

# A BRIEF INSIGHT INTO THE STUDY OF INFORMAL HEALTH CARE PAYMENTS IN ROMANIA\*

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## Abstract

Informal health care payments are a frequently studied topic in Eastern European health care systems, given their impact on the financing of the health care sector. The Romanian health care system is facing the issue of informal payments for a long period. However, little evidence exists regarding the dimension of these payments, or the stakeholders' attitudes towards them. This article aims at identifying people's sources of informal payments, as well as their perceptions about the settings where informal payments are offered. Data were collected by means of a telephonic interview. 1,500 individuals who were part of a nationally representative sample were interviewed, out of which, for the present article, a subsample of 647 respondents was extracted. To serve this purpose, a 5-part questionnaire was developed by the research team. The amount of money offered as informal payments varied between 2 and 3,000 Euros. Out of the total sample population, 44.2% believe that in the inpatient surgery care services gifts are offered most frequently, while 55.31% of respondents place inpatient surgery care as being the place where highest amounts of money are given. This may represent a threat for people's access to this type of services, as well as for the equity of care across different socio-economic categories. As such, policies aimed at addressing informal payments should take into account these particularities.

**Keywords:** informal payments, policies, public facilities, private facilities, health care system.

## **1. Background**

### ***1.1. Past and current perspectives on informal health care payments***

Informal payments are characterizing many health systems from Eastern European and Central Asian states, coming as an inheritance from the past communist period (Fotaki, 2009). Informal payments have been defined as the ‘unofficial amount of money or kind given to an institution or individual in exchange for the beneficial of better health services’ (Lewis, 2000). Informal payments are often correlated with the phenomenon of corruption (Transparency International, 2006). This is frequently encountered in the ex-communist countries, although informal payments are met in numerous healthcare systems, whatever the economic perspectives are (Stepurko *et al.*, 2010). The tendency to correlate informal payments and corruption and place them in a causal relationship is especially strong in settings where unofficial fees are increasing the corruption coefficient (Lewis, 2006). Moreover, because informal payments do not follow any formalized channels and, as long as they are apprehended by the medical personnel without being charged for taxes, these payments are categorized as bribe or fees (Allin and Davaki, 2006). Despite the fact that the distinction between bribe and fee is not clearly defined, recent studies are showing that, from patients’ perspective, gifts are usually meant to express gratitude for medical care and services received (Kornai, 2000; Anderson, 2006) or to create a close connection with the physician for future treatment (Gotsadze *et al.*, 2005). Physicians are motivating the acceptance by ‘extra work’ done in the benefit of the patients (Miller, Grødeland and Koshechkina, 2000). These statements are leading to the conclusion that informal payments, seen as a precondition of receiving medical care, are shaping both patients’ and doctors’ behavior (Miller, Grødeland and Koshechkina, 2000).

### ***1.2. Physicians’ and patients’ attitudes towards informal payments***

There is evidence regarding the fact that individuals expressing the intention of giving informal payments are equally aware of positive and negative outcomes: they pay in order to get rapid medical care and attention, but in the same time they perceive this act as a constraint (Vian and Burak, 2006).

The most significant causal factors contributing to the prevalence of informal payments have been identified as being the stage of regional economic development and long term healthcare resources (Peter and Zelenska, 2010). Also, their reception is determined by physicians’ low income and the privation of transparency of the medical units’ management and administration (Belli, Gotsadze and Shahriari, 2004) as well as by several financial access barriers for the population, and the deteriorating condition of health care facilities (Belli, Gotsadze and Shahriari, 2004).

### ***1.3. Institutional framework of informal payments. Strategies and solutions***

The analysis performed on the implications of informal payments at institutional level reveals the fact that informal fees are affecting, on the one hand, the macro level and, on the other hand, the micro level of health care structure. Concerning the ma-

cro level, informal payments are seen as an effect of transition to democracy (Fotaki, 2009). They are placed on the health reform agenda as one of the top priorities to be approached, being a part of the public health sector which demands seeking methods to cease the phenomenon (Ensor, 2004; Liaropoulos *et al.*, 2008). Investigating informal payments from the perspective of the transition process is related to institutional issues such as lack of policies aimed to calibrate the process of providing health to advanced care structures (Shahriari, Belli and Lewis, 2011). Also, governments have been identified as responsible for the emergence and perpetuation of informal payments, due to their inability to design and implement a policy to address informal payments (Dabalén and Wane, 2008). A part of the responsibility is attributed to the physicians who accept to receive unofficial fees (Lewis, 2006) or to patients, who prefer to pay in order to obtain proper medical care (Mossialos and McKee, 2000).

