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Informal patient payments for health care services: policy challenges and strategies for solutions

Key words: informal payments, health care, policy strategies

■ Introduction

The topic of informal patient payments is rather new in research and policy discussions although the phenomenon has existed for decades [1]. Studies on informal patient payments published hitherto refer mainly to the period after 1990 and mainly to former-socialist countries [2]. Therefore, Thompson and Witter [3] argue that informal patient payments are one of the phenomena, which the transition economies inherited from the communist period. Nevertheless, unofficial payments for health care services are reported in other countries as well. This includes low- and middle-income countries, for example Uganda, Peru and Turkey [4–6], and high-income countries like Greece [7], which are not former-socialist countries. Certain unofficial payments for health care services (even though not widely spread) are reported in some other high-income countries in Europe, such as Italy and Austria [8]. Apparently, the presence of informal patient payments is an important feature of many health care systems around the world [9].

Empirical studies indicate that informal payments are made to both medical staff in hospitals and general practitioners in polyclinics (e.g. [3, 10–17]). Informal patient payments are most often reported for services included in the basic health care package, but services outside the basic package are also affected. These payments are observed in all patient groups irrespective of the socio-economic status of the patients. However, empirical studies in some countries report certain variations among the patient groups. For example, elderly and those with low-level of education are found to pay less informally than the younger and those with high-level of education [7, 17].

The measurement of informal patient payments is a challenging task since these payments are a multi-face phenomenon with different features even within a single country, i.e. in the frame of the same health care system, regulations and traditions [2]. Nevertheless, empirical

evidence indicates that informal patient payments can represent a significant part of the income of the health care providers. In some instances, physicians may earn as much as a full additional salary from informal payments [9, 18]. In more extreme cases (i.e. specialised doctors in Albania), physicians may increase their incomes up to five times through such informal payments [19].

These payments can also represent a significant part of the total health care expenditure. According to Lewis [15], informal health care expenditure represents about 84% of the total national health expenditures in Azerbaijan and 56% in the Russian Federation. More recent studies suggest that informal health care expenditure constitutes about 1.5–4.6% of the total health expenditure in Hungary, about 3.6% in Bulgaria and about 0.3–0.5% in Poland [9, 17, 18]. Although the level and incidence of informal payments are difficult to compare across countries, these payments are substantial in terms of both scope and scale, and should not be neglected.

This paper outlines the negative effects of informal payments for public health care provision and the reasons for their existence. Based on this, the paper discusses a mixture of strategies as a plausible solution to informal patient payments. The focus is on policy mechanisms that can help to deal with this type of payment in a country.

1. Why do informal patient payments matter?

Informal patient payments affect the health care provision in a very complex and interrelated manner. On the one hand, these payments usually exist in a context of limited resources for health care provision and therefore, informal compensations to providers appear to be a feasible solution for receiving treatment. On the other hand, these payments are a threat to public health since those who cannot afford to pay informally might forgo or delay seeking treatment [7, 20, 21, 26]. Thus, informal patient

payments can jeopardise efficiency, equity, and quality of health care provision.

In case of informal patient payments, the providers of health care services are compensated individually, irrespective of the value of health care provision to the society. Thus, the role of health policy and priorities set by policy-makers are undermined by the existence of these payments. The informal cash-flow goes directly from the patients to medical staff in publicly funded health care facilities and remains unregistered. In view of this, informal patient payments can become a major impediment to ongoing reforms because they hinder the estimation of future funding requirements of the health care sector [12, 15].

The existence of informal patient payments can also obstruct the attempts to improve the technical efficiency of health care provision [13, 15]. In fact, these payments might introduce incentives for providing less cost-effective services if patients are willing or accept to pay informally. It is likely that the practice of informal patient payments can lead to resource allocation that is different from the social optimum. Specifically, in case of informal patient payments, resources are not allocated based on the benefits to the society and services are not consumed by those who would benefit most, but rather by those who are able to pay or are easily forced into paying [3, 7, 12, 22]. Thus, social efficiency is adversely affected as well.

