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4 Informal payments for health care



Television spot, autumn 2004, highlighting the problem of informal payments for health care in Lithuania. (TI Lithuania)

Informal payments – charges for services or supplies that are supposed to be free – are common in many parts of the world, especially in developing and transition countries. While it is difficult to draw a line between voluntary gift and mandatory payment, and between payments that should be considered bribes or extortion, and those that are better understood as a coping mechanism for underpaid caregivers, there is less disagreement about the damaging effects these payments have on health systems worldwide.

Sara Allin, Konstantina Davaki and Elias Mossialos look at the causes and consequences of informal payments in Central and Eastern Europe and the Commonwealth of Independent States, where informal financing is a legacy of communist health care systems. They argue that raising the wages of health professionals alone is unlikely to eliminate the problem and point to a number of essential policy measures, such as developing appropriate incentives and suitable information systems to support the accounting and auditing of payments. A case study from Hungary shows that, despite

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the relatively small sums involved, informal payments can lead to a massive distortion of the health system. The example from Morocco demonstrates that small, under-the-table payments can be a serious obstacle to poor patients accessing medical care.

Paying for 'free' health care: the conundrum of informal payments in post-communist Europe

Sara Allin, Konstantina Davaki and Elias Mossialos[1]

Informal payments for health care in the countries of Central and Eastern Europe (CEE) and the Commonwealth of Independent States (CIS – the former Soviet Union excluding the Baltic states) are widespread. Informal, 'under-the-table' or 'envelope' payments are typically defined as direct payments by patients for services they are entitled to for free, usually in a public health system. Informal payments range from the ex ante cash payment to the ex post gift-in-kind. While the common practice of gift giving as an expression of gratitude is, in principle, benign, informal payments that resemble fee-for-service have potentially serious implications.

They can undermine official payment systems, distort the priorities of the health system, reduce access to health services and impede health reforms. They can also provide undesirable incentives and encourage unprofessional behaviour, including rent-seeking behaviour by health workers. It is difficult to disentangle the specific form of informal payment and decipher what constitutes corruption; the different manifestations of informal payment can be placed on a continuum of gravity ranging from nuisance to obstacle to barrier and, ultimately, to self-exclusion.[2] Reducing the extent of informal charging is far from straightforward and represents an enormous task for policy-makers.

Informal payments exist for several reasons, including economic ones such as a general scarcity of financial resources in the public system; and socio-cultural ones, such as the lack of trust in government and a culture of tipping. Most of the CEE and CIS countries' health systems were modelled on the Soviet *Semashko* system of universal health care coverage, with a virtually exclusive role for the state in financing and delivery. Informal payments became a common feature of these health systems, since the state could not deliver what it promised. Following the economic and social crisis with the fall of communism and the break-up of the Soviet Union, health care suffered even further in terms of resource availability and service quality. Health system characteristics that may help explain the prevalence of informal payments include an excess supply of capital and human resources, low salaries, lack of accountability and government oversight, and an overall lack of transparency. Human resource shortages may also drive informal payments as it may lead to providers giving priority to those patients that can afford to pay. A paucity of private services may also drive informal payments, as wealthier patients have fewer options outside of the public system. Also, the population may not be adequately informed of the health services they are entitled to free of charge.

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Some scholars argue that informal payments arose as a reaction by dissatisfied patients and providers to shortcomings within the health system during the communist era.[3] Given the deficiencies regarding quality and availability, there were no opportunities for dissatisfied patients to opt out, as there was no private sector alternative, nor to voice their complaints, as these were regarded as direct criticism of the government. Providers were faced with low salaries and no explicit state-organised rationing mechanisms. Thus informal payments became an established practice and served as an alternative method of enabling patients to pay for better quality.

Throughout the 1990s, staff salaries in CEE countries were, and many continue to be, very low and payments were often delayed. In Lithuania and Ukraine, health care workers are reported to have waited up to three months to be paid, with even longer waiting times in Russia.[4] Money was instead sought directly from patients and provided to staff. While these informal payments allowed health care staff to continue providing services during periods of economic difficulty, the demand for payments also resulted in the exclusion of those unable to pay. Those most severely affected were the poorest and the chronically ill.

