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Rethinking informal payments by patients in Europe: An institutional approach

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ABSTRACT

The aim of this paper is to explain informal payments by patients to healthcare professionals for the first time through the lens of institutional theory as arising when there are formal institutional imperfections and asymmetry between norms, values and practices and the codified formal laws and regulations. Reporting a 2013 Eurobarometer survey of the prevalence of informal payments by patients in 28 European countries, a strong association is revealed between the degree to which formal and informal institutions are unaligned and the propensity to make informal payments. The association between informal payments and formal institutional imperfections is then explored to evaluate which structural conditions might reduce this institutional asymmetry, and thus the propensity to make informal payments. The paper concludes by exploring the implications for tackling such informal practices.

1. Introduction

Over the last two decades or so, a growing literature reveals how patients in many countries around the world, particularly in the former communist countries and other low and middle income countries, use informal payments to seek either better treatment [1–6], an additional service [7], due to their fear of being denied treatment [5,8], because the "doctor demanded payment" [4], because there is a tradition of giving a gift to express gratitude [4,5,9] or just "because everybody does it" [4]. Given that some 35–60% of patients make informal payments in Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine [10], tackling this phenomenon can be seen as central and essential to building a healthcare system which is not based on bribes and corruption, and provides more equal access [11–13].

The aim of this paper is to advance and evaluate a new way of explaining and tackling informal patient payments. Until now, institutional theory [14,15] has been widely applied in health services research and related fields to evaluate for example the adoption of health information technology [16–18], healthcare reform policies in public systems [19], patient-centred preventive care [20] and healthcare expenditure [21]. In this paper, and drawing inspiration from the application of institutional theory to the study of informal economic practices beyond healthcare [22,23], we here for the first time analyse informal payments to patients through the lens of institutional theory.

Viewed through this institutional lens, two approaches to understanding informal payments by patients can be adopted. On the one hand, informal payments to patients can be viewed as resulting from formal institutional imperfections in healthcare services. Indeed, previous literature on the structural conditions that lead to informal payments has identified a number of structural conditions, including legal-ethical, social-cultural (the social custom of expressing gratitude through informal payments), governance failures (e.g. poor accountability) and economic (e.g. underfunding in the face of growing healthcare needs and expectations; explanations based on economic behaviour) conditions [11,24–26]. On the other hand, however, and reflecting the advances in institutional theory when studying other informal practices [22,23], it can be argued that institutions are "the rules of the game" which prescribe what is socially acceptable, and thus both constrain and encourage different types of activity [15]. In all societies, there are not only formal institutions (i.e., codified laws and regulations) that lay out the legal rules of the game, but also informal institutions which are the "socially shared rules, usually unwritten, that are created, communicated and enforced outside of officially sanctioned channels" [27,p.727]. Informal payments will thus arise when the norms, practices and values of the informal institutions are not in symmetry with the formal rules of the game. Indeed, the greater the institutional asymmetry, the greater is the likelihood of informal payments by patients. Until now, neither the formal institutional imperfections nor the institutional asymmetry

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thesis have been evaluated as explanations for informal payments by patients. This paper seeks to fill that gap.

To begin to evaluate these institutional explanations, Section 2 briefly reviews the previous literature on informal patient payments. The outcome will be a set of hypotheses regarding the association between informal patient payments and the degree of asymmetry between formal and informal institutions as well as the association between informal patient payments and formal institutional imperfections. To start to test these hypotheses, Section 3 then reports the data used, namely a 2013 Eurobarometer survey involving 21,121 face-to-face interviews with patients in the 28 member states of the European Union (EU-28), and the analytical methods employed (multi-level logistic regression). The fourth section then reports the results on the relationship between the propensity to make informal patient payments and institutional asymmetry, and how this institutional incongruence and thus the prevalence of informal patient payments might be reduced. The final section draws conclusions on the policy implications of this new way of understanding informal patient payments.

Before commencing however informal patient payments have to be defined. A definition [28] is provided by Gaal et al. [29] according to whom, informal patient payments represent 'a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to'. This phenomenon is also known in literature as 'under-the-table' payments [13], under-the-counter payments [6,13] or unofficial payments [7].

