
Who is Paying for Health Care in Eastern Europe and Central Asia?

Maureen Lewis

Human Development Sector Unit
Europe and Central Asia Region
The World Bank
Washington, D.C.

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Abstract

Informal payments in the health sector in Eastern Europe and Central Asia are emerging as a fundamental aspect of health care financing and a serious impediment to health care reform. Informal payments are payments to individuals or institutions in cash or in kind made outside official payment channels for services that are meant to be covered by the public health care system.

Such private payments to public personnel have created an informal market for health care within the confines of the public health care service network, and are a form of corruption. Unlike gratuity payments to providers, informal payments are required, not discretionary. Part of the problem can be traced to declining revenues without commensurate downsizing of buildings, hospital beds and health personnel, which has meant reductions in salaries and in some countries chronic arrears. Informal payments compensate for lost earnings. Reforms to modernize the Region's health systems must compete with the personal revenues from informal payments, making change difficult.

The frequency of informal payments exceeds 60 percent in the CIS countries for which there are data, reaching 91 percent in Armenia, and are reported in all but a handful of Eastern European countries. Inpatient care carries the highest costs, but

pharmaceuticals are the most frequently purchased health service that public providers do not finance. Informal payments have become a major impediment to health care access leading to both reduced consumption due to unaffordable cost and the selling of personal assets to finance care. Systematic reports of delayed care in Poland, 37 percent reduction in prenatal care in Tajikistan and the fact that 45 percent of rural patients sold assets to finance health care in the Kyrgyz Republic suggest rising inaccessibility and declines in equity.

Options for addressing the problem include comprehensive anti-corruption policies, downsizing of the public system, paring back the set of services subsidized by government, encouraging cost sharing for those who can afford it, improving accountability, and promoting private alternatives.

Introduction

Informal payments in the health sector in Eastern Europe and Central Asia are emerging as a fundamental aspect of health care financing and a serious impediment to health care reform.

Informal payments can be defined as (1) payments to individual and institutional providers, in kind or in cash, that are made outside official payment channels and (2) purchases that are meant to be covered by the health care system. The former encompass “envelope” payments to physicians and “contributions” to hospitals, and the latter the value of medical supplies purchased by patients and drugs obtained from private pharmacies that should be provided by government-financed health care services. Voluntary purchases from private providers are not considered informal payments, but a market transaction at the discretion of the consumer.

Private payments to public doctors, nurses, and other health personnel have created what is essentially an informal market for health care within the confines of the public health care service network. Such payments exist outside the financial control, policy rubric, and audits of national health care systems, and, like the informal sector generally, are often illegal and unreported. In effect informal payments are a form of corruption.

A problem area is distinguishing between informal payments and gratitude payments. It is common practice in parts of Eastern Europe, and in the Commonwealth of

Independent States (CIS) countries,¹ to give gifts or payments to physicians as thanks for their services. The difficulty is determining when a gratitude payment is discretionary and when it is a required contribution. Some qualitative research has explored this question, but circumstances vary. What has emerged is evidence of an increasing necessity to compensate providers, over and above gratitude payments.

With the possible exceptions of Slovenia and the Czech Republic (see World Bank 1999a, 2000b, 2000d), informal health payments have been reported in all countries of the Eastern Europe and Central Asia (ECA) Region. While this issue has raised considerable concern in a number of countries, only recently have the relative importance and implications of the issue begun to be understood. Part of the difficulty has been measuring the extent of the problem, the nature of the process, and the burden that informal payments place on households.

Given the uncertain status of informal payments—in some countries they are clearly illegal, in others their legality remains ambiguous—comparisons across

¹ The CIS comprises Armenia, Azerbaijan, Belarus, Georgia, Moldova, Kazakhstan, the Kyrgyz Republic, Russian Federation, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan.

countries can be tenuous. The lack of consistent information and the varying country circumstances complicate efforts at devising effective policies and actions to address the practice.

This paper outlines the key policy issues of informal health payments, summarizes the available data on the scope and nature of such payments within ECA, and spells out policy implications. It also suggests possible strategies to address the problem.

Background and Historical Context

The health sectors of the Eastern European and Central Asian countries are characterized by excessive physical infrastructure and overcapacity, including overstaffing of physicians and nurses. As revenues have declined in much of the Region over the past decade, health expenditures have also fallen, resulting in large health systems with underpaid or unpaid doctors and inadequate medical equipment, drugs, and supplies. Some efforts have been made to require patients to officially pay part of the cost of treatment, especially for pharmaceuticals, but officially generated revenue has been inadequate to meet the shortfalls in resources (World Bank 2000c).

The use of private payment to gain access to health care was documented early in the transition period in ECA. World Bank studies in the early 1990s estimated that 25 percent and 20 percent of health services in Romania and Hungary, respectively, were paid for by out-of-pocket payments and gratuities (World Bank 1993), and a 1992 Bulgarian survey found that 34 percent of respondents had used a “connection” to attain medical care (cited in Delcheva, Balabanova, and McKee 1997). A related study in Vietnam showed that 81 percent of patients had to pay for medication and treatment at commune health centers that officially should have been free (World Bank 1992). Together, these findings suggest that the Communist system may have fostered informal payments and that its demise, and the subsequent contraction of public resources, may have led to the proliferation of such payments.

In Central Asia, the tradition of patients rewarding or thanking physicians for their services is a long one.

In Eastern Europe, there is a link between the publicly controlled health services under Communism and the emergence of under-the-table payments. This has been documented in Hungary (Gaal 1999b). In both parts of the region, the rigid command nature of the health system led patients to seek better, faster (by jumping the queue), or more thorough services than they could obtain under the public system. This translated into ex-ante payments as well as ex-post gifts of money or items. The distinction between ex-ante and ex-post payments may be important: upfront payments are either insurance or a down payment, while ex-post payments arguably demonstrate gratitude—although the latter may also simply reflect a down payment on treatment for future illness, rendering it less an expression of gratitude than a form of prepayment. Either way, they are different kinds of payment, with varying implications.

Why Informal Payments?

Informal payments are effectively a form of systemic corruption. Originating in government failures, they go on to provide a means by which corrupt public servants can ensure or maximize their income, evade taxes, and effectively “beat the system.” Such patient fees may have the virtue of making providers accountable to their patients, but they ultimately result in greater attention being given to those able and willing to pay for services.

Market Failure. The need for government intervention in health care is premised on the assumption that health care market failure stems from asymmetric information—physicians have good information about diagnosis and treatment, but patients have very little information or understanding of either—and externalities. The unexpected nature of ill health makes risk pooling a valuable means of sharing risk and of dealing equitably with the consequences of illness. In addition, communicable diseases such as tuberculosis, AIDS, or meningitis require aggressive prevention to contain their spread, a function that markets do not address effectively. While these reasons underlie the rationale for a government role in health care delivery and finance, they do not necessarily imply that the public sector should be the direct provider or payer of all health care. They do, however, support the case that government should guarantee access to health care and that it should protect consumers and regulate the health industry. Governments, however, often fail to fulfill their roles as protector of patients and as insurer through which risks are pooled. While market failure requires government involvement in health care, government involvement without accountability is no panacea.

Government Failure. As described above, much of the rationale for government involvement in the health care sector hinges on market failures. The response of many governments has been to assume the financing and delivery of health care, as was the case with the Soviet Union. Unfortunately, jointly financing, delivering, and overseeing health care services within the public sector has translated into government failures, as there is no independent oversight or role for consumers in ensuring that health care supplies are accessible, adequate, and acceptable. Ultimately, providers and administrators are accountable to no one.

The unwillingness or inability of most governments in the Region to reduce their excess capacity, or otherwise adjust to declining overall incomes or government revenues is an additional form of government failure. There has been no downsizing commensurate with declining GNP and government revenues, there is underutilization of health care in countries like Azerbaijan and Ukraine, and in other countries there is a mismatch of specialty needs and specialty services. The numbers of beds and physicians and the lengths of hospital stays—the most costly element of health care—exceed levels in the OECD

countries by two and three times, despite the fact that per capita incomes are a fraction of those found in the world's richest countries. With too many staff, hospitals with low occupancy rates, and virtually no modern management, health systems in much of ECA are spreading their resources too thinly and are unable to adequately fund the breadth of their services (World Bank 2000c). Even where overcapacity is less striking, as in Poland, there is a mismatch between evolving needs, such as oncology, and existing capacity, such as that provided for pediatrics, again resulting in unneeded, publicly subsidized capacity.