In the attempt to propose a feasible model with the intention of stopping the phenomenon of informal payments, based on qualitative and quantitative research, policy makers have developed a series of solutions in this respect. The suggestions provided often lie in status change, namely in formalizing informal payments, i.e. making it legal to accept amounts of money or other goods in exchange of care (Baschieri and Falkingham, 2006; Mossialos *et al.*, 2002) or incorporate them in the official financial gain (Delcheva, Balabanova and McKee, 1997).

Another solution having a major role in reducing the prevalence of informal payments is the development of a well-structured insurance system (Joglekar, 2008; Syhakhang *et al.*, 2011). A recommended solution may be found in the Government initiatives to provide a health insurance scheme based on community infrastructure (Gotsadze *et al.*, 2005).

A different point of view states that raising physicians' salaries would diminish the high impact of informal payments, pointing towards low income as being the leading determinant for the persistence of informal fees (Vian, 2004; Allin and Davaki, 2006).

As a suggestion to improve the health system's performance, the idea of co-payments involves patients contributing to ensure health care services for everyone and hence limit the extent of informal payments (Shahriari, Belli and Lewis, 2011; Gaal and McKee, 2004). Despite the general belief, the enhancement of quality of medical services does not imply higher public costs, therefore it can be realized by implementing the principal of transparency (Gupta, Davoodi and Tiongson, 2000) and enhancing a clearly defined methodology with the purpose of instrumenting control (Vian and Burak, 2006).

Also, advancing an effective management system and monitoring instruments of internal finances is stated to have a large contribution in reducing theft and fraud, therefore corruption coefficient (Transparency International, 2006). This would lead patients to use public services and offer only official payments for their treatment (Gupta, Davoodi and Tiongson, 2000).

All the mentioned policy interventions are designed to decrease the level of corruption and facilitate the access to health care services, endorsing well-defined plans

to ensure accountability and transparency by public finance reform and supervision of control agencies (Vian, 2008). In order to tackle informal health care payments, the proposed solutions should have 'a systematic approach with comprehensive and well-sequenced policy instruments, including clear and realistic entitlements, restructuring and reinvestment of efficiency gains in the health sector, stable and adequate public funding and the absence of a blaming culture' (Gaal, Jakab and Shishkin, 2010). However, Romanian public institutions have been described as resistant to change, despite a long history of reforms and approaches (Antonie, 2012; Țigănaș *et al.*, 2011).

The present study aims at offering an image of informal payments in Romania from the patients' perspective. Moreover, it targets to reveal these specific characteristics by providing details about the proportion of people seeking care in public, respectively private medical facilities, as well as the amounts of money given as informal payments or the source of these incomes.

## **2. Methods**

### ***2.1. Study design and data collection***

The study has a cross-sectional design, with a quantitative approach. Data used in this article (n=647) was extracted from a larger database (n=1,500) containing information on the impact of informal payments on the Romanian health care system. We used telephone-administered questionnaires. Participants in the survey were interviewed by trained operators. All the respondents were over 18 years old and were interviewed only after giving their consent to take part in the study.

### ***2.2. Measures***

The questionnaire encompassed 5 sections, namely general information related to socio-demographic aspects, health status and medical care received, costs implied by medical services, readiness to pay and attitude toward informal payments in the health system and, physicians' characteristics.

### ***2.3. Data analysis***

Data collected were analyzed using SPSS statistical software, version 17. General characteristics of the subsample were computed using frequencies in order to show descriptive features of the subsample, logistic binary regressions and correlations in order to make predictions about patients' choice.