The scale of informal payments

The clandestine nature of informal payments makes accurate accounting difficult. By definition, informal payments are made without any record of the transaction and are often illegal, making both patients and providers reluctant to discuss them.[5] Furthermore, interpretation of what constitutes an informal payment differs across regions and countries, making generalisations and cross-country comparisons inappropriate. For example, discrepancies in the perceived nature of informal payments have been shown between providers and the public in Albania, with providers perceiving payments as gifts and the public viewing fees as necessary to receive services.[6] Despite these difficulties, recent surveys and qualitative studies indicate that informal payments have come to represent a large proportion of total health expenditure in CEE and CIS countries.

Informal payments constitute 84 per cent of total health expenditure in Azerbaijan[7] and out-of-pocket payments contribute around 70–80 per cent of total health spending in Georgia, half of which is estimated to be informal.[8] They are also an important form of health care financing in other countries, representing 56 per cent of total health expenditure in the Russian Federation, and 30 per cent in Poland.[9] In Tajikistan, household spending on health averages US $8.58 per person per annum compared to government expenditure of US $3.75.[10] Similarly, the Albanian Living Standards Measurement Survey of 2002 estimated out-of-pocket (both formal and informal) expenditures constituted more than 70 per cent of total health expenditure.[11]

Survey data of the prevalence of informal payments among service users highlight the severity of the problem and identify substantial diversity across countries. Informal payments are mainly associated with in-patient care settings, particularly surgery, and several surveys have found that they tend to be more common in large towns and cities. A 1999 World Bank/USAID survey observed that 71 per cent of GP visits and 59 per cent of specialist visits involved payments in Slovakia.[12] In Latvia, the TI Annual

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Report 2000 estimated that approximately 25 per cent of patients made informal payments sometimes, while 5.7 per cent made payments on almost every visit. A regional breakdown showed that Riga had the highest proportion of under-the-table payments, with 46.1 per cent of Riga respondents having made such payments.[13] In Bulgaria, informal payments are more common in the capital city, Sofia, with 51 per cent of survey respondents reporting paying without a receipt for a doctor or dentist.[14] In Romania, informal payments are prevalent and account for 41 per cent of total out-of-pocket expenditure.[15] A recent survey of public perceptions conducted by the Centre for Policies and Health Services revealed that 39 per cent of people with high incomes paid unofficial fees or gifts for medical services in 2001, while 33 per cent of people with below-average income paid unofficial fees or gifts.[16]

There is evidence in some countries of an increasing trend in the proportion of health service visits incurring charges throughout the 1990s. Between 1993 and 1998, the number of patients in Slovakia who paid for hospital admissions grew by approximately 10 per cent.[17] In Bulgaria, out-of-pocket payments (including both formal and informal payments) increased from 9 per cent of total expenditure in 1992 to 21 per cent in 1997.[18] In Kyrgyzstan, while 11 per cent of patients who visited a physician reported paying informally in 1993, 50 per cent did so in 1996.[19] In Kazakhstan, while out-of-pocket payments were, at least officially, virtually non-existent prior to 1991, by 1996, 30 per cent of visits were charged either formally or informally.[20] It is not clear whether these changes reflect a real increase in informal payments or an increase in the willingness of individuals to report them, and surveys have not dealt with this issue.

The role of physicians

The role of physicians in shaping expectations regarding informal payments is crucial. The status of the profession can also shape physicians' attitudes toward accepting payments directly from patients. Evidence on private expenditures in Poland reveals that informal payments nearly double physicians' formal salaries, suggesting overall that managing existing resources poses a more difficult challenge than finding new resources. There is also a direct benefit for hospital physicians, where informal payments constitute 46 per cent of all patient expenditure in hospitals, thereby leading to an increase in physician salaries by 15 per cent.[21]

In Bulgaria, doctors allegedly receive informal payments of up to US $1,100, significantly augmenting the average monthly salary of US $100.[22] Evidence from Bulgaria also suggests that the unofficial cost of an operation accounted for more than 80 per cent of the average monthly wage.[23] With health workers in Tajikistan among the lowest paid in the country, informal payments and gifts-in-kind represent the main source of income for many providers.[24] By contrast, informal payments are not high in the Czech Republic where doctors' salaries have risen above the rate of inflation of average wages. A 2000 survey of health care staff and public officials revealed that 5 per cent of Czech doctors confessed to accepting 'something more' than a small gift.[25]