The response in much of ECA has been an explosion in informal payments as patients seek to circumvent the inadequacies in and unresponsiveness of the health system. This consumer role has serious implications for the health care system and for perceptions of and confidence in government.

Government failure in developing countries also translates into nonperformance and fraud in the health system. Preker, Harding, and Girishankar (1999) have examined this issue within an institutional economics framework, and recent empirical work by La Forgia et. al. (1999) and Lewis, Eskeland, and Traa-Valarezo (1999) has documented some of the egregious shortcomings that can be traced to failure in a government-controlled and -operated system. In most countries, evidence of government failure is manifested in the absence from hospitals of key medical personnel, particularly physicians, and the need for patients to supply their own consumables, drugs, and sometimes even independently obtained diagnostic tests (Chawla 1995; Lewis, La Forgia, and Sulvetta 1992, 1996). These practices reflect government failures to establish, monitor, and enforce regulations. They can also be seen as forms of corruption.

In most developing countries, a parallel private market serves private patients, and public physicians commonly refer public

patients to their private practice. The lack of a developed private infrastructure impedes similar practices in the ECA Region, particularly for inpatient or diagnostic services,² causing physicians, nurses, and other health workers and managers to use public venues to supplement their incomes.³

In developing countries, where salaries are low and infrastructure is weak, wage bills are generally met. In the ECA Region, resources are simply insufficient to keep the oversized health care systems operating, leading to a range of measures that undermine the basic operation of health care. In countries such as Georgia, Ukraine, and the Russian Federation, physician salaries have declined precipitously in both absolute and relative terms and arrears in meeting payrolls are common. In Poland, the number of physicians grew by 9.8 percent between 1990 and 1997 (Preker, Jakab, and Schneider [forthcoming]); at the same time, public spending on health care contracted, translating into a decrease in physician salaries. Without serious restructuring of the organization of care and reductions in the size of personnel rosters, there is little likelihood of improvement.

In much of the CIS, wages are low and often unpaid, resulting in either the absence of service or an implicit fee-for-service system. High personal taxation and a pattern of tax evasion make informal payment attractive to providers who can avoid taxes by under-the-table payments; the latter is also true in much of Eastern Europe. In contrast, physician wages in the Czech Republic and Slovenia have kept pace with inflation and the average earnings of doctors are above average national earnings. Informal

² Dental care, however, is increasingly a private service in the region paid under fee-for-service arrangements.

³ In some countries, such as Ukraine and Georgia, nonpayment of salaries has meant that informal payments are the sole source of income. In others, such as Hungary and Poland, they supplement relatively low salaries.

payments in these countries are rare (World Bank 1999b, 2000b), suggesting that physician earning levels may be a contributing factor fueling such payments.

Corruption. One outgrowth of government failure is corruption. Klitgaard (1998) posits that:

$$\text{corruption} = (\text{monopoly} + \text{discretion}) \\ - \text{accountability}$$

The circumstances in the health sector in ECA neatly fit these criteria. First, the public sector has a virtual monopoly on the health sector, a legacy of the Soviet past. There is virtually no private sector in the Region, and insufficient capital to establish one. Upfront investment costs are high, as land and buildings are costly and most equipment must be imported; legal impediments to private inpatient care also exist in some countries. Uncertainty of consumer ability to pay also restricts the growth of a competing private sector. Private health care thus remains in its infancy in most of ECA, leaving government with a monopoly on infrastructure and equipment.

One of the most disturbing implications of informal payments is that it fuels corruption and the growth of the “gray economy,” undermining government efforts to improve accountability and public sector management. Its importance in Ukraine was highlighted by a study of corruption among consumers, which found that respondents listed health care second only to automobile inspection as the most corrupt of public services (Ukraine Legal Foundation 1998). In Tajikistan, where 70 percent of respondents expected to have to pay for health care (Mirzoev 1999), the sector was perceived as more corrupt than any public service except for education. And in the Slovak Republic, a survey of 1,800 people in and out of government showed that health care was perceived as the most corrupt sector of the government (Anderson 2000). Public opinion polls for the Slovak Republic

conducted between 1996–98 indicate a slow but steady rise over the period in perceived corruption (Sicakova 1999).

Monopoly power emerges from lack of transparency, which has assisted the state capture and state monopoly of the health care sector. State capture refers to the actions of individuals or groups in both the public and private sectors to influence the formation of laws, regulations, decrees, and judicial decisions that serve their own interests (World Bank 2000d). This often applies to physicians in the health sector as they lead government ministries, and control and staff hospitals. The competition that would potentially break this monopoly power lies with physicians outside the public system, but they lack the resources, infrastructure, and client base to provide an alternative. Legislative barriers (a symptom in some cases of policy capture) and inadequate household demand also discourage the establishment of an effective competitive alternative.

Lack of accountability is evidenced by the low probability of getting caught and of minimal sanctions for those who are—punishments for accepting illegal payments are virtually nonexistent. The governments in the Region remain largely incapable of monitoring the health system in general, much less identifying and addressing the problem of side payments. Management information systems and quality assurance or other systematic tools for management and oversight generally do not exist.

The discretionary authority of health providers is also extensive, particularly of physicians who make medical decisions with minimal supervision. Hospital directors, while they are often audited on public expenditures, are not evaluated on performance or quality of services. The lack of accountability to a higher authority—to the ministry of health, hospital director, the general public, or patients—is limited, as performance is rarely, if ever, the basis for

reward or penalty. This again contributes to the emergence of corruption.

Despite the conducive environment for corruption, its nature and structure remain vague. Who is paid, how much, and by whom is only beginning to be understood, but greater understanding is important if abuse of the system is to be addressed and resolved.

It is useful to put the ECA situation in the context of the industrialized countries, many of which also have publicly dominated health care systems. In the industrialized countries, public accountability to society and to government authority is high; policy, actions, and programs are transparent; and clear penalties are exercised where needed.

Monopoly power is blunted by other interests that have equal footing, such as patient advocates, nursing associations, and hospital managers, among others. These same agents reduce the discretionary power of physicians. There is thus greater balance in these health systems, and therefore also less risk of state capture and of the resulting corruption that plagues many ECA countries. The conditions for fostering growth of informal payments are clearly in place, and as the evidence that follows suggests, in some systems they are entrenched. The source of the practice has been outlined above; the next sections address the importance and the magnitude of the issues. Methods to address corruption are dealt with in the concluding section.

Why Do Informal Payments Matter?

By definition, informal payments are unaudited and unreported. As such they have implications for governance, equity and access, government priorities, and incentives faced by both health providers and managers.

Access and Equity. Requiring payments from patients restricts access to health care to those who can pay, makes payment levels and terms arbitrary, and can render essential services unaffordable. One of the primary reasons for government involvement in financing health care is to pool the risk of illness across the population and to therefore pool resources to ensure equity both across the healthy and the sick, and among those who cannot afford health care. The present arrangement undermines those objectives, producing what is effectively a private, unregulated system operating within a public shell. Without the government regulations that in a formal private system ensure standards and the financial solvency of insurance, there can be neither fairness nor fiscal responsibility, and this is the case with a system based on informal payments. Both quantitative and qualitative studies suggest that the poor as well as the nonpoor may be disadvantaged from using the public system as they are unable to pay. However, the burden falls more heavily on the poor, given their more limited ability to pay.

Undermining the Functioning of the Health Care System and Impeding Health Care Reform. The informal nature of “envelope” payments reduces the role of public policy and the likelihood that

resource allocation decisions will be made in the public interest. Since payments are set with virtually no involvement of the system sponsor—the government—it is patient ability and willingness to pay that determines where resources flow into the system. Priority expenditures, such as maternity care, are not necessarily realized, as investment decisions are determined by the market, driven by provider decisions as to whom should benefit from services, rather than by general need. In short, government objectives become marginalized.

In Hungary, efforts to encourage downsizing of the health sector have achieved little. Likewise, the inefficiency and poor quality of the health system in much of the ECA Region will persist under the current organizational, financial, and regulatory arrangements. Funds from informal patient payments often go to individuals rather than to facilities or to the overall system. Inadequate investment in medical equipment upgrades, heating system improvements, and efforts to introduce better and more cost-effective medical protocols or generally to ensure the proper functioning of the health care system are all victims of financing that is largely informal.

