

PROJECT POLICY BRIEF

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Title: **Informal patient payments: Concepts and challenges**

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Informal patient payments: Concepts and challenges

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SUMMARY

Informal patient payments affect the overall functioning of health care system in a very complex and interrelated manner. On the one hand, these payments usually exist in a context of limited resources for health care provision and therefore, informal compensations to providers appear to be a feasible solution for receiving treatment. On the other hand, these payments are a threat to public health since those who cannot afford to pay informally might not seek or delay seeking treatment. Thus, informal patient payments can jeopardise efficiency, equity, and quality of health care provision.

There are various explanations for the existence of informal patient payments, including cultural perceptions, insufficient funding of the health care sector and/or lack of control and accountability in the health care system. Before attempting to deal with informal patient payments, it is necessary to understand the phenomenon, its roles in health care provision and its mechanisms. This could indicate the extent to which informal patient payments can be influenced by policy, as well as relevant strategies for dealing with these payments.

Project ASSPRO CEE 2007 aims to study the pattern and magnitude of informal patient payments in Central and Eastern European countries. In particular, the project considers informal patient payments as a criterion relevant for the analysis and assessment of patient payment policies implemented or proposed for implementation.

The concept of informal patient payments

The term “informal patient payments” has a variety of definitions that assign different meanings to this phenomenon. Despite the difference in the definitions, it is generally accepted that informal patient payments are not official (i.e. they are made without official receipt outside the official payment channels and thus, they are not registered). However, confusions arise when these payments are also defined as illegal since informal patient payments cannot be illegal as long as they are not reported. It should be noted, that this confusion in the terminology is not specific to the health care sector but it is one of the characteristics that confronts any issue related to the grey economy in a country. Yet, a distinction between the terms “illegal” and “informal” is required when discussing informal patient payments.

The term “informal” is neutral and does not judge the nature of the phenomenon. Payments can be considered informal when they are not accounted for in the official statistics (i.e. they are not reported and not audited). In contrast, illegal activities are activities which are not permitted by law, or if they are permitted, the rules set by the law are deliberately violated. Some activities are informal, in the sense that they are not officially registered, but not illegal as long as the existing laws and regulations are not breached. Moreover, if informal payments – like gifts and donations – are not directly related to the service received, they are usually legal and frequently even tax deductible. Thus, according to the attitude of policy-makers toward informal patient payments and their effectiveness in enforcing laws and regulations, the same patient payments can be informal in one country and illegal in another country. It is also possible to define quasi-formal payments, which include those payments that are illegal even though formal, but for some reason they are tolerated by policy-makers.

Scope and scale of the phenomenon of informal patient payments

The topic of informal patient payments is rather new in the literature and in policy discussions, although the phenomenon has existed for decades. Informal patient payments are mainly associated with health care provision in former-socialist countries inherited from the communist period. Nevertheless, unofficial payments for health care services are reported in other countries as well, including some high-income countries in Europe, which are not former-socialist countries (source: Health Consumer Powerhouse. Euro Health Consumer Index 2008).

Evidence indicates that informal payments are made to both medical staff in hospitals and general practitioners in policlinics. Informal patient payments are most often reported for services included in the basic health care package but services outside the basic package are also affected. Informal payments are sometimes made due to the patients’ gratitude for services provided, but such payments also result from the misuse of market power by the health care providers. These payments are observed in all patient groups irrespective of the socio-economic status of the patients. However, some countries report certain variations among the patient groups. For example, elderly and those with low-level of education are found to pay less informally than the younger and those with high-education. Nevertheless, patients’ income is rarely a significant indicator of informal patient payments.

The differentiation between the type and nature of informal patient payments is considered to be essential because it can show the providers' ability to induce such payments. In some countries, informal patient payments can represent a significant part of the income of the health care providers. They can also represent a significant part of the total health care expenditure. Therefore, in countries where informal patient payments exist, their scope and scale need to be considered in policy analysis and decision-making to assure the adequacy of policy outcomes.

Explanations of the phenomenon informal patient payments

There are various explanations for the existence of informal patient payments, including cultural perceptions, insufficient funding of the health care sector and/or lack of control and accountability in the health care system. Since informal patient payments can be initiated by the patient or can be requested by the health care providers, these payments can be seen either as donation or as fee-for-service.