Significant quality improvements, as a result of informal patient payments seldomly exist. Overall, health care providers are not interested in reinvesting these payments in the public health care system (e.g. for purchasing new medical equipment) but are more likely to invest them in their own private practices (if dual-practice is allowed and if informal payments are invested at all). In the long run, this leads to better quality of services provided in the private sector, even when provided by the same physician. Thus, the public health care provision remains underfunded even when informal patient payments are widely spread. This does not mean however, that the health care providers remain under-paid. Yet, there are no incentives for health care providers to improve current conditions and working patterns when they provide public health care services and receive informal payments [15].

The most adverse effect of informal patient payments concerns equity. When informal patient payments are established as a practice, patients who cannot afford to pay informally either avoid or delay seeking treatment, or more likely, use personal savings, loans and sell assets to cover these payments [26]. The ultimate effect is the same as referring patients to the private health care sector [13]. Thus, the burden of informal patient payment is not distributed equally within different socio-economic groups. In some instances, patients with very low earnings are found to pay informally about six times more in relation to their income than those in high-income groups [20, 21]. Therefore, informal patient payments are highly regressive even when compared to formal patient fees [15].

Since informal patient payments are provider-determined (excluding expressions of gratitude where patients are intrinsically motivated to make informal payments),

there is a hypothesis that health care providers can cross-subsidise unofficially when charging wealthier patients with higher informal payments than the poor patients [13]. However, the validity of this hypothesis depends to a large extent on the social structure and level of solidarity within the society [23]. The rationale behind the theory of cross-subsidising is quite weak since willingness-to-pay is a more important determinant of informal patient payments than the ability-to-pay, especially when immediate care is needed and where the choice of providers is limited [13]. There is no reason to expect that wealthier patients will pay more informally than the poor. In fact, the empirical evidence shows rather the opposite [20, 21].

The issue of informal patient payments is also relevant to policy-making when formal patient payments are introduced or considered for introduction. There is an overall concern that official charges do not have the ability to eliminate the informal ones, and their introduction may result in a mixture of formal and informal payments by the patients [24–26]. If no effective measures for dealing with informal patient payments are introduced, the effectiveness of the exemption mechanism for vulnerable population groups that accompanies official charges, could be undermined.

2. Why do informal patient payments exist?

Before attempting to deal with informal patient payments, it is necessary to understand the reasons for their existence and their role in health care provision. This could indicate the mechanisms through which these payments can be influenced by policy, as well as relevant strategies for dealing with these payments.

The literature offers various theoretical explanations of informal patient payments. Namely, Gaal and McKee [27] develop a cognitive behavioural model on informal payments, which draws on the theory of government failure and extends Hirschman's theory of "exit, voice, loyalty" (INXIT theory). The INXIT theory is applicable in different situations, i.e. indentifying quality-conscious patients and physicians, and analysing their response to a decline in performance, as well as to key dilemmas in the health care systems seeking to improve equity and efficiency [27].

Another theory that could offer a way of understanding informal patient payments is the theory of Bourdieu [28]. This theory is constructed in response to theory of rational choice as an explanation of human behaviour. It emphasises the role of practice and embodiment or forms in social dynamics and worldview constructions. Bourdieu [28] uses the concepts "field" and "habitus", where "field" is a social arena in which people manoeuvre and struggle in pursuing desirable resources and where "habitus" is a system of dispositions toward various practices.

Theories from the field of sociology and psychology (such as theory of rational choice, theory of social exchange, psychology of change, theories of reasoned action and planned behaviour) also appear relevant for

explaining the phenomenon of informal patient payments. For example, Vian and Burak [29] analyse the existence of informal payments from the perspective of intentions, past behaviours, attitudes and beliefs.

Empirical evidence confirms these theoretical explanations. It indicates that informal patient payments are sometimes made due to the patients' gratitude for services provided [10, 12], but such payments also result from the misuse of market power by the health care providers due to monopoly or due to the principle-agent relation between providers and patients [7, 13, 25].

As reported in empirical studies (e.g. [3, 7, 10, 12, 15, 30–32]), the main reasons why patients make informal payments and why physicians or medical staff accept/request such payments, can be summarised as follows:

Patients make informal payments in order to:

- thank the physician and medical staff;
- reduce waiting time from referral to hospitalisation;
- obtain services with higher quality or obtain more services;
- obtain treatment at specific health care facilities or from specific physicians;
- obtain services that are not available formally in the medical institution;
- substitute for a high formal patient payment;
- respond to the request of physician or medical staff to pay informally;
- establish a good relationship with the physician (in order to get good service next time or to get the service at any time).