Reform requires that those who run the health systems—both medical and administrative leaders—become convinced of the benefits of the shifts in incentives, behaviors, and practices that define reform. Where projected individual losses appear great, the resistance of these leaders can undermine efforts for change. Management theory in fact hinges corporate restructuring on change agents able to lead and convince the key players in the system to move toward new ways of work

The change agents in health care must be the sector leaders, both those in the ministries of health and those in the major health centers. But where the existing system is lucrative

for these major players and the future uncertain, as it is in much of ECA, engendering reform will likely be difficult and resisted. Given the Region's upheavals in the past decade, change is unlikely to be embraced with alacrity.

The more entrenched corruption and informal payment arrangements become, the more difficult it will be to reform the system. Reform always produces winners and losers, and if it is those currently in power who stand to lose the most, reform will remain elusive. The powerful must buy in to the reform if the levers of the system are to be reached and change to be achieved.

Measuring Informal Payments

Informal health payments are difficult to measure for the same reasons that the size of an underground economy can only be a best guess: there are no records of transactions or of pricing, much is accomplished in secret, and little is openly discussed. By definition, informal payments pass between payer and payee without records or audits, and where such payments are illegal they are even more difficult to trace and estimate. Data collection on the subject is therefore complicated.

Generalizations about the practice of informal health payments are also inappropriate. Given its illegality in much of Eastern Europe, providers have been reluctant to admit or discuss informal payments. The patterns of requesting, pricing, collecting, and distributing proceeds also differ by country. In the countries of the CIS, for example, informal payments are not always illegal, partly because the tradition of gift giving blurs the line between gratitude and required payment. In Poland, administrators reportedly share the proceeds from physicians; in other countries, they do not. In some countries, individual payment to every service provider is demanded; in others, this is uncommon. The difficulty of obtaining data thus combines with diversity of practice to make generalizations unreliable.

The differing interpretations of what constitutes an informal payment also impede the data collection process. For example, is an ex-post gift considered an informal payment? Can a gift in kind be seen as a bribe? And are purchases of drugs formal or informal expenditures? The different understanding of these kinds of questions

can lead to uncertain answers and ambiguous results.

Despite these difficulties, however, there is a growing body of relevant and interrelated information and evidence on the practices of informal payments and of their influence on health system operation. Table 1 summarizes the types of surveys that have been conducted since the early 1990s that include information concerning informal health payments, as well as the scope of the surveys and the measurement method for informal payments. These surveys range from small qualitative efforts to series of in-depth interviews with users and providers, major household surveys of multiple rounds, and dedicated household surveys that focus exclusively on informal payments.

General household surveys are the most common source of measurement. The World Bank's Living Standard Measurement Surveys (LSMSs) and variants of it (indicated in Table 1 by LSMS in parentheses) provide the best sources for comparison because they use a standard questionnaire, representative samples, and the application of special health modules

Table 1
Summary of Studies/Surveys of Informal Health Payments

Country (Survey Year)	Data Source/ Author (Year)	Type of Survey	Sample Size (number of individuals)	Types of Informal Payment Measures
Albania (1996)	World Bank (1997)	LSMS Household Survey	523	Survey covered three cities. Survey not totally representative
Armenia (1999)	World Bank (2000)	National Institutional Review Survey of Households	100 households	Detailed survey of official and unofficial payments
Armenia (1999)	Kurkchian (1999)	Interviews with managers, medical staff, and others	99 interviews, 17 focus groups	Costing of informal payments for related diagnoses. Interviews conducted at 10 hospitals and four polyclinics
Azerbaijan (1995)	World Bank (1997)	Azerbaijan Survey of Living Conditions	2000	
Bulgaria (1994)	Delcheva, Balabanova, and McKee (1997)	Survey of State Health Services	700	Average cost of treatment and per capita income
Bulgaria (1997)	Balabanova (1999)	Survey and focus groups	1,547	Informal payments by gender, in kind/cash; payments by quartile; timing of payments
Bulgaria (1997)	Gallup data set (1997)	Bulgaria Integrated Household Survey (BIHS)	9,750	Little health expenditure data
Georgia (1997)	World Bank (1999)	Household survey (LSMS)	14,486	
Georgia (1999)	Georgian Opinion Research Business International (1999)	Focus groups	50 in focus groups	Only includes providers, six different focus groups
Georgia (1997)	Mays and Schaefer (1998)	Government accounts	N/A	Health expenditure (government accounts)
Kazakhstan (1996)	Sari, Langenbrunner, and Lewis (2000)	LSMS Household Survey	7,223	Per capita income by location, poor/nonpoor, national spending
Kyrgyz Republic (1993)	Abel-Smith and Falkingham (1996)	Kyrgyz Health Financing Survey	8,509	Detailed information on formal and informal costs to households, how they cover costs, and deterrents to consumption

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Country (Survey Year)	Data Source/ Author (Year)	Type of Survey	Sample Size (number of individuals)	Types of Informal Payment Measures
Kyrgyz Republic (1993/96/97)	Dorabawila (1999)	LSMS Household Survey	10,000 (1993) 8,995 (1996) 13,734 (1997)	Health module only to adults in 1991, but to all individuals in the other years
Macedonia (1997)	Farley, Nordyke, and Peabody (1998)	Household survey of health status, health insurance and economic status	8,277	Measured out-of-pocket payments, not distinguishing between formal and informal
Moldova (1999)	Ruzica et al. (1999)	Survey of physicians, nurses, and patients	390	130 physicians, 130 nurses, and 130 patients interviewed in Chisinau (75 percent) and two judets. Group interviews also conducted
Poland (1994)	Government Statistical Office (GUS) (Sept, 1994). Chawla, Berman, and Kawiorska (1998)	Household survey	12,359	First household survey of medical care use and expenditure, with details on informal payments
Poland (1997)	Chawla et al. (1999)	Household survey of outpatient services in Krakow	12,359	Cost of treatment. Details on payments to different kinds of providers. Distinguishes formal and informal payments
Poland (1998)	Government Statistical Office (GUS) 1999	Household survey	11,983	Gratitude payments to doctors and medical staff; payment for drugs and supplies; other inpatient services
Poland (1999)	Lewis et.al. (2000); Shahriari, Belli, and Lewis (forthcoming)	Survey of discharged/treated patients from insurance roles; and focus groups and in-depth interviews with patients and providers	511 inpatients and outpatients; 122 in-depth interviews; 63 people in focus groups	Qualitative interviews of patients (95) and providers (27) at identical locations. Qualitative and quantitative surveys in two cities, and quantitative in two rural municipalities
Romania (1994)	World Bank (1997)	Integrated Household Survey (LSMS)	76,852	

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Country (Survey Year)	Data Source/ Author (Year)	Type of Survey	Sample Size (number of individuals)	Types of Informal Payment Measures
Russian Federation (1997)	Feeley, Sheiman, and Shiskin (1999); Boikov and Feeley (1999)	Household informal payments survey	3,000	Detailed survey of formal and informal payments, use of private sector, and equity effects of policies and practices
Russian Federation (1997)	World Bank data set (1997); Glinskaya, Langenbrunner, and Chellaraj (1998)	Russian Longitudinal Monitoring Survey (RLMS)	8,701	Health module
Slovak Republic (1999)	Anderson (2000); Sicakova (1999)	Corruption survey/interviews, including health	1,800	Interviewed general populations and government officials
Tajikistan (1999)	World Bank data set (2000); Falkingham (2000)	LSMS Household Survey	14,142	First national household survey
Ukraine (1998)	Kiev International Institute of Sociology (1999)	Exit and household quantitative surveys and qualitative methods: interviews, focus groups, patient diaries	100/200	In-depth discussions with providers as well as patients. Focus on perceptions
Ukraine (1999)	Way (1999)	Qualitative surveys in three cities	200	Interviewed patients and providers

that enable the collection of more detailed information. These surveys are also set apart by their careful investigation of household income (often measured as consumption). Household expenditures are carefully probed and constructed to capture formal, in-kind, and informal earnings. To date, LSMSs have gathered informal payment information in Albania, Armenia, Azerbaijan, Bulgaria, Georgia, Kazakhstan, the Kyrgyz Republic (multiple rounds), Moldova, Romania, Russian Federation, and Tajikistan.

General household surveys by governments also contribute data on the phenomenon. The Central Statistical Offices in Poland (GUS) and Hungary collect informal payment data as part of general surveys, and in future these promise to be the main source of such data. Quality, however, is uneven, based on evidence from these two countries. While Poland's data correspond well with those of other surveys (GUS 1999; Chawla et al. 1999), Hungary reports one-third to one-tenth of the incidence of informal payments reported by other surveys (various sources reported in Gaal 1999a). The sources of discrepancy will be important as data collection is mainstreamed and confidence in the collected data becomes important for policy.