## **3. Results**

### ***3.1. Sample description***

60.8% of the total number of participants were women and 39.2% were men. 60.1% were living in urban areas, whereas 39.9% were rural area residents. 63.1% of the respondents were suffering of a chronic disease and more than half of the individuals included in the study had a secondary education level (55.4%). Concerning the ethnicity of the participants, most of them were Romanians (87.9%), followed by Hungarians (6.4%).

### ***3.2. Health status and the frequency of visiting a physician***

41.1% of the individuals were ill and visited a doctor during the previous 12 months, while 14.5% were not ill but visited a physician (for prevention purposes). Out of those who were ill and visited a physician, 18.34% were suffering of a severe illness, most of them having seen a doctor immediately (48.05%).

### ***3.3. Public versus private health care facilities***

84% of the respondents used public medical facilities. 19.25% of those choosing a private medical facility argued a better quality-price ratio and 16.15% reported a reduced waiting time compared to public facilities.

Binary logistic regression was performed to elicit the factors responsible for choosing a private facility. Results indicate that, for individuals reporting a reduced waiting time in the private medical facilities, the probability to address this category of facilities is 102 times higher. Also, the regression model pointed out a probability of 88 times higher to choose private medical care because of better hosting conditions. Moreover, physicians' expertise is also significant in patients' choice. There is a 33 times higher probability to choose private medical care if the patient perceives that the physician is more experienced.

Of those who visited a doctor working in a public facility, 56.98% argued they had insurance and the right to free medical care. The regression model also revealed that, for private settings which provide policies that are not available in the public system, the probability to address them is 14 times higher.

We also explored the relationship between socio-demographic characteristics and people's choice between private and public health care services. Pearson correlation coefficient showed a negative correlation between income variable and public services choice ( $r=-0.022$ ,  $n=616$ ) indicating that an increased income determines people to address more to private medical care. Also, the relationship between education variable and choice between private and public health care services was assessed using Pearson correlation coefficient, showing a positive relationship between them. Results display the fact that the less educated people are, the more they use public medical services.

### ***3.4 Contents and receivers of informal payments***

18.1% of informal payments consisted in gifts and/or services. 29.8% of other costs which intervened consisted in medicine and 22.4% for food. Of those who offered money, 95.92% gave them individually and 2.04% collectively. 58.8% of those who paid informally had the money from their monthly income, the minimum amount of money given being 2 Euros and the maximum amount 3,000 Euros.

Concerning the directionality of informal payments, surgery is indicated as being the most frequent hospital section where informal fees are offered (44.2%), the place where the most expensive gifts are given (58.8%) and where the highest amounts of money are given (55.31%).

#### 4. Discussion

Our study's findings come as a confirmation of empirical knowledge regarding informal payments. According to our results, Romanian patients spend considerable amounts of money for informal payments offered to health care professionals, as well as for services which should otherwise be provided by the health care system (out-of-pocket payments). Moreover, we report differences in the amounts of money and frequency of paying among various sectors of services. This finding is important due to its capacity to create differences in the access to and quality of these services delivered to different categories of patients. Moreover, Gaal and McKee (2005) suggested that a variable distribution of informal payments would be an argument for a gratitude character of the payment, whereas uniform distribution is more characteristic to coercion payments. Although we found that the amounts of money given to health professionals varied across a large interval, we cannot say that this is an argument for the gratitude character of the payments. The coercion factor cannot be eliminated, since there are important variations in people's incomes, which can eventually reflect in the amounts of money offered to health professionals.

Although presumably informal payments should be responsible for people's choice of private services instead of public facilities, our study demonstrates that the absence of informal payments in the private system is not among the most important factors accounting for this choice. However, more in depth analysis is needed to confirm this aspect. Alternative explanations for this finding may be related to the social desirability involved when individuals answered the question regarding the importance of informal payments.

Although reforms meant to tackle informal payments would be challenged to a great degree by the particularities of the Romanian public institutions (Mora and Țiclău, 2012; Hințea, 2011), successful examples from other countries, such as Kyrgyzstan, might prove helpful (Gaal, Jakab and Shishkin, 2010).

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