Physicians or medical staff accept/request such payments due to:

- low level of income and salaries;
- possibility to receive unregistered cash that is several times higher than formal fees;
- incoherence between official fees and physicians' perception of their true costs;
- perceived higher expertise than colleagues, who receive the same reimbursement;
- lack of resources for purchasing necessary equipment, instruments, and materials;
- lack of resources for professional development and improvement;
- lack of regulations and unresponsive government.

Thus, informal patient payments can be seen either as "donation" or as "fee-for-service" [9]. The donation hypothesis affirms that gratitude payments do not adversely affect efficiency in health care provision in cases when the gratitude payments are sustainable [26]. Gratitude payments can improve the responsiveness of health care staff, ensure sustainable supply of human resources, and provide incentives for physicians to stay in the profession, especially in countries where medical staff is under-paid [9]. The fee-for-service hypothesis states that informal patient payments can exhibit the adverse effects of formal co-payments but with additional complication of lack of transparency, which makes it difficult to control them [3, 10, 15, 27]. Still, these are only hypotheses and they need to be tested to explain the existence of informal patient payments in some parts of the world and their absence in others.

3. Three areas for possible solutions

Overall, the reasons for the existence of informal patient payments discussed above, suggests three areas for possible solutions to the problem of informal patient payments: cultural perceptions, insufficient funding of the health care sector and lack of control and accountability in the health care system.

Cultural perceptions

People use gifts to express their gratitude. Thus, gratitude payments for health care services could be seen as a part of the social culture (see e.g. [10, 12]). However, informal patient payments are gratitude payments as long as they are gifts in kind with negligible monetary value and are given after the service provision [1] by the thankful patient without any request or hint by the staff. Truly gratitude payments would be sustainable for the patient and patient's family, and would not adversely affect efficiency in health care provision. The elimination of such informal payments would require a change of culture, which means inter-sector efforts and generally more time to be achieved. Nevertheless, informal payments that are not truly gratitude payments (e.g. expensive gifts in kind or informal cash payments often requested by the staff or given by the patient as a bribe for service provision) may also look or may be even presented like gratitude payments. To be able to deal with such "gratitude" payments, strategies for dealing with corruption should be followed [30, 33].

Insufficient funding

In countries where the public health care sector is under-funded, the existence of informal patient payments is often excused by insufficient health care resources (see e.g. [3]). As a result, informal patient fees are charged by providers to fill in the gaps in funding of medical supplies, diagnostics, pharmaceuticals and hospital hotel services. Informal compensations are also requested (directly or indirectly) to supplement the low salaries of health care providers. Under these circumstances, informal payments become a means for the patient to receive more attention by the health care staff, as well as to ensure better quality and quicker access to health care [7, 26, 31]. Informal compensations also provide incentives for low-paid physicians to stay in the profession. However, the implementation of formal patient fees with an adequate exception mechanism in addition to a suitable health care funding mechanism, would be a more appropriate solution to insufficient health care resources. Nevertheless, Lewis [5] shows that this is not sufficient to eliminate informal payments. The formal fees should be accompanied by a suitable rewarding mechanism for the physicians.

Lack of control and accountability

Governance and accountability in the health care sector emerge as important determinants of the performance of the health care systems (see e.g. [27, 33]). Nevertheless, they are still under-estimated and even neglected in some countries. Poor governance and poor accountability contribute to the existence of corruption and create a favourable environment for informal patient payments. The incapability to maintain the rule of law leads to non-ethical behaviour of medical staff, who can use their bargaining power to increase their earnings [34, 35]. Thus, the development of a transparent system for monitoring and control of health care provision and patient payments can be essential steps in dealing with informal payments.

4. Strategies for dealing with informal patient payments

There is no single solution since the phenomenon of informal patient payments is not isolated but rather connected to the overall performance of public health care sector in a country (e.g. [3, 13]). Moreover, different strategies for dealing with informal patient payments have various disadvantages [3, 13].