Dedicated household surveys, such as those of Feeley, Sheiman, and Shiskin (1999) for the Russian Federation, Abel-Smith and Falkingham (1996) for the Kyrgyz Republic, the World Bank (2000a) for Armenia, and the Polish Statistical Office (GUS 1999), are best suited to understanding the extent and nature of informal health payments. These surveys seek to understand the details of the process, but at the same time have the drawback of often applying unique, country-specific questionnaires. Farley, Nordyke, and Peabody (1998) have a dedicated household survey, but only examine out-of-pocket payments rather than distinguishing between formal and informal expenditures.

The drawback of the general household surveys is their breadth and their correspondingly limited attention to the health sector. For example, they often simply ask if illegal or side payments were required. In countries accustomed to gratitude

payments or in which gifts in kind are not perceived as payment, the insight that such questionnaires provide into the informal health care market may therefore be misleading. While dedicated surveys can avoid underestimation of this sort, their lack of comparability handicaps the ability to draw cross-country generalizations about informal payments. Additionally, both types of surveys focus exclusively on users, ignoring the equally important providers who define and operate the informal payment system.

Another promising and possibly less costly survey approach is only canvassing patients. Such canvassing can be accomplished through exit surveys, as was the case in Vietnam (World Bank 1992) and on a more limited basis in Ukraine (KIIS 1999), or by telephone survey (Chawla et al. 1999). Recent experience in Poland (Lewis et al. 2000), however, suggests that these latter two approaches may not always be feasible in ECA. The Polish experience involved an exit survey of a random sample of inpatients after discharge, and outpatients at the completion of treatment, with the goal of eliciting feedback on informal and formal payments, service satisfaction, and other factors. Efforts to apply the survey were met with virtual silence. A history of government informants in Poland may explain the reluctance of would-be interviewees to discuss informal payment practices on the premises of health services; the illegal nature of such practices in some countries additionally makes acknowledgement, much less discussion, of the subject undesirable for patients.

An alternative to exit surveys, and one that is becoming increasingly feasible, is to identify patients through insurance rolls, as was accomplished recently in Poland (Lewis et al., 2000), and following up either in person or by telephone.

In many instances, surveys are clumsy tools for capturing the perceptions and beliefs that underpin the practices of informal payments. Qualitative data can help explain the quantitative findings of surveys and make sense of them, by enabling participants to contribute information

and views, often anonymously, to discussions and focus groups.

Qualitative information gathering targeting patients and/or providers has been conducted in Armenia (Kurkchiyan 1999), Bulgaria (Balabanova 1999; Delcheva, Balabanova, and McKee 1994), Georgia (GORBI 1999), Moldova (Ruzica et al. 1999), Poland (Shahriari, Belli, and Lewis [forthcoming]) and Ukraine (KIIS 1999; Way 1999), shedding light on the motivation and process of informal payments from both the provider and patient perspectives.

Like all qualitative results, the information thus gathered should not necessarily be seen as representative, and generalizations need to be evaluated accordingly.

The comparative analysis that follows draws on all of the sources detailed above to shape a view of the practice of informal payments and its attendant issues. The analysis hopefully reflects the creativity and breadth of efforts over the past few years to understand and measure the phenomenon of informal payments.

Extent and Nature of Informal Payments for Health Care

This section provides an overview of the frequency, patterns and levels of informal payment for inpatient care, outpatient services, and drugs. It also briefly explores some additional aspects of payment, drawing on the quantitative and qualitative results of existing research. Distinguishing between formal and informal payments has proven difficult, as the definition is blurred in the posing of the questions and in the understanding that respondents have of the concept.

Even in cases where fees are paid officially to a cashier, patients cannot always separate what is legally required and what is technically discretionary. The status of out-of-pocket payments for drugs, for example, can also be ambiguous: if the government is meant to cover the cost of such purchases, any payment the patient makes for them is therefore informal; if it is stated policy that drug purchases are not financed by government, then patient purchases are expected and technically do not constitute informal payments. The intention here is to capture only informal payments, but patient confusion over payment policy can cause the uneven capture of such data. The results presented here are only meant to refer to those instances where each form of payment is distinguished.

Frequency and Rationale for Informal Payments

The importance of informal payments is evidenced by their frequency, and an understanding of the rationale and motivation for patient payment of such charges can shed light on its continued practice. Together these measures provide a sense of the potential burden that informal health payments place on the average household.

Figure 1 reports the frequency of informal payments in 12 countries, including Vietnam, another transition country with a high propensity for informal charges. In Bulgaria and Albania, 20 percent and 21 percent respectively made informal payments, the lowest percentages reported (Balabanova 1999; World Bank 1997a). At the other end of the scale, 91 percent of patients receiving hospital care in Armenia made informal payments (World Bank 2000a). Unreported in the table but nonetheless relevant, 87 percent of all national health expenditures in Georgia are out-of-pocket—mostly informal—payments (Mays and Schaefer 1998), a figure that is consistent with the findings for Armenia, Azerbaijan, and the Kyrgyz Republic. In Macedonia, patients cover 23 percent of all expenditures, both formally and informally (Farley, Nordyke, and Peabody 1998). Data for Bulgaria indicate that in 1994, 43 percent of health care incurred informal payments; in 1997, the figure was much lower, at 21 percent. This discrepancy is possibly explained by oversampling in the earlier survey of urban areas, where informal payments appear to be more common (Balabanova 1999). Data for Romania indicate that 38 percent of patients are not receiving free outpatient physician services

and are expected to pay for care (Charney Research 1998).

Figure 1
Estimated Frequency of Informal Payments in Selected ECA Countries



Notes: **Armenia:** Non representative national sample data, inpatient care only. **Poland:** Inpatient care only. **Russian Federation:** Represents frequency of paying public hospitals but not at cash register. **Moldova:** Based on qualitative surveys of patients, includes money and gifts. **Tajikistan:** Outpatient consultation only of money or gifts. Sources: World Bank 1992, 1997a, 1997b, 1999c, and forthcoming; Falkingham 2000; Anderson 2000; Kurkchiyan 1999; GUS 1999; Dorabawila 1999; Balabanova 1999; Feeley, Sheiman, and Shiskin 1999.

The Russian Federation figure of 74 percent refers to payments to hospitals—a smaller proportion of people paid physicians. Overall only 16 percent of all household payments were informal, with the remainder representing formal copayments, direct purchases of drugs, or, less commonly, private health care. Formal payments in the Russian Federation are considerable, with formal pharmaceutical drug purchases accounting for 55 percent of all household health expenditures. If it is assumed that drugs should be provided by the health system, the estimate of informal expenditures would rise accordingly (Feeley, Sheiman, and Shiskin 1999).

Trend data are limited due to a lack of comparable data. Some figures nonetheless are

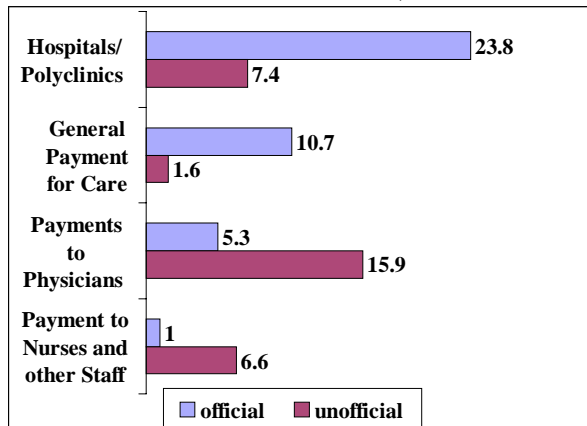
available. In the Kyrgyz Republic, the percentage of patients making informal payments for inpatient care began at 11 percent in 1993, rose to 25 percent the following year, and reached 75 percent in 1996 (Dorabawila 1999). In Azerbaijan, the proportion of household income spent on health care rose steadily from 1.7 percent in 1990 to 3.6 percent in 1994 and 5.1 percent in 1995. While some of this increase may be due to an overall decline in income, it also reflects the rising burden of health care costs for households (World Bank 1997b). In Poland, real household health expenditures climbed almost fivefold between 1990 and 1997, despite the fact that free health care is enshrined in the country's constitution, and private options are few (Lewis et al. 2000).

