median	28.9	9.6
		Mean (SD)	80.5 (161.3)	32.2 (62.4)
Use of in-patient (hospital) services during the last 12 months	No	N (%)	846 (83.7)	816 (81.6)
	Yes	N (%)	165 (16.3)	184 (18.4)
	Number of hospitalizations	Median	1.00	1.00
		Mean (SD)	7.85 (6.87)	1.48 (0.81)
Payments for in-patient (hospital) services by users	No	N (%)	65 (39.4)	48 (27.0)
	Yes	N (%)	100 (60.6)	130 (73.0)
	Total payments	Median	86.9	95.9
		Mean (SD)	149.7 (160.1)	195.9 (235.2)
Informal payments for in-patient (hospital) services by users	No	N (%)	79 (49.0)	87 (49.4)
	Yes	N (%)	82 (51.0)	89 (50.6)
	Total informal payments	Median	130.3	38.3
		Mean (SD)	143.9 (129.2)	81.2 (121.1)

Note: All amounts in the table are presented in euros. First, amounts in local currency for 2011 and 2009 are converted to 2010 values based on Consumer Price Index per country (*Source*: World Bank), then these are converted from local currency to euros based on average conversion rate for 2010 (*Source*: ECB – European Central Bank).

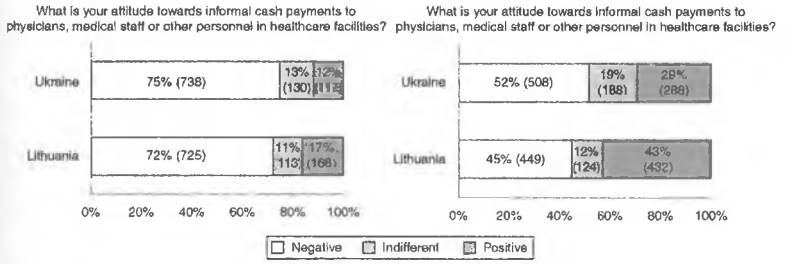

Figure 9.2 Public attitudes towards informal patient payments in Lithuania and Ukraine

providers' behaviour, and thus the specific patient–provider relation, from which informal payments originate.

Therefore, recent data on public attitudes and opinions are very important. Figure 9.2 shows the valid percentage and number of respondents per country who stated their perceptions and attitudes towards informal patient payments. Generally, the attitude towards informal cash payments, and to a lesser extent towards in-kind gifts, is negative overall. The attitudes towards cash informal patient payments are rather negative (72.2% in Lithuania and 74.9% in Ukraine), whereas a relatively lower percentage of people in Lithuania and Ukraine (44.7% and 51.6%, respectively) report negative attitudes towards in-kind gifts, and people are not afraid to voice a positive attitude towards such gifts.

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 with cash payments (Balabanova and McKee, 2002; Belli et al., 2004; Cockcroft et al., 2008; Tatar et al., 2007). Although in-kind gifts (like 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 patients' means. Tokens of gratitude are common practice all over the world, but the extent of the gift-giving practice differs (Abbasi and Gadit, 2008; Spence, 2005), as in some countries clear regulation of physician behaviour is more developed and adhered to (Gaufberg, 2007; Kutzin, 2010; Rechel et al., 2011). Moreover, when gifts are not expected or encouraged, they do not adversely affect efficiency in provision (Gaal and McKee, 2005).

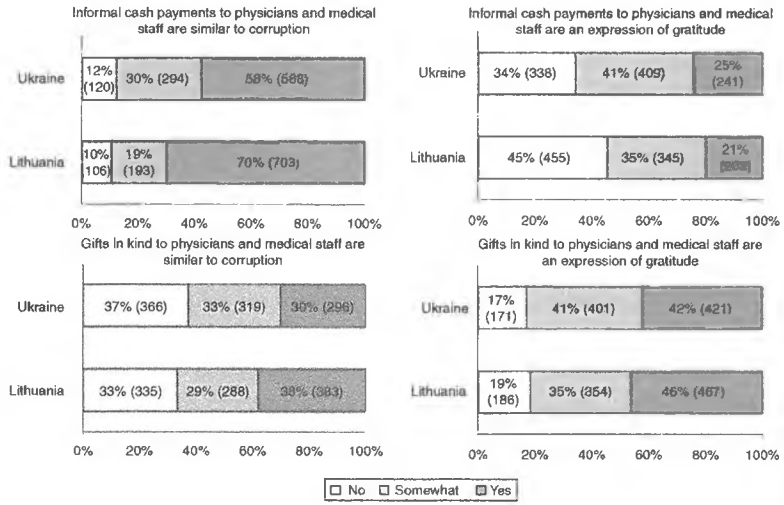

Figure 9.3 Public perceptions of informal patient payments as corruption or gratitude