Punitive measures

Penalties can be imposed on those who receive/request informal payments. One of the basic characteristics of the environment where informal payments are prevalent is a weak regulatory system. Strengthening the control and accountability in the health care sector will be essential for dealing with corruption. However, if the financing of the health care system is insufficient, it is hard to expect that imposing sanctions to providers would be an effective measure for dealing with informal patient payments. Among other things, imposing sanctions could be one of the driving forces for shifting providers from public to private sector. The government should continue to invest in the improvement of health care quality and access to health care services.

Higher salaries for health care workers

The income of physicians and medical staff could be increased. Informal patient payments often supplement the low salaries of physicians and medical staff in the public sector. However, the simultaneous increase in the income level of physicians and medical staff is a rather challenging task since it depends on the overall economic growth in the country. An alternative is to implement a provider payment mechanism that will allow for a more fair compensation for service provision (e.g. based on quality and professional skills) rather than a uniform central payment scale for physicians and medical staff. This, however, should be combined with a significant increase in the incomes of providers who offer good services, to assure the acceptance of this new provider payment mechanism by the medical lobby.

Introduction of formal patient charges

It is assumed that patients who pay informally would be in favour of introducing official charges for public health care services. Yet, there is an overall concern that official charges do not have the ability to eliminate the informal ones, and that their introduction would result in a mixture of formal and informal payments by the patients. Moreover, vulnerable population groups who are exempted from formal charges might continue to pay informally, especially if the medical staff refuses to grant the formal exemption and requests an informal payment. This could result in a failure of the exemption mechanism that accompanies the official charges and could create public opposition towards these changes. It is necessary to assure that formal charges replace informal payments immediately after their introduction.

Development of private sector alternatives

The effect of informal patient payments is similar to shifting the patients to the private sector. Therefore, the development of the private sector could help to formalise the informal payments. In particular, patients could be offered the option to use health care services included in the basic health care package but provided by private health care providers. This could result in a direct competition for patients and some physicians might decide to be involved in both sectors. Lower or no official charges in the public sector compared to the private sector might stimulate the use of public health care services. However, better quality of services provided in the private sector, even when provided by the same physician (if dual-practice exists), might shift patients to the private sector. Given the potential weaknesses of each of the above options, a mixture of strategies is advisable for dealing with the problem of informal patient payments. The successful implementation of these strategies and the possibility to circumvent their weaknesses will depend on the particular setting and the overall conditions in the country [3, 13]. The prevalence of corruption in the society is crucial. Dealing with corruption at all social levels will be a precondition for dealing with informal patient payments.

5. Changes in attitudes as a precondition for success

Changes in attitudes of the health care consumers, providers and policy-makers will also play a crucial role in eliminating informal payments for health care services. This could help to build a social resistance against this type of payments.

Health care consumers

While consumers are generally interested in solving the problem of informal patient payments, they often accept these payments as a means of gaining more attention, better quality and quicker access to health care. Information campaigns among health care consumers are needed to change their attitude towards informal

payments [10, 29]. In addition to this, patients need to be well informed about the size of the official fees that they are obliged to pay for health care service *prior* to the use of these services. Patients are often unable to make a distinction between formal and informal payments, especially if they do not know the exact size of the formal charge. Also, there is a need of a formalised channel for filing complaints by patients who are asked to pay informally for health care services. The procedure for filing such complaints should be easy and simple.

Health care providers

Health professionals are often reluctant to comply with strategies for dealing with informal patient payments and attempt to maintain the “status quo”. They might even try to sabotage measures aimed at eliminating informal payments (e.g. by creating unnecessary delays for patients). Therefore, the power of the medical lobby will play a key role in eliminating informal payments [3, 13]. Mechanisms to improve integrity and ethics in health care provision will be essential. It is necessary to develop a professional code of conduct for physicians and other health professionals related to medical and non-medical activities. The main objective of such codes should be to ban the request or acceptance of any informal payment (either in cash or in kind), including gratitude payments and gifts.

Health policy-makers

Informal patient payments are not always seen as a negative phenomenon by policy-makers, especially in countries with very low fiscal capacities and insufficient financing of the public health care sector [15, 26]. In these countries, informal patient payments could be the only factor that maintains the survival of the public health care system and keeps physicians working in public health care institutions (e.g. hospitals). Thus, policy-makers might address informal patient payments since they are of an unethical nature, but they might decide to neglect these payments in their decisions since they do not have an alternative for filling in the gaps in the public health care budgets. Due to the non-transparent nature of the informal patient payments, health authorities might even deny the existence of bribes in the health care system [3]. Under such circumstances, solutions to the problem of informal patient payments would not be a priority. Changes in the attitude of policy-makers toward informal patient payments will be essential.