However, poor pay alone does not seem to explain physicians' readiness to accept informal payments. Doctors in Bulgaria, Slovakia and the Czech Republic were more

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likely than the average government official to have reported a second income, and were also well above average in their reporting of having a 'family income' that was enough for a 'fair' or 'good' standard of living. More significantly, while poor pay increased the willingness to accept gifts, it was those with the highest salaries and the highest family income who received such payments more frequently, a likely result of the positions of power held by these individuals.[26] It is not enough, therefore, to increase the salaries of doctors in line with or even above general wages or general public sector incomes. For example, in Greece, substantial increases to hospital physician salaries after the introduction of a national health service in the early 1980s had no impact on the prevalence of informal payments.[27]

The impact of informal payments

The impact of informal payments on the health system is difficult to measure. Payments that solely express gratitude in the form of a donation and are given willingly after a service is delivered may not have any adverse impact on efficiency, quality or equity. However, in countries where this gratitude form of payment is common, the fee-for-service type of informal payment that physicians may demand and may determine access to and/or quality of services has serious adverse effects on efficiency and equity.

Informal payments can be viewed either as contributing to the cost of services, or as an abuse of power by the physician since the patient is placed in a situation with little choice of provider and immediate need of service. The two types of informal payment require different policy responses: the former calls for increasing health resources, in part by formalising payments, while the latter necessitates regulating and monitoring providers.[28] However, in either case, it is likely that the practice of informal payments contributes to resource allocation that is distorted away from the social optimum: rather than being allocated to those in most need, health services will instead favour those who are able to pay, or are easily coerced into paying.

The impact of informal payments on quality is uncertain. Some argue that the quality of services is better for those who pay informally, while others contend that payments lead to unnecessary additional services. Using data from a survey of hospital patients in Kazakhstan in 1999, Thompson and Xavier found that informal payment and the amount paid are generally associated with better-quality services. This is evidenced by decreased waiting time, longer length of hospital stay and patients' subjective ratings of quality.[29] But if service quality is improved when payment is made, the benefits are restricted to that individual. Moreover, physicians are likely to keep the payment for their own personal gain rather than improve services by investing it in the facility. As a result, improved medical equipment, more efficient heating systems and infrastructure, raised nursing standards and other necessary elements of a health system are neglected.

There is little evidence on how informal payments affect utilisation, but patients who cannot afford the extra cost are either unable to obtain treatment or they cannot access the same quality of services or have to wait longer for care. Poorer patients have to make significant sacrifices in order to pay for essential health care services, as seen

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in Romania.[30] In Kyrgyzstan, one in three patients reported borrowing money for in-patient care, and in rural areas, 45 per cent of in-patients sold produce or livestock to cover hospital costs.[31] In Georgia, qualitative evidence highlights several examples of sacrifices people have to make for health services, such as paying 12 lari for treatment for poisoning (compared to the average monthly salary of 15 lari), while others are forced to borrow money or sell household valuables to pay for health services.[32]

Evidence suggests that informal payments are regressive: although poor individuals pay less in absolute terms than the rich, they pay more as a proportion of their income. This is the case in Albania, Bulgaria, Georgia, Kyrgyzstan, Kazakhstan and Moldova. In Kazakhstan, the poor spent 252 per cent of their monthly income on in-patient care, compared to only 54 per cent among the better off for the same type of services.[33] The percentage of household income spent on informal payments in the late 1990s ranges from 4.1 per cent in Romania, 4.4 per cent in Bulgaria, 9.1 per cent in Albania, to 20.6 per cent in Georgia.[34] In Georgia, 94 per cent of survey respondents were unable to seek health care in 1997 due to its high cost, similar to findings from Albania and Tajikistan.[35] Likewise, surveys conducted in 2001 found that in Armenia and Georgia, over 70 per cent of people reporting illness but not seeking care reported not seeking care because they could not afford it.[36] In addition to the financial barriers imposed by fees, patients in some countries are further deterred by the uncertainty about prices caused by informal payments. Nonetheless, there is no evidence as to whether official fees affect equity more strongly than informal payments do.