In addition to informal charges, countries in the Region have over the past decade introduced formal fees for public health care services. In the Russian Federation and in much of Central Asia and the Caucasus, it is privatized pharmacies that are now the main source of drugs, as governments have responded to their inability to finance all aspects of health care. The limited available data show a wide variance in the percentage of patients making formal or informal payments, in part because definitions often vary and patients can confuse formal and informal fees. In Armenia, for example, 74 percent of patients are reported to pay informally and 41 percent formally, but in Georgia, only 29 percent of patient out-of-pocket payments are reported to be formal copayments. The figures for the Russian Federation are 7.4 percent informal and 23.8 percent formal (Kurkchiyan 1999; Mays and Schaefer 1998; Feeley, Boikov, and Sheiman 1998). In urban Albania, patients paid formal fees twice as often as informal charges (World Bank 1997a). Although there are exceptions, informal fees generally exceed formal payments.

The differences in the types of care that carry charges may also help to explain the lack of a consistent pattern across countries. Figure 2 shows the distribution of official and unofficial payments in the Russian Federation. Hospitals and general charges tend to be formal, but physicians and other staff charge patients

directly. In the Russian Federation survey, a clear distinction between paying the cashier (formal payment) and paying outside the cashier may also have helped respondents identify the payee, although this too can be confused.

Figure 2
Percentage of Russian Federation Households Making Official and Unofficial Payments for Health Care Services, 1997



Sources: Feeley, Sheiman, and Shiskin 1999.

The reasons for making informal payments are somewhat complex. In a Romania patient satisfaction survey of primary care services, 30 percent of respondents indicated they made payments to physicians. More than half of these were in the form of food as a gratitude payment, a practice common in much of the Region. In Ukraine and Poland, focus groups identified the low wages of physicians and wage arrears as important factors behind informal payments—without patient payment, the system could not function. Another patient suggested simply “no grease, no motion” (KIIS 1999; Lewis et al. 2000), an observation that was repeated by Bulgarian and Polish patients.

Polish respondents noted that patients sometimes pay to seek higher quality care or to soften staff attitudes toward them; Polish patients also mentioned paying to guarantee access to specific services and facilities, and to save time (Lewis et al. 2000). Studies in Hungary report that gratitude motivates some under-the-table payments, with income, convenience, and the attitudes of providers towards patients also emerging as important (Gaal 1999b). Bulgarian research suggests that

higher-income, urbanized populations with the means to purchase better services are the most likely to make informal payments (Balabanova 1999).

Interestingly, the results of a 1997 opinion survey in the Russian Federation indicates that 25 percent of respondents sought out private care because they lacked confidence in the professional qualifications of public health physicians. Another 20 percent noted the “lack of sensitivity” of medical personnel in public clinics. Both of these observations are consistent with the Bulgarian perceptions (Feeley, Sheiman, and Shiskin 1999). In Poland, reaction to informal payments ranges from acceptance (“Doctors need to be rewarded somehow . . . when they do the job well”) to ambivalence (“It would be different if they had higher salaries. I am neither in favor nor against”) to condemnation (“Doctors should be forbidden to take bribes” and “Doctors are the white Mafia. It’s criminal”) (Shahriari, Belli, and Lewis forthcoming). The Kyrgyz Republic patients have less patience with informal fees, with 70 percent stressing the need for free care (Abel-Smith and Falkingham 1996).

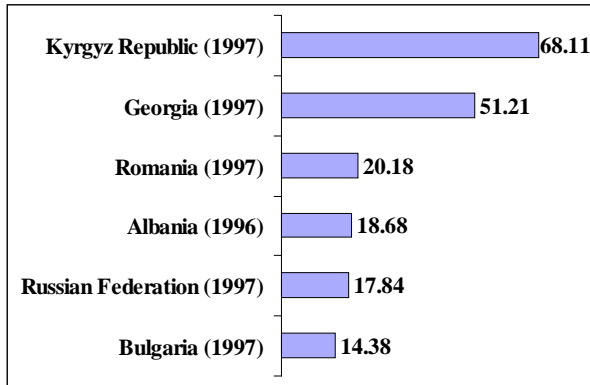
The needs to expedite treatment, to ensure responsiveness and quality, to keep the system working, and to compensate underpaid medical care workers all seem to contribute to patient willingness to pay. The issue is, are all patients able to pay?

Levels and Patterns of Informal Health Expenditure

Informal payments represent a significant proportion of household income in some countries. In a few of these, total informal spending exceeds that of the government. Figure 3 summarizes the average total per capita expenditure on informal payments among those who sought health care for selected ECA countries, using either reported totals or aggregations of inpatient and outpatient payments, costs of drugs, and other categories. Fees for diagnostic tests, specialist consultations, direct physician contributions, and consumables are unfortunately not reported for some countries

only, thus limiting the comparability of the data. The available data nevertheless provide orders of magnitude. The reported fee levels provide a snapshot of total expenditures, without benefit of details of the distribution of that expenditure across different categories.

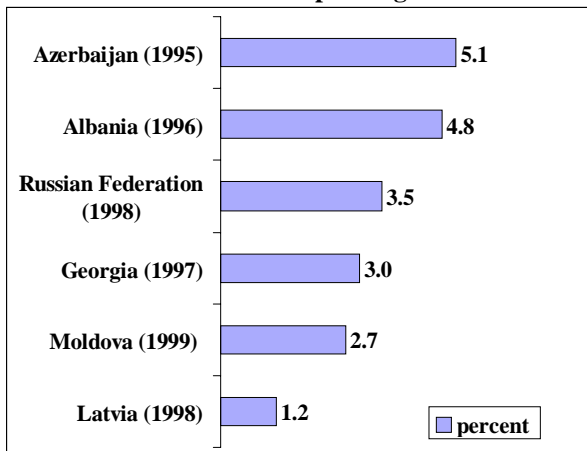
Figure 3
Average Total Informal Health Expenditures per Capita for Selected ECA Countries (1995 US Dollars¹)



¹Exchange rates used are PPP-adjusted, from the WDI. Sources: Abel-Smith and Falkingham 1996; Balabanova 1999; Chawla et al. 1999; Feeley, Sheiman, and Shiskin 1999; GUS 1999; Ruzica et al. 1999.

Figure 4 summarizes health expenditures as a percentage of annual household spending. As much as 5 percent of consumption goes to health care, although this proportion is considerably larger among low-income families.

Figure 4
Informal Health Payments as Percentage of Household Spending



Sources: World Bank 1997a, 1997b, 1999b, and 1999c; Feeley, Sheiman, and Shiskin 1999; Central Statistical Bureau of Latvia 1999.

Informal expenditures represent 84 percent, 56 percent, and 30 percent of total national health expenditures in Azerbaijan, the Russian Federation, and Poland respectively.

These figures point to the increasing importance of informal fees, but it should also be noted that aggregating across households hides the disproportionate burden faced by the few families that either suffer a catastrophic event or that have limited income to cope with poor health.

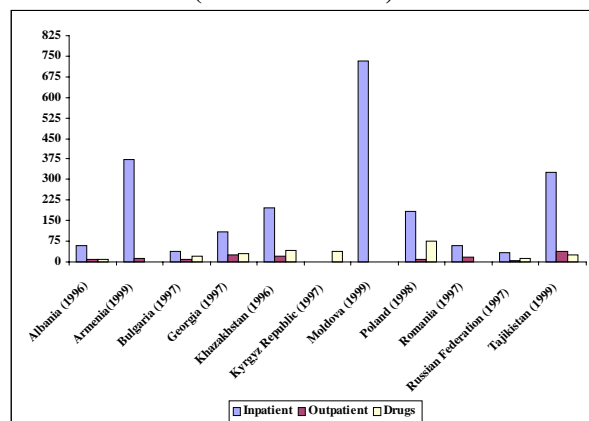
Figure 5 presents the average out-of-pocket payment in US dollars by expenditure type: inpatient, outpatient, and drugs. In some cases the data are not strictly comparable across countries, but have been adjusted to conform as closely as possible to common definitions of average expenditure in each type of service. Not surprisingly, inpatient care is significantly more costly than outpatient services, and average drug expenditures often exceed the cost of ambulatory care. Since drug expenditures can be recurring, and can possibly also affect other family members, the average expenditure for a single illness can be quite high. Drug costs also vary by the pharmaceutical cost structure in each country, something that is obviously not controlled for in the reported data.

