Institutional Issues in Informal Health Payments in Poland

Report on the Qualitative Part of the Study

Shahriari H, P Belli and M Lewis

February 2001
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1. CHAPTER 1. OVERVIEW OF THE STUDY

1.1 INTRODUCTION

A growing pattern within the ECA (East Europe and Central Asia) region is informal payments to doctors, hospital administrators, nurses and others connected with health service delivery. These payments have implications for governance of health systems and for equity and access, as well as for incentives for both health providers and managers.

The phenomenon, as this study shows, has complex and deep-rooted causes. Informal payments are mainly a symptom, not a cause, of major imbalances present within the health system. In turn, they contribute to fostering and maintaining such imbalances, as no strong interest group demands real change. Thus, the policies needed to contain informal payments and reduce their negative impact involve a multiplicity of interventions. At the same time, not all of forms of informal payments are negative and need to be suppressed.

Informal payments raise efficiency as well as equity concerns. With regard to efficiency, informal payments undermine government efforts to improve accountability and public sector management. At the same time, since these payments are not taxed they contribute--along with the low amount of taxable income--to the shortage of real revenues upon which the system depends for financial resources.

The informal nature of these health care payments also diverts decisions regarding public policy and resource allocations away from the public interest. The government defines priorities and makes resource allocations based on a distorted perception of the flow of resources into the health system. With informal payments, providers set payments and there is virtually no involvement of the sponsor of the system--the government. As in a private market, the ability and willingness of customers (patients) to pay determines where resources really flow.

Finally, since funds go to individuals, not to facilities or to the overall system, up-to-date medical equipment, efficient heating systems, effective nursing arrangements and other elements of a functioning health care system do not receive adequate financing.

As far as equity is concerned, one of the most important consequences of requiring payments from patients when they are entitled to free care is restricting access to those who cannot pay. Informal payments can render essential services unaffordable. A primary reason for government involvement in health care financing is to ensure equity, particularly for those who cannot afford health care. The existence of informal payments can undermine that objective.

Building on the existing literature, this research is aimed at: (1) identifying the nature, extent, and economic dynamics (mechanisms of collection and revenue distribution among different
actors) of informal payments; (2) understanding the leading causes of informal payments; (3) identifying the consequences of informal payments on accessibility and quality of care, and (4) articulating policy options to reduce the size and negative impact of such payments.

1.2 BRIEF SUMMARY OF MAJOR RESEARCH FINDINGS

1.2.1. Nature and forms of informal payments

According to the research findings, informal payments are widespread in the Polish health sector. They include both cash and in-kind contributions. The study reinforces the existing anecdotal evidence as well as evidence from studies in other countries of the ECA Region and shows that the phenomenon has, if anything, become more widespread over the last few years (Lewis, 2000).

Informal payments are both paid voluntarily and coerced by providers in one way or another. As Chapter 2 shows, the main reasons for paying for medical services are to ensure quality care, to buy future care, and to jump queues. Providers are also paid to show gratitude and appreciation. In addition, users contribute in-kind for ancillary services. For instance, they bring their own sheets, food, or even medicines to the hospital because the hospital is not providing them.

1.2.2. Causes of informal payments

The reasons for the prevalence of informal payments are multifold and in most cases interrelated. They include:

- Low salaries of medical personnel
- Imbalances in the health care system between mandated health care and available resources
- Poor incentives for health providers
- Shortage of critical medical supplies
- Inefficiency in the system
- Lack of transparency in health facility operations
- Cultural factors: paying for quality services is deeply ingrained in the Polish attitude.

There is a lack of incentive among all actors in the health care system (e.g., providers and even in some cases patients) to halt the practice of informal payments since the majority of the actors benefit. The sickness funds do not prevent the payments because they enable doctors to supplement their low incomes, thus easing the pressure of unrealistic expectations (compared with the financial means available) for public delivery of health services. Doctors benefit from this arrangement not only because they earn additional income, but also because they have access to free medical equipment for their private use that would be unaffordable for most in a private practice. In turn, patients who can afford it prefer to pay for quicker and better care and
for better medical equipment and supplies, even if standard care is available free. At least in the short term, the only ones who suffer from the present arrangements are the poorer segments of society. These are also the more powerless groups and those least able to demand change. In the long term, however, the present system prevents not only improvements in the public sector, maintaining a fiscally unsustainable system, but also healthy development of the private sector as an independent and competitive alternative to the public one.