In some countries, providers may make exemptions for low-income households and engage in price discrimination. Results from a recent study in Georgia suggest that informal payments depend to some extent on the provider's assessment of a patient's ability to pay which, though vague and likely inaccurate, may minimise the financial barrier to access.[37] Nevertheless, the reverse has also been seen, with evidence from Armenia suggesting a refusal to care for people unable to pay informal fees.[38]

One of the most important implications of informal payments is that they undermine governments' efforts to improve accountability and contribute to the growth in corruption endemic in many CEE and CIS countries. The relationship between corruption and informal payments is complex and bidirectional. To simplify, a lack of resources generates the need for additional income, hence informal payments are made and over time become established practice. This, coupled with a lack of regulatory capacity and a lack of monitoring and payment systems that are not linked to output, exacerbates existing corruption in public policy. The existence of informal payments is at odds with transparent public policy and erodes trust in government.

Policy options

In order to reduce informal payments, serious efforts are needed to rebuild lost trust in health care, raise salaries, ensure good quality of care and improve accountability and transparency. Governments should be explicit and reasonable in defining a benefits package of services provided at a sufficiently high standard for everyone within the

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funding that is available. Efforts should be made to adequately inform the population of the benefits package provided by the state and any services that do incur charges.

One possible policy option is to formalise informal payments and develop appropriate exemption schemes. However, formalising informal payments will not solve the problem since informal payments may continue to exist alongside the formal charges, which has been the case in Georgia and Bulgaria.[39] One difficulty that governments face in converting informal payments into formalised cost-sharing arrangements is securing compliance from providers, many of whom may lose income. Experience from low-income countries suggests that a successful conversion to formal cost-sharing depends on the ability of government to regulate providers and set priorities or limit the services on offer.[40] For example, in Bulgaria, payments were formalised in 1997 with no significant increase in revenue (less than 1 per cent of municipal health expenditure) and there is no evidence that exemptions are being used.[41] While the formalisation of informal payments is one possible option, it is essential that these payments be transparent and monitored in order to ensure they actually replace informal payments. Moreover, funds should remain in the health sector, with decentralised retention of revenue to allow local improvements in quality of care. If payments translate into staff bonuses, these should reflect performance in order to provide incentives to improve quality and productivity.

In addition to formalising informal payments, private sector involvement can take two forms: private provision and private health insurance. Some argue that allowing private sector involvement in health care delivery may help curb the rise in informal payments by allowing wealthier patients an alternative to the public system, and offering providers an alternative or supplementary salary. Private health care organisations have developed significantly in Lithuania, for example, and the number of physicians working in the private sector has increased in recent years. Surveys in that country reveal a decline in informal payments corresponding with the growth of private providers.[42] This trend seems to follow the Czech experience regarding the role and compensation of providers, where there is a clear division in earnings between physicians in private practice and those employed by the state, although average earnings of public physicians have stayed above the average national earnings and informal payments are rare.[43]

However, perverse incentives associated with permitting private practice among public physicians may arise, which may compromise the quality of care and increase waiting times of individuals who cannot afford to pay for private care. It is possible that allowing private practice may boost incomes and lead to a reduction in informal payments but, if public time and facilities are used for private practice, resources are directed to the wealthier individuals and away from those who cannot afford to pay. Also, physicians may make cross-referrals from their public to their private practices, in order to generate more income.

Private insurance may also be an option to formalise informal payments while also pooling risks. However, informal payments and cultural tendencies regarding the financing of medical care may restrict the growth of private insurance. Patients may be more comfortable paying physicians and other providers directly, while paying third-party entities may be viewed as needlessly meddling with the doctor–patient

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relationship and reducing assurances of quality care.[44] In Slovakia, informal payments are significant and the market for private medical insurance is not substantial. This is despite the fact that a 2001 Agency Markant survey found that one-third of respondents were distrustful of the General Health Insurance Company while almost two-thirds did not trust the Ministry of Health.[45]

At the same time, indiscriminate support of private sector expansion and encouraging individuals to opt out of the public system may not be such a good idea since there is a risk that the majority of quality-conscious patients would leave the public sector, and it is likely to lead to a two-tier system: a poorly performing public and a well performing private one. Enough financial resources should rather be made available to provide the services of a realistic benefit package at a reasonably good standard to everybody, and new innovative methods of accountability should be made available for the transparent handling of local performance problems. The key issue is to ensure a high quality of care.