Another dimension of consumers' acceptance of informal transactions is to label the payment as 'corruption', 'bribery' or 'gratuity'. As shown in Figure 9.3, there is widespread adherence to the notion that informal cash payments are similar to corruption and that in-kind gifts are an expression of gratitude. Still, diversity of opinions is observed in the midpoints; for example, about 22% of the public in both counties believe that informal cash payment can be seen as gratitude. Also, 30% of respondents in Ukraine and 38% in Lithuania think that in-kind gifts given to medical staff can be treated as corruption. However, Polese (2008) and Morris and Polese (2014) suggest the term 'brifts' 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.

As the role of media in shaping public attitude is very powerful, it is also important to take a deeper look at individual consumers' perceptions. Specifically, attitude coupled with previous experience is a personal construction that ensures specific behaviour in a given situation and is a regulatory mechanism of human behaviour. However,

it is difficult to measure, especially in case of informal patient payments. Therefore, we attempted to examine perceived behavioural statements related to informal payments (which indicate personal disposition towards these payments). As a result, we observe that patients who feel uncomfortable without a gratitude payment, and who feel unable to refuse payment informally if asked, more often report making informal payments than the rest of the respondents.

As shown in Table 9.4, the Lithuanian and Ukrainian scores are almost the same for such statements as 'feels uncomfortable leaving without giving gifts' (about 60% of respondents answered 'no' in both countries) and 'ready to pay informally in case of serious health problems' (about 11% negative answers in both countries), which may indicate quite similar cultural contexts. However, more Lithuanians state that they 'would not refuse to pay informally if asked to make such payments' (28% in contrast to 41% of Ukrainians). Perhaps differences in patterns of patient–physician communication with the more empowered Lithuanian patients may explain the diversity in the scores, as well as consequences of such non-payment. Overall, obedience to the requests of medical staff to pay informally can be conditioned by patients' expectations of better treatment or by a fear that treatment may be denied (Belli et al., 2004; Lekhan et al., 2007). The latter is explained

Table 9.4 Public perceptions and attitudes towards informal patient payments

	Sample size	Lithuanian	Ukrainian
		N = 1,012 Valid %	N = 1,000 Valid %
Feels uncomfortable leaving without giving gifts	No	61.0	56.3
	Yes	16.4	14.7
	Uncertain	22.6	29.0
Would recognize the hint for informal payments	No	16.0	10.5
	Yes	63.5	57.5
	Uncertain	20.5	32.0
Would refuse to pay informally if asked to make such payments	No	28.0	41.1
	Yes	35.1	26.6
	Uncertain	37.0	32.2
Prefers to use private healthcare because of the informal payments	No	24.1	32.7
	Yes	51.9	34.0
	Uncertain	26.7	33.3

by the market power of healthcare providers, who do not always follow moral principles, as well as by external pressure (e.g. by low-paid medical staff) (Miller, 2006). Still, as data is lacking, it is difficult to track the changes of consumers' disposition with regard to economic, legislative and healthcare sector development.

Opinions on the eradication of informal patient payments

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. Perhaps, in Lithuania and even more in Ukraine, the public are willing to change their pattern of behaviour, but poor governance, economic development and low healthcare funding leave much to be desired (as the SPACE-analysis matrix demonstrates).

A key function of informal payment in services provision is seen as supplementing inadequate healthcare funding (Lewis, 2007). Indeed, in Lithuania and in Ukraine, per capita government expenditure on healthcare is even lower than in other countries in the region where informal payments are negligible, namely the Czech Republic and Slovenia (Leive, 2010). In addition, our survey results indicate that about 25% of Lithuanian respondents consider informal payments to be inevitable because of low healthcare funding, whereas this percentage is even higher for Ukraine (44%). Furthermore, the Lithuanian and Ukrainian public support the statement that informal patient payments should be eradicated (73% and 66%, respectively); only about 8% of them think that this is not necessary.