1.2.3. Consequences of informal payments

There are various consequences related to informal payments. One of the most pressing concerns is the issue of equity. Informal payments, according to this study, are not a precondition for receiving treatment when a patient is admitted on an emergency basis. In the great majority of cases, inability to pay does not seem to impede access to the health sector for the most urgent and severe cases. In other words, a minimum standard of care seems guaranteed to almost everyone.

In general, though, it is difficult to ascertain where the minimum is acceptable and where it is not. For example, having to wait for months for an operation meant death for a patient with cancer, the sister of one of the participants in a focus group in Wroclaw, who could not afford to pay; for terminally ill patients, ability to pay for health services can determine life or death. Serious equity issues were also reported for the elderly (see section 5.3, on equity and access), who complain of being constrained by their low pensions from receiving certain forms of medical care, such as effective but expensive drugs. Their difficult financial situation also restricts their access to private health services.

Many who cannot afford to pay have to postpone treatment, use up their savings, borrow, or seek alternative means such as home remedies. They tend to show up in emergency rooms at the last minute.

The social status of users does not seem to be a factor in paying informally. People with considerable education and those with less (such as farmers) report a similar level of helplessness for coping with the “gray zone” when they experience it.

Similarly, no significant differences in informal payments emerged across regions or between rural and urban areas. In urban settings where the private sector is more developed, at least in outpatient care, informal payments are concentrated in hospitals. However, in some areas, especially with respect to certain procedures—for instance, in most cases of elective surgery, gynecology, or urology—the informal payment system can affect most of the users. In rural areas as a result of the scarcity of qualified specialist care, medical facilities are used only as the last resort. A number of our respondents living in rural areas who could not afford to pay and who, as one of them said, “have not been lucky enough to meet an honest doctor”, rely on home remedies.
1.3 CONCLUDING REMARKS

On the basis of the empirical material, we can say that the phenomenon of informal payments in the public health services is becoming close to commonplace. A decided majority of our respondents expressed the belief that doctors have much higher earnings (three times higher, on average) than officially disclosed, mainly due to private practice and to the generosity of patients through envelope payments, brick payments (donations to a facility by purchase of a token brick) and other gifts. In the minds of both service users and providers, the difference between salary, bribe and voluntary gift is obliterated, and this means that pathology is becoming a norm in the functioning of the public health service. It should be added that there is a belief that doctors should have better earnings, but legally.

As the study indicates, acceptance of informal payments is deeply rooted in the Polish mentality. They are a consequence of decades of imbalance between what the state promised and what it was actually able to provide. The study also shows that the problem is very complex and that we should not aim at eradicating informal payments completely. Some of them, those given in the form of gifts, have a positive function because they make providers more responsive to consumers.

Moreover, if we imagine that prices within the health sector are basically dictated by a central-planning style, then informal payments can be seen as signals for resources to flow from one part of the health system to another. If factors could shift more flexibly, the informal payments would be temporary and they could move around within the system depending on where relative scarcities were at any given time. If conditions are rigid, though, as they are at present, the signaling value of the informal payments is frustrated and the payments become pure rents that can persist indefinitely. It seems, therefore, that one of the antidotes to informal payments is increasing factor mobility. That might mean, for example, retraining doctors and nurses, or it might mean closing some wards or even hospitals and opening others.

Certainly 9 months of the recent reform at the time this research was done is not enough to evaluate all its effects in an objective way. But the exceptional concurrence of the opinions of patients and health care staff is that not much has improved as a result of the reform and that there are unquestionable difficulties and constraints in access to medical services. In this situation private practice becomes important, with probably all our respondents agreeing that private services are clearly of so much higher quality that it is not necessary to waste time and energy to overcome the bureaucratic barriers separating patients from doctors in the public sector.

However, as mentioned, the private sector is not developing as an independent and competitive alternative to the public sector. Rather, the public and private sectors seem to be interlinked in a rather awkward symbiosis. The private sector is benefiting from the poor funding, disorganization and lack of control in the public sector. At the same time doctors supposedly employed full-time in the public sector in fact get a substantial part of their earnings from private practice, using their public employment mainly to develop a clientele for their private activity and to utilize expensive equipment they could not personally afford. So they continue working in the public sector, without demanding change. We believe this is a pathological phenomenon that impedes real improvement not only of the public sector, but ultimately of the private sector.
as well. The Polish health system probably needs a stronger private sector, but that can only happen within a well-functioning public sector and regulatory framework.

