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Informal payments for health care services – Corruption or gratitude? A study on public attitudes, perceptions and opinions in six Central and Eastern European countries

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ABSTRACT

In this study we aim to compare the public perceptions towards informal patient payments in six Central and Eastern European countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine). Overall, around 35–60% of the general public in each country has ever made informal payments, though informal cash payments are perceived negatively, mostly as corruption. In-kind gifts are often seen as a token of gratitude. However, significant differences among countries are observed. Despite the public support for the eradication of informal payments, there are population groups who favor their existence and this should be taken into account in policy-making.

1. Introduction

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

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

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Two cross-country studies, carried out in Central and East European countries about 10 years ago confirm the variation in attitudes across the region (Belli, 2002; Cockcroft et al., 2008). In particular, Hungary and Poland are indicated as countries where negative feelings about informal out-of-pocket payments prevail while the attitudes among the Romanian population are less negative (Belli, 2002). Also, a study in the Baltic countries reports that half of households perceive informal payment to a health care professional as a form of corruption (Cockcroft et al., 2008).

This paper contributes to the literature by providing new insights on public attitudes, perceptions and opinions regarding informal patient payments based on recent data for six Central and East European countries. More specifically, the paper aims to compare the public opinion on informal patient payments in six Central and East European, post-communist countries, namely Hungary and Poland (developed Central European countries), Bulgaria and Romania (less advanced East European countries), Lithuania (former Soviet republic, EU-member) and Ukraine (non-EU member, former Soviet republic).

The subsequent section provides background information about countries included in the study and about the circumstances that accompanied informal patient payments, followed by the sections on research methods and results. The discussion of the results is used to draw conclusions about policy and research.

2. Background

Across the Central and East European region, health care systems proceed on their own road of development, failures, and achievements. This is accompanied by other notable differences in other areas: governance, laws, economic and socio-political situation, including levels of corruption, cultures of moral and financial incentives in obtaining services at state facilities.[1] Communist past of all these countries in transition have brought collision of new and old values, which resulted in "social shock" (Berend, 2007, p.275). This past also meant an absence of clear goals, continuation of old institutional base, crisis of public trust and passive civil position (Gorobets, 2008). Though prevalence in public moods of nostalgia for lost security, or vice versa, intention to escape communist past urgently, by joining Europe, for example, differs among countries (Berend, 2007). Despite these general differences across the region, out-of-pocket payments have become a common feature of health care delivery, which is in major contrast to the free-of-charge service provision during the Soviet times (Rechel and McKee, 2009). Patients are now paying either formally or informally, in order to have access to, or adequate quality of health care. Although some governments in the region continue to ignore the existence of informal practices in the health care sector, others have employed varying strategies, although not always effectively, to eliminate informal payments.

Among the six countries that are included in our study, Hungary and Bulgaria introduced official charges for health care services, which among other things aimed at the elimination of informal payments. Since 2000, Bulgarian patients are required to pay for each visit to a physician and for hospitalization. However, the amount of the formal payment is related to the minimum wage in the country and thus, it changes, which brings uncertainty in prices. Also, informal patient payments continue to exist in Bulgaria (Atanasova et al., 2010). In Hungary official charges for physician's visits and hospitalization were introduced in 2007 and one of their main policy objectives was to replace the informal payments by formal ones. The formal charges were later abolished due to strong opposition of the public expressed in a nation-wide referendum (Baji et al., 2010). Nevertheless, the practice of informal payments continues to exist (Baji et al., 2012).

Another strategy for dealing with informal patient payments relates to anti-corruption campaigns. All new members of the European Union were requested to decrease the level of corruption in all sectors before they could join the Union. Such changes have been widely discussed by politicians, media and the public at large. In Poland and Bulgaria there have been strong government campaigns against corruption in general and informal patient payments in particular. Although for Bulgaria evidence is lacking, it is suggested that in the case of Poland, this campaign, in combination with other policy measures, has contributed to a substantial reduction of informal patient payments in the recent years (Golinowska, 2010). Indeed, Corruption Perception Index in 2010 (presented in Appendix A) confirms moderate corruption in Poland, while in Bulgaria this problem is not under control and still extensive. This questions the effectiveness of the anti-corruption campaigns in the Bulgarian health care sector.

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

- *health care* itself, for example, poor quality, access and administration, as well as insufficient funding;
- *state*, for example, lack of accountability and transparency, as well as poor governance resulting in failures to establish the rule of law and to adequately enforce patient rights;
- *consumers*, for example, tradition of "gifts giving" expressed by patients and the specific supply-demand relation in health care.

[1] Information about the countries included in the study can be found in Appendix A.