The donation hypothesis for the existence of informal patient payments affirms that gratitude payments do not adversely affect efficiency in health care provision in case when the gratitude payments are sustainable. Gratitude payments can improve the responsiveness of health care staff, ensure sustainable supply of human resources, and provide incentives for physicians to stay in the profession, especially in countries where medical staff is under-paid. The fee-for-service hypothesis states that informal patient payments can exhibit the adverse effects of formal co-payments but with additional complication of lack of transparency, which makes it difficult to control them.

Still, these are only hypothesis and they need to be tested to explain the existence of informal patient payments in some parts of the world and their absence in others.

Possible consequences of informal patient payments

Informal patient payments affect the overall functioning of health care system in a very complex and interrelated manner. On the one hand, these payments usually exist in a context of limited resources for health care provision and therefore, informal compensations to providers appear to be a feasible solution for receiving treatment. On the other hand, these payments are a threat to public health since those who cannot afford to pay informally might not seek or delay seeking treatment. Thus, informal patient payments can jeopardise efficiency, equity, and quality of health care provision.

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

Although informal patient payments might be seen to a certain extent in a positive light given their contribution to health care system funding, it is overall recognised that their effect on efficiency is negative. In particular, the existence of informal patient payments can hinder the attempts of policy-makers to improve the technical efficiency of health care provision. In fact, these payments introduce undesirable incentives for providing less cost-effective services if patients are willing or accept to pay informally. Moreover, it is likely that the practice of informal patient payments can lead to resource allocation that is different from the social optimum. Specifically, in case of informal patient payments, resources are not allocated based on the benefits to the society and services are not consumed by those who would benefit most, but rather by those who are able to pay or are easily forced into paying. Thus, social efficiency is adversely affected as well.

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

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

Policy challenges presented by informal patient payments

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

However, there is no single solution since the phenomenon of informal patient payments is not isolated but rather connected to the overall performance of public health care sector in a country. Moreover, different strategies for dealing with informal patient payments have various disadvantages that could result in additional problems with efficiency, equity and quality of health care provision.

For this reason, a mixture of strategies is often proposed as a plausible solution to informal patient payments, including for example:

- Increase in the physicians' and medical staff's income.
- Penalties against those who receive informal payments.
- Incentives for the development of private sector.
- Cost-containment measures.
- Reforms in the provider payment mechanism.
- Introduction of official/formal patient payments.

The successful implementation of these strategies and the possibility to circumvent their weaknesses depend on the particular setting and the overall conditions in the country. The prevalence of corruption in the society and the degree of social solidarity are two examples of relevant contextual factors.

In addition to this, the attitudes of the health care actors also play a role. Even though in general, the public is interested in the solution to the problem of informal patient payments, health professionals are often reluctant and attempt to keep "status quo". Moreover, informal patient payments are not always seen as a negative phenomenon by policy-makers, especially in countries with very low fiscal capacities and insufficient financing of the public health care sector. Due to the non-transparent nature of informal patient payments, health authorities might be even not aware of the exact scope and extent of these payments. Under such circumstances, solutions to the problem of informal patient payments present a major policy challenge.

Informal patient payments and formal patient charges

Project ASSPRO CEE 2007 aims to study the pattern and magnitude of informal patient payments, as well as the variation in these payments within different population and providers groups, in six Central and Eastern countries included in the project – Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine. Analyses on patient payments in Albania and Russia are also included in the project. In particular, the project considers informal patient payments as a criterion relevant for the analysis and assessment of patient payment policies implemented or proposed for implementation.

There is an overall concern that official charges do not have the ability to eliminate the informal ones, and that their introduction results in a mixture of formal and informal payments by the patients. Thus, data on informal patient payments can help policy-makers to develop an adequate system of official patient payments. In particular, these data can indicate what health care consumers are already paying and for which health care goods.

If no effective measures for dealing with informal patient payments are introduced, the level of official fees should be reduced correspondingly in order to reflect the existing informal charges. Moreover, data on informal patient payments within vulnerable population groups (e.g. elderly, children, low-incomers and chronically sick individuals) can indicate possible failures of equity protection measures (e.g. limits, exemptions or fee reductions) that need to accompany the official patient payment mechanism.

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