The “parasitic” growth of the private sector is not a consequence of informal payments. Indeed, in the long run it could contribute to solving or at least reducing the problem of informal payments in the public sector. However, it is basically another manifestation of the same phenomenon: the use of public facilities mainly as a tool for promoting private interests. In the meantime, as the private sector is not yet sufficiently developed, informal payments keep the system going. Paying doctors or other health providers informally is openly tolerated by all parties involved.

To remedy this situation, adjustments around the edges will not suffice. First of all, Poland needs a clear redefinition of what the state will guarantee in terms of health coverage. In formulating this, the Polish government can roughly follow one of two options. The first is to move toward a Western European type of health system in which an acceptable standard of public care must be guaranteed for the whole population. It is clear that this path poses a greater burden on public finances, and so it must also be made sustainable through appropriate budget transfers, payroll or other tax contributions and user fees (though in a transparent and regulated way). If this first option is pursued there is a role for the private sector, mainly in service provision, though from a base independent of the public sector. Doctors should choose whether to stay in the public sector full-time or move to the private sector, with differentiated career profiles.

The other option is to move toward an American type of health system, largely based on private incentives in both financing and provision. Then the state should retain only the roles of providing services for the poor and for those excluded from private insurance (such as chronically ill patients) and of regulating the system. Such residual roles may in fact turn out to be significant and cumbersome for the state, as is the case in the United States (where for each dollar spent on health, approximately 45 cents comes from the public purse), due to insurance market failures and equity concerns. Yet the general principle underlying public health interventions in this second case is clearly different: health is not a universal right to be distributed according to need, but rather a commodity allocated, as are all other commodities, according to willingness and ability to pay.

At present, the health system in Poland pretends to be looking to the West European model, but in practice it seems to have all the drawbacks and none of the relative advantages of the West European and American systems. It does not enjoy the benefits of competition, in terms of quality of services, like the American model, nor does it offer the security and accessibility of care of the Western European model. In the absence of a private alternative, the imbalances of the system have manifested themselves in a widespread use of informal payments. In the future, such imbalances may have a different manifestation and informal payments may be contained.

The recent reforms also provide an opportunity to redress the imbalance between the mandate of health care (universal access) and the available resources, as well as their misallocation. Poland does not want to waste this opportunity.
2. CHAPTER 2. GENERAL BACKGROUND

2.1. HISTORICAL BACKGROUND

Chawla (2000) provides a thorough introduction to the history of the Polish health system from the time of World War II to the most recent reforms. This section will draw liberally from his work.

Before 1972

After 1945, health care was declared a public responsibility by the Communist regime. Beginning in 1972, the state was able to offer free universal public health care. All facilities were brought under state ownership and financed from the center through budgetary transfers. As for the delivery system, the health care system in Poland was based on hospital care, according to the Siemaszko model of the Soviet Union. Originally, a vertical and segmented approach to disease management characterized the system. This was best suited to addressing communicable diseases, which at the time constituted most of the burden of care. As a result the national budget, either directly through the Ministry of Health or through other ministries such as Defense, Interior, Transportation and Industry, supported an increasing number of state-financed hospitals and clinics, often devoted to a single specialty.

The period following the war was the time in which the Polish health system achieved the best results in terms of reducing of infant mortality rates (down to 40 per 1,000 in the 1960s from 110 per 1,000 in the 1950s {Zatonsky, 1996}), and mortality rates for communicable disease (especially TB; see Magdzik &Czarkowsky, 1994). By 1965, life expectancy of the Polish population was nearly equal to that in West Germany (Zatonsky, 1994).

1972-1988

In 1972 over 500 Zespół Opieki Zdrowotnej (zoz), or integrated health and social service units, were created to serve the 49 voivodships, or provinces. To manage them, the system developed a multi-level governing structure. Public funds from Warsaw were assigned to the provincial voivodships or to the gmina (independent local governments) and passed from them to the zoz. Tertiary care hospitals and some public health programs were directly funded by the central government. The zoz funded and managed local hospitals, outpatient clinics and specialists and primary care, as well as some social services.