Although one possible policy approach is to shift toward more decentralised social insurance models of health system organisation, this may not necessarily reduce the extent of informal payments. While surveys conducted before and after the implementation of a national insurance scheme in Lithuania reveal a decline in the extent of informal payments,[46] no decrease was observed after the implementation of a national health insurance system in Romania, despite the fact that monthly contributions under the Romanian system are compulsory regardless of whether any services are actually received.[47]

The ability to improve efficiency and quality without jeopardising equity critically depends on a number of policy measures, including the skills and capacity of staff, the development of appropriate provider incentives, and the existence of suitable information systems to support the accounting and auditing of payments. Health reforms should also target excess capacity, since incentives created by informal payments can lead to overuse of available staff. Reducing the number of physicians, where appropriate, can also help increase wages and the professional status of medical staff, although wages alone are unlikely to have long-term effects. Evidence supporting the view that increased wages reduce informal payments may be found in the Czech Republic, where a reduction in number of Czech physicians was accompanied by salary increases, and in Poland, capitated primary care physicians, who were the highest paid, were the only ones not making additional charges.[48]

The challenges facing CEE and CIS countries regarding informal payments are great. They represent an important source of revenue in countries in which pre-payment systems have collapsed, so phasing them out without developing suitable alternatives may be damaging. It is clear that multiple, concurrent strategies are needed to eliminate informal payments and to convince the population that good-quality health services can be available without paying under the table. The first step is for governments to acknowledge the existence and full impact of informal payments and to develop more appropriate and affordable benefits packages, and information and monitoring systems with genuine penalties for infringement. This is also contingent upon the existence of political will to address corruption and lack of transparency in broader public policy.

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Notes

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Gift, fee or bribe? Informal payments in Hungary

Péter Gaál[1]

After 15 years of reform, informal payments for health care, a legacy of the socialist health care system, still generate heated debates in Hungary. In 2004, a young father set up a website, halapenz.hu,[2] where parents of newborn babies were invited to share their experiences about the obstetrician that delivered the baby, including how much they paid for the service. What makes this story remarkable is that Hungary has a social

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insurance system in which virtually everybody is entitled to receive almost all health services, free of charge. The doctors who appeared on the list were quick to react, demanding the website be shut down – which was unsurprising since such payments are subject to income tax and should have been declared. The case attracted strong media attention, especially when the website was shut down after the ombudsman said it violated the doctors' right to privacy. The incident sparked an intense debate about the legality of informal payments, the motivation of the patients and whether or not the practice should be banned. But after a couple of months, interest faded and it was back to business as usual.

How widespread are informal payments?

Research has shown consistently that informal payments are widespread in the health sector in Hungary, but the findings vary widely as to the magnitude. An analysis of available data shows that the share of informal payments was 1.5–4.5 per cent of total health care expenditure in Hungary in 2001.[3] This amounts to 1–3.5 per cent of yearly net income for the average household, even if we take into account that only one-third of households reported expenditures on informal payments in 2001.[4] This does not seem much in comparison with other former communist countries, where the majority of health expenditures are informal payments (see 'Paying for free health care', page 64).

To understand the impact of informal payments, however, the aggregate total of money is less important than its distribution. Surveys in Hungary have shown that 90 per cent of payments go to medical doctors and to particular specialities and services, with deliveries and surgical procedures being the best 'paid'.[5] Using the low estimate and distributing the amount equally among doctors in specialities where informal payments exist, income from informal payments contributes about 60–75 per cent of physicians' official net salary. This suggests that the significance of informal payments stems not from their overall magnitude but from the consequences of their unequal distribution. The case of Hungary shows that policy-makers should not ignore the phenomenon of informal payments, even though the total sums involved are small.