The distribution of patient purchases for health care indicates where patients contribute to health care costs. Table 2 shows the distribution across six categories for a few ECA countries. The results show an absence of any consistent pattern for informal payments. For example, the percentage of overall informal payments spent on a single category ranges from 6 percent spent on drugs in Kazakhstan to 92 percent spent on outpatient services in Krakow, Poland. Even physician payments do not converge, although the discrepancy is narrower. These findings indicate the diversity of informal payments across the Region, and, if the Polish experience is any guide, across inpatient and outpatient services within individual countries.

Drug expenditures are generally more common than health care services, whether formal or informal. For countries with available data

(excluding the Kyrgyz Republic), drug payment exceeds expenditures for health care services. In contrast to their low health care service payments, 90 percent of Bulgarian patients and 98 percent of Poles purchased drugs (Balabanova 1999; GUS 1999).

Figure 5
Average Informal Payments per Visit for Inpatients, Outpatients, and Drugs for Selected ECA Countries (1995 US Dollars)



Sources: World Bank 1997a, 1997b, 1997c and 1999c; Falkingham 2000; Kurkchian 1999; GUS 1999; Dorabawila 1999; Balabanova 1999; Feeley, Sheiman, and Shiskin 1999, Sari, Langenbrunner and Lewis 2000; Mays and Schaefer 1998.

Data for outpatient care in Krakow, Poland showed drugs constituted 68 percent of all

informal outpatient expenditures (Chawla et al. 1999). In the Kyrgyz Republic, three-quarters of admitted patients were required to purchase drugs that were meant to be free (Abel-Smith, and Falkingham 1996). In the Russian Federation, private purchase has become the norm, resulting in a low proportion paying informally for drugs; 16 percent already purchase pharmaceuticals outright (Feeley, Boikov, and Sheiman 1998).

Table 3 compares per capita income with the percentage of income devoted to all health care for those who sought services and with the percentage of income spent on drugs. The latter is a subset of the total and may therefore capture discretionary pharmaceutical purchases, but its importance to households is nonetheless considerable, given that such expenditures are made both with and without the benefit of medical advice and in the latter case therefore cover the cost of self-treatment. The Kyrgyz Republic stands out for its high percentage of income spent on health care, and Moldova and Tajikistan for the percentage of income needed for the average inpatient stay.

Clearly, health care is a significant expense for households in these three countries, and one whose burden will be most keenly felt by the poor. This is the issue that is discussed next.

Table 2
Distribution of Informal Payments across Categories of Health Services in Selected ECA Countries (percentage)

Country	Year of Survey	General Hospital	Physicians	Nurses/ Medical	Drugs	Test/ Supplies	Other	Total
Bulgaria	1997	6	66	12	16	—	—	100
Kazakhstan	1995	28	32	—	6	34 ¹	—	100
Kyrgyz Republic	1994	—	18	—	61	14	7	100
Moldova	1999	10	7	0.5	49	16	18 ²	100
Poland ³	1998	6	42	9	16	3	25 ⁴	100
Poland: Krakow ⁵	1998	8	—	92	—	—	—	100
Russian Federation	1998	31	21	7	18	—	23 ⁶	100

1 Defined by the authors as "procedures."

2 Mainly additional food payments and other therapeutic services; statistic for general hospitals includes about 5 percent for food.

3 Only includes outpatients.

4 Includes payments for outside assistance, private hospital payments, and undetermined expenses.

5 Only includes outpatients.

6 Largely privately financed dental care.

Sources: Abel-Smith and Falkingham 1996; Balabanova 1999; Chawla et al. 1999; Feeley, Sheiman, and Shiskin 1999; GUS 1999; Ruzica et al. 1999; Sari, Langenbrunner, and Lewis 2000.

Table 3
Average Per Capita Income and Average Percentage of Monthly Income Informally Spent on Health Care and Drugs¹

Country	Year of Survey	Average per Capita Income	Average Expenditure as % of Income	Outpatients Expenditure as % of Income	Inpatients Expenditure as % of Income	Drug Expenditure as % of Income
Albania	1996	\$205	9.13	4.52	29.47	4.82
Armenia	1999	139		7.55	266.60	
Bulgaria	1997	328	4.39	2.87	10.99	5.80
Georgia	1997	251	20.43	10.29	44.27	12.26
Kazakhstan	1996	373		5.86	52.34	11.18
Kyrgyz Republic	1997	127	53.72			28.64
Moldova	1999	129			571.11	
Poland	1994	765		0.95	23.97	9.67
Romania	1997	491	4.11	3.60	11.67	
Russian Federation	1997	472	3.78	0.59	6.87	2.61
Tajikistan	1999	61		60.56	534.53	41.39

¹ Exchange Rates used are PPP-adjusted from the WDI. Per capita income is calculated from the WDI.

Sources: World Bank 1997a, 1997c, 1999b, 1999c, and 2000a; Dorabawila 1999; Ruzica et al. 1999; Balabanova 1999; Feeley, Sheiman, and Shiskin 1999; Falkingham 2000; Sari, Langenbrunner, and Lewis 2000.

Effects of Informal Payments on Equity and Access

The intent of government-financed and -provided health services includes ensuring access to health services for those who need health care, regardless of income. Informal payments can restrict this access for those unable to pay for care.

The only multivariate analysis measuring the probability of making an informal payment for inpatient care is available for two major Polish cities. Age, being male, and patient perception of the severity of the illness all raise the likelihood that a payment will be made. The only medical department where payments are highly probable is gynecology, however. Since many patients in parallel qualitative research indicated that they made payments as insurance, it is not surprising that the elderly—heavy users of the system—make the most frequent payments. The severity of illness would also be expected to be an important correlate of spending in health care, since demand is less elastic as severity increases. This would also suggest inequity across patients.

For outpatient services in the same study, the employed are more likely to pay for care, possibly to expedite service. However, the higher the patient's income, the less likely the patient is to pay. This may reflect the growing private sector in outpatient services, catering mainly to the better off, and that wealthier patients seek alternative providers; alternatively, it may be that those who can, pay well for inpatient services that cover outpatient care (Lewis et al. 2000).

Household income appears important in determining the patterns of health service

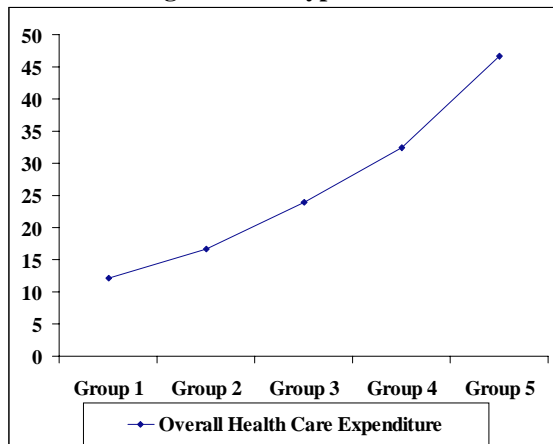
consumption. In the Kyrgyz Republic, 41 percent of those in the bottom quintile reporting ill health sought care, while 62 percent of the top quintile did. In one-fifth of cases the cost of inpatient care exceeded the total cash income of all household members for that month (Abel-Smith and Falkingham 1996). In the 1998 Russian Federation survey (Feeley, Sheiman, and Shiskin 1999), official payments constituted 27 percent of household income of the lowest quintile, in contrast to 9 percent for the highest quintile. In contrast, a study a year earlier found that 41 percent said they could not afford drugs and 13 percent could not pay for medical care. There is evidently some discrepancy in the Russian Federation experience, although the careful distinction between informal and formal payments in the more recent work may explain the differences (Feeley, Sheiman, and Shiskin 1999).

How much low- and high-income groups spend on health care can be seen through the structure of payments across income groups. In Ukraine, the average expenditure per household varied from 50hrn for poor households to four times as much for higher-income households. In Kazakhstan among those who sought care, the poor expended 252 percent of monthly income on inpatient care; the better off spent only 54 percent of monthly earnings for the same type of services (Sari, Langenbrunner, and Lewis 2000).

The results of the 1997 survey in the Russian Federation indicate considerable inability to afford health services and prescription drugs, especially among some income groups. Figure 6 summarizes the percentage of households, across four income categories, reporting nonconsumption of health care due to lack of resources.

The lowest income group (those earning less than US\$60 per month) did not purchase half of the prescribed drugs and had to forego more than one-third of medical visits due to income constraints. Even those in the highest of the four income groups were deterred from purchasing drugs and outpatient services roughly one-fifth of the time.