Primary health care in this system was produced and delivered by a vast network of over 3,000 service centers. In urban areas, primary health care was provided in przychodnias, or large polyclinics, which also offered some specialist and diagnostic services. In rural areas, primary health care centers were generally smaller and usually had one physician and one nurse. In-
patient services were provided in local general hospitals administered by the zoz, in voivod-owned general and specialist hospitals located in urban centers across the country and in highly specialized teaching hospitals of the 11 medical universities.

All health care personnel were salaried state employees, and levels of compensation were low. There is some evidence of private practice by physicians in this period and of informal payments, though not much is known about the extent of these payments.

As a result, the practices that grew up in response to these incentives in the health sector were similar to those in other parts of Poland’s socialist planned economy. First, given the nature of funding, the management of health facilities in the voivods, gminas and zozs had few incentives to develop fiscal and strategic planning functions. The predictability of budgetary allocations undermined any impetus to improve managerial and organizational capacity and slowed down innovative progress and the ability to respond to change. Second, the system of compensation based on salaries obscured the importance of effort and productivity. There was little effort to improve efficiency and quality of care, and patients faced a situation of erratic services. In addition, physicians’ salaries were kept low, causing them to look to other sources to augment their incomes. Over time, a general feeling of apathy set in among all the major stakeholders in the Polish health system, and this was exacerbated during the period of martial law.

The period after 1970 was also the time when the adult mortality rate among men started to worsen in Poland, as well as in the rest of Eastern Europe, while that for women stagnated at the level reached in 1970. The standardized mortality rate for men aged 45-64 rose from 1,230 per thousand in 1965 to 1,660 per thousand in 1988 (Zatonsky, 1996). The incidence of noncommunicable diseases, especially cardiovascular disease, increased, probably due mainly to unhealthy lifestyles with poor diets and high alcohol and tobacco use (tobacco use increased sharply in the 1960s and 1970s and stabilized in the 1980s)\(^1\).

1989-98

In January 1990, the Government of Poland introduced a package of reforms to change the centrally planned Communist system into a free-market economy. Prices were permitted to fluctuate freely, money supply was tightened, the currency was devalued, and the privatization of public enterprises was initiated. At the same time, a number of health system reforms and enabling legislation were introduced in finance, organization and management of health services. The general direction of these reforms has been toward new provider payment mechanisms, greater autonomy for hospitals, decentralization in health care administration, recognition of patient choice and, effective from January 1, 1999, social insurance and establishment of sickness funds to finance health care.

Another focus of the reform process was primary care. A new primary care specialty was created and retraining programs for doctors were initiated. This was meant to be the first step in a more profound reorganization process, aimed at eventually developing a new role for general practitioners as “gatekeepers” to the rest of the health system.

\(^1\) In the 1990s tobacco use decreased slightly for men, but today there are still more than 10 million smokers in Poland, in a population of 38.6 million people; Peto, 1992, 1994 and Doll et al., 1993 estimate that 40% of adult male deaths in the 1980s were caused by tobacco consumption.
In order to initiate the reform of the provider payment system, providers’ legal status had to be changed. Since paying public physicians by any method other than salaries was not possible under existing regulations governing state employees, any physician accepting alternative methods of payment first had to resign from government service. This led to the creation of a whole new class of private medical practices supported by public funds.

In terms of health outcomes in the first years of the transition to a free-market economy, up until 1991 mortality rates continued to worsen, especially due to externally caused deaths that increased by 25 percent from 1989 to 1991. Then there was a marked, as well as unexpected, improvement. From 1991 to 1994 the overall mortality rate decreased from 1,062 to 971 per 100,000 men and from 550 to 519 per 100,000 for women (Zatonsky, 1996). The sharpest decline was in deaths from cardiovascular disease, which fell by 25 percent in the 20-44 age group and by 15 percent in the 45-64 age group.

**From 1999 onward**

In January 1999 mandatory health insurance was introduced. This is provided through 16 regional sickness funds, and funding is through premium contributions of 7.5 percent of individual income. Sickness funds provide coverage of almost all primary and secondary health care services, while tertiary services provided by the medical academies and teaching hospitals continue to be financed by the state under the old system of budgetary transfers.