The pressure to pay

Determining whether informal payments are fees, gifts or bribes is important in determining what can be done to curb them but, more importantly, whether they should be eliminated at all.[6] It is not easy to dismiss the donation explanation of informal payments. In Hungary, many surveys found that the majority of patients paid the doctor out of gratitude, or at least the majority said they were motivated by gratitude when they made the payment.[7] On the other hand, a more thorough analysis reveals subtle contradictions, which indicate that surveys are not always the best tool to capture patients' true motivation.

Indeed, in our survey, follow-up interviews with respondents reveal that the motivation behind informal payments is multifaceted and that even in apparently straightforward

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cases of gratitude payment there is always pressure to pay.[8] For instance, patients take it for granted that a chosen doctor must be paid extra or, in certain cases, patients feel that they must give something, if the doctor pays more than usual attention. These findings suggest that informal payment is rarely motivated by gratitude alone. Yet despite the arguments against it, the gratitude motive has deeply infiltrated the explanation of the phenomenon in Hungary and is stubbornly adhered to by patients, doctors and policy-makers alike.

At the systemic level, informal payments can rather be explained as the response of patients and doctors to the shortages generated by the state's socialist health care system. Though several systemic features contributed to this shortage, the most notable was the low salaries of health care professionals. Low salaries alone created shortage, either because doctors lowered their performance ('No one can expect me to work hard for such a low remuneration!') or because they had to take part-time jobs and made patients suspicious about the quality of the provided service ('Can I be certain that this overworked doctor will provide me with the service I need?'). Taking into account the information asymmetry between patients and doctors, low salaries could also erode trust ('Is it realistic to expect this underpaid doctor to do everything to cure me?'). Hence shortage does not need to be real to generate informal payments.

Lessons from the Hungarian experience

Informal payments in Hungary seem to stem from a reaction by dissatisfied patients and doctors to the shortage generated by the socialist health care system, which was long on promise and short on delivery. Patients and doctors adapted to the situation by reinterpreting the declared but unfulfilled official entitlement to comprehensive high-quality care and a decent salary for honest work. Where the reassessment of patients and doctors coincided, a new, unwritten set of entitlements emerged.

The health sector reforms of the past 15 years have not fundamentally changed this set-up. Informal payments continue to be a challenging problem for health policy since they have the embedded incentives of a fee-for-service policy, without the transparency and control of formal out-of-pocket payments. Neither taxing informal payments nor legally enforcing non-payment are viable policy options since both patients and doctors have seen unrealistic rules flouted. Successful policies have to tackle shortage in the health sector, either by curtailing the generous benefits package and/or incorporating additional funds by formalising informal payments as co-payments.[9]

Mapping informal payments could help in the design of a co-payment system that would be accepted by the population, but it cannot be assumed that the existence of a formal out-of-pocket payment system will necessarily prevent patients from paying extra. Indeed, payment is likely to continue until patients are wholly convinced the system will deliver effective care without additional incentives. Hence attempts to eliminate informal payments require concerted action to rebuild the lost trust in health care. Local initiatives such as the Hungarian care coordination pilot,[10] which builds on partnership and participation, can help to re-establish the trust-based relationship between the public and physicians, and thus provide a different set of expectations for

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their future encounters.[11] Under this programme, local health care providers (doctors, clinics or hospitals) assume responsibility for the whole spectrum of care for residents in their area, and they are provided with data on their patients by the national health insurance fund to monitor actual service utilisation.

Nevertheless, any reforms have to take into account the political complexities of the current system, as well as the resistance that will inevitably ensue if attempts to eliminate informal payments are made. Though important, recognising that the concept of 'gratitude payment' is no more than a convenient myth that has been used to make an unacceptable phenomenon acceptable is only the first step towards the formulation of more effective policies in this area.