Conclusion and policy recommendations

This paper reviewed the policy challenges related to informal payments for public health care provision and strategies for dealing with these payments. Although we recognise that the exact measure for eliminating informal patient payments depends on the country context (e.g. prevalence of corruption, and attitudes of health system stakeholders towards informal payments), we outline

several policy recommendations that might be useful for policy-makers confronted with this health care problem.

In particular, we suggest that policy-makers should strengthen the control and accountability in their health care sectors and create a system of penalties for those who receive/request informal payments. A simple and easily accessible system for filing complaints by patients, who are asked to pay informally for health care services, should be in place. At the same time, it will be necessary to assure continuous government investments in the improvement of health care quality and access to health care services, as well as an adequate system funding for the normal functioning of the public health care sector.

The implementation of a provider payment mechanism that allows for an adequate and fairer compensation for service provision (depending on quality and professional skills) could also facilitate the elimination of informal patient payments. There should be also incentives for the development of a private sector that leads to direct competition between public and private providers, but the dual-practice by physicians should be prohibited.

These mechanisms for dealing with informal patient payments could be coupled with the introduction of official/formal patient charges with an adequate exemption and fee reduction mechanism for those who cannot pay or who use health care frequently. It is also necessary to identify instruments to assure that formal charges replace informal payments immediately after their introduction to avoid the double financial burden to patients, as well as the failures of the exemption mechanism. Moreover, a transparent system of official patient charges should be created. Information about official charges and free-of-charge services should be available and easily accessible to patients prior to service use.

Information campaigns targeting health care consumers, providers and policy-makers should be launched in order to mobilise a social opposition against informal patient payments. This will be an important precondition for the successful elimination of these payments.

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Abstract:

The topic of informal patient payments is rather new in policy discussions although the phenomenon has existed for decades. These payments are a threat to public health since they jeopardise efficiency, equity and quality of health care provision. Most importantly, those who cannot afford to pay might not seek or delay seeking treatment. Before attempting to deal with informal patient payments, it is necessary to understand the reasons for their existence and their role in health care provision. This could indicate the mechanisms through which these payments can be influenced by policy, as well as relevant strategies for dealing with these payments. This paper outlines a mixture of strategies as a plausible solution to informal patient payments. The successful im-

plementation of these strategies depends on the particular setting and the overall conditions in the country (e.g. prevalence of corruption, and attitudes of health system stakeholders towards informal payments).

■ Streszczenie:

Nieformalne opłaty pacjentów za świadczenia opieki zdrowotnej: wyzwania dla polityki i strategie rozwiązań

Słowa kluczowe: opłaty nieformalne, opieka zdrowotna, strategie polityki zdrowotnej

Nieformalne opłaty pacjentów, choć występują od wielu dekad, są tematem stosunkowo nowym w dyskusjach z zakresu polityki zdrowotnej. Opłaty te są zjawiskiem niekorzystnym, ponieważ zagrażają efektywności, równości i jakości opieki zdrowotnej. Co najistotniejsze, osoby które nie stać na poniesienie opłaty, mogą zaniechać korzystania z opieki zdrowotnej lub wizytę u lekarza opóźnić. Przed podjęciem prób zwalczania opłat nieformalnych istotne jest zrozumienie powodów ich istnienia i roli, jaką pełnią w dostarczaniu świadczeń opieki zdrowotnej. Pozwoli to na wskazanie mechanizmów, poprzez które polityka zdrowotna będzie oddziaływała na opłaty nieformalne, a także istotnych strategii ich zwalczania. W artykule przedstawione zostały różnorodne strategie oraz prawdopodobne rozwiązania problemu opłat nieformalnych. Skuteczne zastosowanie tych strategii zależy od uwarunkowań danego systemu, a także ogólnych warunków istniejących w kraju (np. powszechności zjawiska korupcji i stosunku uczestników systemu opieki zdrowotnej do opłat nieformalnych).

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