2. Explaining the informal patient payments: an institutional approach

Since the turn of the millennium, a burgeoning literature has revealed how, especially in developing and transition countries, patients make an additional informal payment to the medical staff apart from the official fees for medical services. This has been identified in studies conducted in large geographical areas, such as in 35 European countries [26], Central Asia [30] as well as in 33 African countries [31], or in smaller studies comprising only one nation as, for example, Bulgaria [1,6,13,32,33], Poland [34,35], Hungary [2,36–40], Greece [4,41], Lithuania [34,42], Russia [43,44]; Ukraine [34,45], Moldova [46], Serbia [47], Kazakhstan [48], Albania [5,49,50], Kosovo [8], Tajikistan [51,52], Kyrgyzstan [53], Taiwan [54], Cameroon [55], Tanzania [3,56] and Turkey [57]. Nevertheless, informal patient payments phenomenon is poorly examined at a cross-country level. Examining the prevalence of this informal practice, previous studies reveal considerable cross-national variations in the proportion of patients who make informal payments, ranging from 50% in Tajikistan [52], 43% in Bulgaria [13], 36% in Greece [4], 29% in Turkey [57], 25% in Moldova [46] and 23% in Russia [44].

To explain these cross-national variations in the commonality of informal payments by patients, such payments are for the first time here analysed through the lens of institutional theory [15]. Following advances in institutional theory in relation to the study of broader informal economic practices, it can be argued that all societies have both codified laws and regulations (i.e., formal institutions) that define the legal rules of the game [14,15,58], as well as informal institutions, which are the 'socially shared rules, usually unwritten, that are created, communicated and enforced outside of officially sanctioned channels' [27,p.727]. When there is asymmetry between these codified laws and regulations (formal institutions) and the socially shared unwritten rules (informal institutions), the result is the emergence of practices based on unwritten socially shared rules which are 'illegitimate' in terms of the formal written rules. Informal payments to patients can be thus seen to result from this institutional asymmetry. The greater the institutional asymmetry, the higher is the prevalence of informal payments. Whether health services can be treated theoretically in the same way as other informal practices (e.g., buying food products) is open to discussion, especially when the decision to pay (or not) to skip a queue can be a matter of life and death in some instances. Here therefore, and to test whether the likelihood to make informal payments to medical staff is associated with the degree of asymmetry between formal and informal institutions, the following hypothesis is proposed for investigation:

Institutional asymmetry hypothesis (H1): the propensity to make informal payments is higher in populations with greater asymmetry between their formal and informal institutions.

Indeed, most previous studies reveal that women are more likely to make informal payments for health care services [6,40,42,46,59], as do younger persons [6,45,47,49,60], better educated persons [6,40–42,47,49], those having a job [41], those married [49], those living in a smaller household [40,49,50], those living in rural areas [45,60,61], and those with lower income [31,37,57,61]. By testing this hypothesis, whether these populations also have a higher institutional asymmetry can be evaluated.

It is important however, not only to test this new institutional asymmetry thesis. Institutional asymmetry is propounded to exist due to formal institutional imperfections. Viewed through this institutional lens, therefore, the structural conditions that previous literature has identified as associated with the greater prevalence of informal payments need to be evaluated as both determinants of, and ways of tackling, the level of institutional asymmetry. As previous studies reveal, these formal institutional imperfections include not only the existence of formal institutional voids, such as lower expenditures on healthcare [6] and inefficient resource allocation which results in a low range and reach of healthcare services [12,25,26,39,44,62], but also formal institutional inefficiencies, such as the poor quality of government, poorer performing healthcare systems and those concentrating on curative rather than preventative care [12,24–26,33,34,43,61]. To test whether these formal institutional voids and inefficiencies are associated with greater levels of informal payment, the following hypotheses can be thus evaluated:

Formal institutional imperfections hypothesis (H2): the propensity to make informal payments is higher in health systems with greater formal institutional imperfections.

Formal institutional voids (H2A): the propensity to make informal payments is higher in health systems with greater formal institutional voids.

Lack of financial resources (H2A1): the propensity to make informal payments is higher in health systems with low expenditures on health.

Lack of a basic health service (H2A2): the propensity to make informal payments is higher in health systems with a low range and reach of service provision.

Formal institutional inefficiencies (H2B): the propensity to make informal payments is higher in countries with greater formal institutional inefficiencies.

Quality of government (H2B1): the propensity to make informal payments is higher in countries with a lower quality of government.

Health system performance (H2B2): the propensity to make informal payments is higher in health systems with lower performance levels.