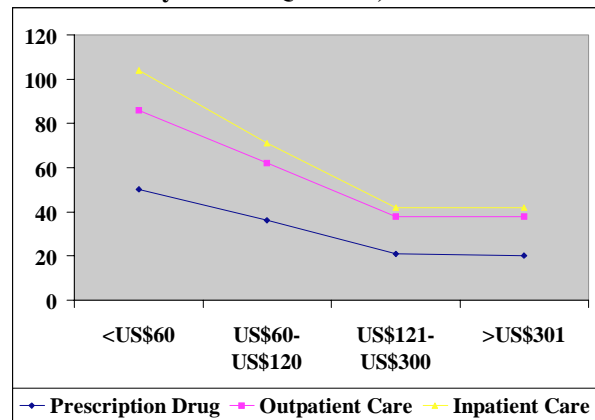
Figure 6
Percentage of Russian Federation Households Unable in December 1997 To Pay for Health Services Due to Lack of Income, by Income Categories and Type of Service¹



¹The Russian State Statistical Committee established minimum subsistence in the fourth quarter of 1997 as 408,500 rubles (about US\$60 at 1997 exchange rate). Sources: Feeley, Boikov, and Sheiman 1998.

Patterns of outpatient use across the income quintiles for Poland can be seen in Figure 7. The highest income group in this case spends roughly five times what the lowest quintile household does. Evidence from the Kyrgyz Republic shows similar results. While 36 percent of the population overall could not afford to fill prescriptions, 70 percent of the poor were unable to do so (Abel-Smith and Falkingham 1996).

Figure 7
Average Per Capita Expenditures for Outpatient Care in Poland by Income Quintiles, 1998

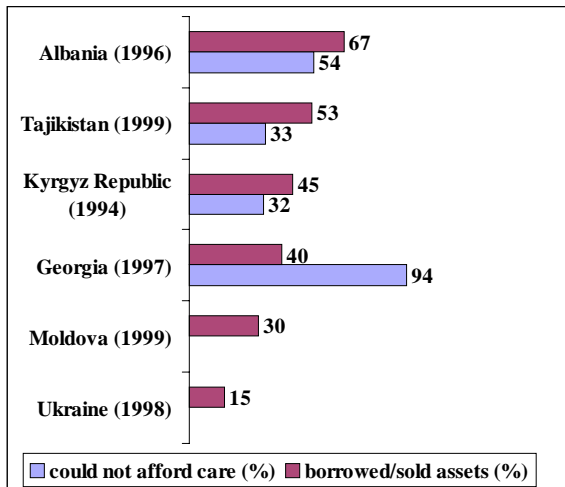


Sources: Chawla et al. 1999.

Why the poor pay less on average for services may be due to their lower or more limited consumption, or that they pay less for comparable services. The fact that demand for health care does not rise on a one-to-one basis with income would also suggest that the poor would spend relatively less than higher-income patients. Qualitative results from Azerbaijan and Ukraine suggest that providers will often set prices that discriminate in favor of low-income patients, particularly in rural areas (World Bank 1997b; KIIS 1999); this practice appears to be uncommon in Armenia, however (Kurkchiyan 1999).

Reports of the sick not seeking assistance due to the high cost of care suggest further impediments to access. Data illustrating the financial impediments to health care in six countries are shown in Figure 8. In Georgia, 94 percent of respondents were unable to seek health care in 1997 due to its high cost. High costs elsewhere, notably Albania and Tajikistan, also posed major difficulties for many people. A significant proportion of the populations in all six countries could not afford, or found it hard to find the resources to pay for, health care.

Figure 8
Indicators of Financial Inaccessibility of Health Care



Sources: KISS, 1999; Ruzica et al., 1999; World Bank 1997a; 1999b; Abel-Smith and Falkingham, 1996; Falkingham, 2000.

Another useful indicator for determining affordability is the need to borrow, sell produce, or otherwise raise funds for health care. Figure 8 contains available data on the forced acquisition of resources to pay for care. In the Kyrgyz Republic, one in three inpatients borrowed money, and in rural areas 45 percent sold produce or livestock to cover the costs of hospital care. In Tajikistan, almost half of those who sought care were forced to borrow, and another 5–10 percent sold livestock. In Moldova, one-third went into debt and another quarter sold assets to finance care, and in Ukraine, about 15 percent of users dipped into savings or borrowed from family. In 1997, 5 percent of poor Moldovan households spent their entire monthly income on medical care. These findings suggest a severe inaccessibility to inpatient care, particularly in rural areas where incomes tend to be lower than in urban centers. They also indicate that low-income households tend to get less care than higher-income families, since durable goods, loans, and assets tend to be less accessible to poorer households (Abel-Smith and Falkingham 1996; Falkingham 2000; World Bank 1997a and 1999b; Ruzica et al. 1999; KIIS 1999).

While the variable nature of health care makes periodic expenditures of large amounts

universal, the uneven distribution of illness makes ability to meet the costs of such events onerous for the poor. What is striking about the findings in Figure 8 is the pervasiveness of the inability to pay and the high costs incurred by such a large percentage of households.

Reports have also emerged of people's inability to afford care in specific circumstances. In Poland, 11 percent of the population could not afford prescription drugs; another 26 percent additionally found them sometimes too costly. Among retirees, 14 percent found prescription drugs to be unaffordable, suggesting that even in a relatively well-off country like Poland, out-of-pocket costs are high and some forms of health care are out of reach for certain segments of the population (GUS 1999).

In addition to inability to pay, a significant decline in patient visits for health care indicates a serious undermining of access to care in some countries. While overutilization has in the past characterized much of health care in the Region, the impediments reported in the surveys drawn on above suggest that there may now be growing financial impediments to health care, resulting in underuse by some households. Between 1993 and 1994, health care use dropped 25 percent in Kyrgyz Republic (Abel-Smith and Falkingham 1996). In Tajikistan, 37 percent of pregnant women did not seek prenatal care due to its cost, and almost one-third of recent births occurred at home, representing a break from past practices of hospital births and systematic pre-natal care (Falkingham 2000). Similar reports emerged in 1995 from qualitative surveys in Azerbaijan (World Bank 1997b). In Armenia, administrators and physicians note a dramatic decline in the number of patients since the Russian Federation economic crisis of 1998 (Kurkchiyan 1999). In Poland, qualitative work suggests that, with the exception of cases of acute need, people regularly delay seeking health care because of its high cost (Shahriari, Belli, and Lewis (forthcoming)).

In Armenia, qualitative interviews indicate that declines in utilization are leading physicians to aggressively seek patients—some are becoming known as “patient hunters”—and are

increasingly recommending inappropriate care to increase their incomes. One positive outcome of the former development is that some physicians are becoming more courteous, considerate, and engaged providers, whose axiom has become “patience brings patients.”

The downside is characterized by the remark of an Armenian doctor—“My colleague makes no secret of the tactics he employs to increase the number of patients having surgery, which is usually well paid for by patients”—which is indicative of the methods used to manipulate people into undergoing treatment. In addition, tactics such as not divulging the full cost of treatment from the onset, refusing to complete treatment without further payment, and prescribing harmless but nontherapeutic drugs in which physicians have a financial interest have

become increasingly common (Kurkchiyan 1999).

The market nature of health care in Armenia may translate into greater concern for the comfort and satisfaction of patients, but it also raises the invidious aspects of unregulated private health care: malpractice, an oversupply of care, and unaffordable care for some segments of the population.

High expenditures appear to impede access, based on both direct and indirect evidence, and the poor are disproportionately affected. Public health care systems in much of the ECA Region appear not to be serving their populations adequately. The final section discusses some of the reasons for the problem, and options for addressing it.

Policy Implications and Proposed Actions

The implicit or explicit acceptance of informal payments is most troubling as it places governments in the position of either ignoring or abetting illegal practices. In some countries anecdotal evidence suggests that governments take estimates of such payments to determine physician wages. Discussions with providers point to the necessity of their soliciting gratuities or “envelope” payments to supplement low salaries and arrears in earnings. Permitting informal payments acknowledges government inability to meet costs under the current system, reduces its effectiveness as manager of the overall system, and undermines its credibility as both guarantor and regulator of the health care system.