Perspectives on informal patient payments in post-Soviet countries

Informal patient payments present a huge challenge for post-Soviet countries in their drive towards more efficiency and equity in healthcare. Empirical results show that informal payments are often used in healthcare services consumption, even though they provoke negative opinions and perceptions among users.

Informal patient payments have a variety of facets described by various neutral characteristics, such as nature, timing, reason and initiator, as well as other particularities tinged with different attitudes, perceptions and beliefs. On the surface, the approach of labelling 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 solely initiated by the giver without expectations of reciprocity. However, empirical data and analysis suggest a more complex reality. For example, does the 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 (1) feeling uncomfortable leaving a physician's office without gratitude, (2) preference for the private sector as being uninfected with the 'gift' 'virus', as well as (3) underfunding of the healthcare sector as a key factor for the presence of informal patient payments. Therefore, do healthcare service users really 'spontaneously' (instead of planned intentional action) 'decide' (instead of being requested or feeling 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 and motives for resorting to 'gratitude money' or 'non-monetary gifts' to physicians, including institutional (political, cultural, economic) pressure.

A gap between the official discourse and reality (Polese, 2014) and the image of state withdrawal, as well as the lack of trust in government and public institutions in transition societies, induce the substitution of weak formal practices with informal ones. A variety of strategies in the legal and quasi-legal space are noticed at all levels of the economy. In order to find a solution for today's urgent needs, the achievement of social welfare goals, suggesting continuous improvement of the socio-economic and political arrangements, has been postponed. Still, anti-corruption measures and the elimination of informal payments are on the agenda of the government of Lithuania, but not Ukraine. A key obstacle to activating government policies eliminating informal payment practices is the lack of motivation of policy-makers. However, among post-communist countries in the region, Poland, with its relative effectiveness of state institutions, presents a case of a 'season of corruption' in contrast to the deep-rooted 'climate of corruption' in other countries (Miller et al., 2001). Having administrative capacity and political will, Poland provides an example of anti-corruption measures realized in cooperation between related sectors (Golinowska, 2010).

Possibly, anti-communist public mood and lack of nostalgia, as well
the intention to join the EU, facilitated reforms in virtually all secto
(Leven, 2005). Moreover, an output-oriented performance is crucial f
diminishing the extent of informal patient payments and of the shado
sector in general. Also, quality of governance is stimulated by the pre
ence of civil society, which can influence policy-making and, thus, affe
the level of corruption (Grimes, 2008). Thus, civil society is seen as a
'anti-corruption watchdog' (Grødeland and Aasland, 2011). However
strong civil society is an attribute of a political regime, and it is still
the process of creation and development in the post-Soviet countries.

Also, informal exchange practices may reflect the challenging ec
nomic environment. While governance is considered essential for ec
nomic development (Lewis, 2006), economic development is tight
related to fiscal revenues allocated to 'non-profit' sectors. Gover
ment inability to ensure adequate levels of public service provision
often attributed to insufficient resources. Informal payments (e.g. f
healthcare services) are more deep-rooted in countries where the gover
ment tolerates and relies on informal payments, since these paymer
are an additional source of funding. This misuse of informal paymer
causes a mismatch between the healthcare sector goals and the measur
applied to achieve these. Therefore, in order to prevent rising info
mal exchanges in the market, healthcare system performance should
stimulated by implementing adequate regulations rather than relyi
on informal contributions.

Furthermore, market relations are still connected to the social ar
cultural context of the society, which is less clear from the strateg
stewardship angle. Changing consumer perceptions about informal pa
ments is an important part of government policies focused on t
consumer side. However, the means of achieving this are doubtful, sinc
on the one hand, social as well as individual values and beliefs are stab
and, on the other hand, the effects of activities within political, ec
nomic and other institutions (e.g. healthcare organization and fundin
are unpredictable.