Notes

1. Péter Gaál is assistant professor at the Health Services Management Training Centre, at Semmelweiss University, Hungary.
2. *Hálapénz* is the Hungarian term for informal payment. It literally translates to 'gratitude payment'.
3. Péter Gaál, *Informal Payments for Health Care in Hungary* (London: London School of Hygiene and Tropical Medicine, University of London, 2004).
4. Hungarian Central Statistical Office, *Yearbook of Household Statistics 2001* (Budapest: Hungarian Central Statistical Office, 2002).
5. For a summary of these surveys, see Péter Gaál, Tamas Evetovits and Martin McKee, 'Informal Payment for Health Care: Evidence from Hungary', *Health Policy* (forthcoming).
6. Péter Gaál and Martin McKee, 'Fee-for-service or Donation? Hungarian Perspectives on Informal Payment for Health Care', *Social Science and Medicine* 60, 2005.
7. For a summary of the findings of surveys see Gaál, *Informal Payments for Health Care in Hungary.*
8. Ibid.
9. Péter Gaál and Martin McKee, 'Informal Payments for Health Care and the Theory of "Inxit"', *International Journal of Health Planning and Management* 19, 2004.
10. Péter Gaál, *Health Care Systems in Transition: Hungary* (Copenhagen: WHO Regional Office for Europe on behalf of the European Observatory on Health Systems and Policies, 2004).
11. Gaál and McKee, 'Fee-for-service or Donation?'

Box 4.1 Informal payments take a toll on Moroccan patients

'My husband injured his hand at work and was taken to a public hospital. He had to pay 300 dirhams (US $33) to get an X-ray and 200 to have the injury stitched. He then had to pay another 500 dirhams just to be allowed to stay in the hospital.'

(Woman interviewed in Casablanca)

'When my wife went to the hospital they examined her and prescribed some pills. They said that none were available there, but if we paid 20 or 30 dirhams (US $2–3), someone could provide the "free medication". The problem is, we can't afford the drugs.'

(Man interviewed in Casablanca)

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Four out of five people interviewed in a Transparency International (TI) Morocco survey in 2002 described corruption in the public health system as 'common to very common'.[1] Morocco has a system of 'poverty certificates', designed to guarantee the poor access to basic care, but this system has been prone to corruption and a market for obtaining the certificates has developed. The health minister summed up the problem by admitting that '56 per cent of those that have the means to pay are benefiting from public hospitals, while 15 per cent of the country's poorest are paying out of their pockets'.[2]

According to TI Morocco's study, which surveyed 1,000 households,[3] of those who had been in contact with members of the public health service, 40 per cent admitted to making an illicit payment for a service or supply that was supposed to be free. Of those who required hospital treatment, 59 per cent admitted to paying to be examined or admitted into hospital, while 26 per cent paid for treatment. When asked whether the payments had achieved results, 81 per cent said that the expected result had been reached, compared to 3 per cent who claimed that the 'bribe' was ineffectual. This 'success' rate has to be qualified by the fact that 85 per cent of citizens who paid bribes to public health officials were entitled by law to receive the service for free. The average size of the bribe was 140 dirhams (US $15).

While informal payments can be seen as a coping mechanism for poorly paid health workers, everyone pays for corruption in this sector. Citizens who do not consent to making informal payments do not receive access to care. Public hospitals pay because potential revenue is lost, goes unrecorded or is diverted into the hands of medical staff who abuse their position to extort from patients, and equipment and medicines are wasted or are sub-standard. The credibility and perceived integrity of health personnel suffers. The cost for the state is a failed public health policy.

To remedy this situation, hospital staff must be made aware of the duties they have to their patients, and both health system workers and users must be made aware of patients' rights. Pay structures and working conditions in hospitals must be re-evaluated and whistleblowers who denounce corrupt practices need protection.

Azeddine Akesbi, Siham Benchekroun and Kamal El Mesbahi (TI Morocco)

Notes

1. TI Morocco, *La Corruption au Maroc, Synthèse des résultats des enquêtes d'intégrité* (Corruption in Morocco, a summary of the National Integrity System survey) (Rabat: TI Morocco, 2002). The interviews cited here are from a focus group discussion.
2. *La Vie Economique* (Morocco), 4 February 2005.
3. Of the 1,000 interviewed, 80 per cent came from big cities and 20 per cent from rural municipalities. Of those surveyed 79 per cent were men and 21 per cent were women.

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