Solutions to the increasingly entrenched practice of under-the-table payments are neither painless nor easy, but without action, governments abrogate their role in ensuring access to health services to their populations and in setting and maintaining basic standards of care. As discussed below, many of the initiatives most likely to address the problem effectively entail major restructuring of the sector. The previous Soviet structure has contributed to the underlying difficulties that have led to the widespread practice of informal payments. As a result, solutions must address the faults of that structure and its invidious effects on provider behavior. Any single intervention is unlikely to be adequate, however, and a multi-pronged strategy is required.

First, public leaders must be clear that side payments and other “off-budget” exchanges between public employees in any sector or service and citizens are unacceptable and not to be tolerated. Actions must also follow policies. Without a clear, overarching policy framework that clarifies the government’s position regarding corrupt practices, including informal health payments, it is difficult for a

single sector, such as health, to resolve the issue.⁴

Second, the existing public health systems are bloated and inefficient. They are too big, and in many settings function as employment services rather than public services. Downsizing to manageable size with clear linkages between policy, programs, and budgets is essential. Budgets currently cannot cover the costs of excessively large workforces, overreliance on expensive inpatient services, excessive numbers of hospitals, and broad service coverage. Efforts to retain the largesse of the past in the face of budget constraints have resulted in expenditures being distributed over too broad an area, and in front-line providers seeking alternative sources of funding.

⁴ National perceptions can also be at odds with policy in the health sector. For example, despite national policy against informal charges, the Hungarian Medical Association’s recently revised code of ethics does not condemn such practices (Gaal 1999b), making the rooting out of such payments extremely difficult.

A good example is physician numbers and earnings. With little attrition of personnel and declining or modestly increasing expenditures, real wages have declined. Reducing the number of physicians should offer the opportunity to downsize hospital capacity, reduce costs, and raise the salaries of the remaining doctors (World Bank 2000c). Two regional examples help illustrate this. In the Czech Republic, the number of physicians has declined somewhat and earnings have exceeded or kept pace with growth in overall wages. Side payments to physicians appear much less common than in the other countries in Eastern Europe (World Bank 1999a and 2000b).

Poland provides a more robust example. Table 4 shows the average informal payment required by different public providers; only the capitated primary care physicians did not charge additionally—i.e., those whose earnings were highest given the adequacy of the capitated payment and the patterns of demand (Chawla et al. 1999). In Armenia, the introduction of formal fees combined with the Russian Federation financial crisis reduced physician informal incomes, both because the number of patients declined and because the amount that patients can pay physicians is reduced by the required formal payments to the facility (Kurkchian 1999). These examples provide some indication that higher earnings may offer a possible, partial solution, at least in some settings. Higher physician earnings are in themselves unlikely to be a solution, however.

Table 4
Annual Informal Expenditures for Outpatient Care
by Type of Provider, Krakow, Poland, 1998

Health Care Providers	Amount of Expenditure ('000 Zlotys)
Public Outpatient	25,979
Public Capitated Outpatient	0
Public Hospital Outpatient	2,904
Public Emergency Care	164
Cooperative Specialist Care	818
Private Specialist	624
Private Home Visit	205

Source: Chawla et al. 1999.

Strategies for downsizing would include voluntary severance pay schemes and establishment of loan funds for entrepreneurial investments, to encourage alternative economic activity. The introduction of medical standards and the disallowing of outdated medical practices by those unable to master basic skills provide another basis for downsizing. The potential of such policies to fall prey to corruption, as was the case in Armenia (Kurkchian 1999), suggests that they be approached with caution, despite the necessity of action.

Third, governments need to be aware that comprehensive, free services cannot persist in a budget-constrained environment. What is in place is unaffordable. In addition to contracting capacity and raising salaries, there needs to be an acknowledgement that government cannot afford to maintain its current services, which means that either the scope of financed services be reduced or users be required to cover the costs of some aspects of care. There are no other choices given income levels.

As with manpower, hospitals and clinics require scaling back. This may be achieved through closing some facilities, closing hospital wings, reducing the number of operating rooms, reducing the number of beds, and eliminating other costly services, many of which are already underutilized. Multiple buildings, all of which need to be heated, combined with poor insulation and large common areas contribute to unnecessarily high costs in some countries. Incentives can be used to encourage reducing capacity. In many countries, budgets remain driven by input requirements, creating perverse incentives to maintain excess capacity, inflate utilization rates, and generally promote broad service capacity. The budgeting process and the overemphasis on inputs needs attention from policymakers if they are serious about downsizing, improved efficiency, and higher quality.

The range of services offered can also be restricted, reducing the financial burden on the public sector. While Armenia has had mixed results with such attempts (World Bank 2000d),

Western European governments have successfully limited some publicly financed services, leaving them to private providers and payers. ECA countries have similar options as they reduce the scope of services commensurate with available resources.

Charging users or simply formalizing current practices but with greater transparency, accountability, and attention to equity can improve the financial footing of health care systems. Such changes can take various forms:

- marginal payments for many services (a variant on current practices);
- a sliding fee scale that imposes higher charges on affluent patients and that fully subsidizes those who cannot afford to pay;
- offering upgraded hotel services and personal attention for a premium (a practice already applied in some systems);
- payment for inpatient care on a per diem basis, even if the amounts are nominal to discourage unnecessary hospital days;
- formal payments for private physician services in public hospitals;
- health insurance to cover the costs of inputs (e.g., for drugs and supplies) that are commonly the responsibility of patients. This type of system appears to be successful in the Kyrgyz Republic, although it only covers a small segment of the population.

Any or all of these options can apply in a given setting. Patients are already paying and there clearly exists a willingness to pay; the issues at stake are how much should be charged and who should pay. These issues need resolution at the country level.

The different options deserve debate and experimentation if they are to guide policy. The basic tenet of cost sharing is inevitably either to finance the range of services desired (particularly in Eastern Europe), or to only make basic services available (particularly in the CIS countries). In effect, governments need to take a

proactive approach to addressing the financing/service scale gap, acknowledging that they cannot do it all and determining where subsidies should go and to whom. At the moment, the systems are adrift and at the discretion of providers and, to a lesser extent, patients. Greater accountability and enhanced management capacity are both prerequisites and goals for reform.

Fourth, health systems require basic oversight and accountability for all providers, and swift punishment for transgressors.

Performance is currently both hard to measure and a new concept in health care. Achieving a more affordable, fair, and equitable system requires that relative performance can be assessed, that performance benchmarks be set, and that providers be held accountable for results. Fundamental to this are the use of acceptable accounting standards and ex-post auditing of hospital accounts, combined with tools to ensure that hospital managers comply with national policies regarding financial management and informal payments. Policy without monitoring and enforcement has proven and will continue to be ineffective in addressing informal payments.

The status of informal payments needs to be clarified within the context of the implications of allowing them to continue, and oversight put in place to ensure that such practices do not persist. For example, hospital directors who permit charging of informal payments should be forewarned that they will be held accountable. If such practices continue and are identified, by auditing, spot checking, or other means, then the director needs to be replaced. The same principle should apply also to heads of hospital departments. Swift, consistent action is needed to signal that the government is serious about its commitment to good management. At the same time, however, if the principles of accountability and performance-based leadership are to work, hospital managers must be given the authority to manage and operate the hospital with some degree of autonomy.

Finally, private alternatives need to be allowed and promoted for those who choose to use them. The lack of alternatives for both providers and patients contributes to the emergence of a gray market within the public system. The two should be separated, and the government is in a position to foster that division. Private sector services should be competitive and independent of the public system: currently, much “private care” is either (partly) financed by government or entails the use of public infrastructure by doctors treating their private patients. Adequate regulation and oversight of private health care are essential to prevent the kinds of quality-of-care abuses that are currently emerging, and to ensure the financial solvency of truly private providers and payers.

The initiatives outlined here address the components of corruption described by Klitgaard (1998). Any one strategy cannot reverse the monopolistic role, broad discretion, and absence of accountability that lead to corruption. Progress on multiple fronts,

however, can begin to dismantle the corrupt practices in the health sector, and in the process raise quality and efficiency.

Given that the interests of the current leadership of the health sector are often best served by maintaining the status quo, the political challenge of phasing out informal payments is formidable. Successful reform will require a consistent, broad plan. Ministries of finance will play a central role in the restructuring, particularly in effecting a move away from line-item and input-driven budget allocations. They will also need to support the ministries of health in establishing accountability criteria. Similarly, parliaments need to support efforts to reduce corruption, both generally and in the health care system. These measures have political and social implications, including the vital acknowledgement that the governments of the Region cannot do everything, given their income levels and public revenues. But in the absence of commitment to reform, informal payments will continue to define public health care systems in ECA.

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