Pre-eminently, poor governance, undeveloped civil society and t
lack of resources discussed above prevent post-Soviet societies fro
achieving effective sector reforms. Still, interventions to eradicate info
mal patient payments can be developed considering the dimensio
indicated in the SPACE-matrix analyses (see Figure 9.1). Five key la
ers related to the formalization of certain activities can be identifi
to eradicate informal patient payments from the healthcare syste
environment:

(1) Assuring adequate remuneration of staff and reimbursement of healthcare facilities. Lower physicians' salaries compared with the country average or the industrial sector average, coupled with quality and access problems in healthcare, provide a motive for consumers and providers to enter into informal payment arrangements. From a macro-level perspective, adequate remuneration of healthcare providers is crucial for strengthening sector capacities. When work conditions 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 healthcare sector (Ensor and Duran-Moreno, 2002). Informal payments can provide a motive for physicians to stay in practice.

(2) Defining clear professional rules (e.g. staff performance assessment and punitive measures for underperformance) as well as standardized provision of healthcare services (clinical, informational and service aspects). Also, increased remuneration will not be a panacea for the problem of informal patient payments. For example, in Lithuania, healthcare providers' salaries were increased in 2005–2008, but informal patient payments still prevail. In this case, the assessment system and punitive measures can create a negative staff disposition towards informal payments. This can include the implementation of strict moral and ethical standards (Code of Ethics), penalties and sanctions for underperformance (such as the acceptance of informal payments), bonuses for good practices, and staff training, as well as participation in professional committees (Lewis, 2006). Moreover, 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 healthcare can be lowered by the provider in order to make the patient pay informally for better service quality.

(3) Assuring adequate investment in, and an efficient use of, healthcare resources. The lack of suitable investment leads to outdated equipment and facilities' buildings being in an unsatisfactory state. Also, shortages in medical supplies are seen as a direct result of underfunding, but also of inefficient management of healthcare resources. Still, increased funding is a matter of political interests and the overall economic situation, and the government can play an important role in assuring an efficient allocation of the

scant resources. A clearly defined and properly sized basic package of services that fit the available resources will be important for the elimination of informal payments for these services. Additionally, a performance-based provider payment mechanism may play an important role in stimulating the provision of sufficient service quality and quantity. A uniform central payment scale does not take account of quality of services and professional skills of the personnel, and therefore, efficiency in healthcare becomes less feasible.

(4) Introducing clear patient payment policies (e.g. presence of formal fees together with relevant exemptions) and raising patients' awareness about their rights and payment obligations. Although official charges cannot replace informal ones, because, in practice, the two types of payments serve different purposes (Baji et al., 2011, 2012), still, the presence of official payment channels can stimulate retrieving funds from the shadow sector. The need for informal payments can be reduced when patients are stimulated to use the official channels exclusively, when providers are adequately remunerated, and when public healthcare services are provided with adequate quality and access. The concern that official fees increase the burden for vulnerable population groups is 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 (in the absence of clear government regulation of formal payments, as in Lithuania). If official patient charges for healthcare services are introduced, consumers have to be well informed about fee levels and exemptions. Service consumption mechanisms only work when they are clear to all patients (Belli et al., 2004). Complicated schemes and regulations regarding provision become a barrier to use and can lead to informal payments. Thus, raising patients' awareness about their right to services with adequate quality and access and with no informal charges or gratitude payments, as well as empowering the patient to object to paying informally, are essential policy strategies for the elimination of informal patient payments.

(Pavlova et al., 2010; Vian, 2008; Vian and Burak, 2006)

(5) Developing the private healthcare sector to support alternatives to public provision (Ensor, 2004). The data from our survey shows that there is little inclination in Lithuania and Ukraine to use private services as a response to informal payments. Overall, developed

> private markets create a competitive climate, and this may bring improvements in public healthcare service provision as well.
> (Ensor and Witter, 2001; Thompson and Witter, 2000)

These specific healthcare system strategies are seen as an essential part of the overall anti-corruption strategies. Only drastic, multidimensional measures can be effective in decreasing the scope and the scale of informal patient payments. To be successful, the implementation of priority measures should be combined with the other, more general strategies for the elimination of informal payments discussed earlier. Also, only by securing the political commitment and involvement of all stakeholders in the process of elimination of informal patient payments can appreciable effects be ensured.

Note

1. More details on study design are available on the webpage of ASSPRO CEE 2007 project, www.assprocee2007.com.

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