Changes in financing of the health sector brought about by introduction of social insurance have been accompanied by significant changes in the organization, management and delivery of health care. The sickness funds set contracts directly with independent **zozs**, thereby marginalizing the role of the **gminas** and the **voivods**. In turn, many **zozs** contract with independent physicians and private health care units to provide health services. The **zoz** managers deal directly with the insurance funds, negotiating rates, terms of financing, service focus and delivery hours.

In primary care, individual doctors contracted by the sickness funds receive an adjusted capitation funding. They are financially responsible\(^2\) for referrals of patients to most outpatient specialists. At the same time, patients must obtain a referral from primary care doctors to access specialist care. (For a discussion of the issues raised by these new arrangements, see section 3.2.5.)

### 2.2. Definition of Informal Payments

Mukesh Chawla (2000) defines informal payments as:

> payments, in cash or in kind, made by patients, or others on behalf of the patients, to an individual or institutional public health care provider directly or to any person arranging for provision of health care from such public health care providers, for health services received or expected to be received, that the recipients of these payments are not authorized to receive under the existing laws of the land, including the Constitution of Poland, 1997, and the Health Insurance Act, 1997, or under the rules of business of the health facility.

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\(^2\) Primary health care physicians are paid about 60 zl. for each registered patient (more for those above 65 and younger than 5). Once a patient needs referral, it is from this pool of money that the costs are paid. For more information on types of payments, see Chapter 3.
According to this definition, “informal” and “illegal” payments coincide. Informal payments are those from which providers improperly benefit. Chawla provides a detailed listing of formal and informal payments based on the above definition.

In practice the distinction between formal and informal payments is not always clearcut. First, the line between a voluntary gift and a coercive payment is hard to draw, as many examples in the following pages show. Second, there is a gray area of payments that is not illegal in a strict sense but that nonetheless goes unreported, mainly to avoid taxes; it is neither formal nor informal according to the above definition. Third, a relevant portion of out-of-pocket payments is formally legal but is illegal in substance. An example is the many “advance” payments to specialists in their private clinics, technically a legal form of payment. If these are reported, they are also “formal”. But in reality, the patients are not paying for the private visit; rather, they are seeking access to a public hospital. Similarly, the distinction between informal payments associated with outpatient visits and with inpatient stays is not always well defined. In sum, payment may take place in an outpatient clinic but be motivated by the desire for hospital admission.

Moreover, as the following pages show, the distinction is largely unclear and irrelevant to patients. Respondents in general lacked information about their rights and the correct payment and referral procedures. Sometimes patients complain about paying for services to which they are no longer entitled according to the Health Insurance Act of 1997 (for example, most types of dental care). However, they accept paying for services that should be free according to the law. More important, as we have seen, patients in general perceive informal payments as a necessary means for obtaining good and timely care.

Finally, there is a difference between payments from which providers directly benefit and those that reflect financial gaps of medical institutions. For example, most forms of in-kind payments, such as bringing one’s own clean linens and food during hospital stays (as reported by some patients), reflect the dire financial situation of the institution.

In the discussions ahead, this report refers to Chawla’s definition of informal payments as a benchmark, but it also considers other forms of payments that may lie outside the definition.

2.3. SCOPE OF INFORMAL PAYMENTS

According to official figures, from 1990 to 1997 out-of-pocket payments (formal and informal) sharply increased as a portion of total health funding, from 6 percent to an estimated 23.4 percent (Health Care Systems in Transition, Poland, WHO 1998), posing an increasing burden on households. Considering both outpatient and inpatient care, out-of-pocket expenditure by households (1990 fixed prices) grew by 388 percent between 1990 and 1997, with the largest annual increase in early 1990, when inflation was eroding health employees’ real salaries (Health Care Systems in Transition, WHO, 1999). Wages in 1997 were still only 78 percent of the 1989 level in real terms, despite a GDP real growth of 27 percent over the same period.
Table 1

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<tbody>
<tr>
<td>Household health expenses, fixed</td>
<td>201.2</td>
<td>320.0</td>
<td>419.7</td>
<td>640.3</td>
<td>812.4</td>
<td>804.4</td>
<td>877.3</td>
<td>983.4</td>
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<tr>
<td>prices (million zl)</td>
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<tr>
<td>Annual growth in household expenses</td>
<td>N/a</td>
<td>59.1</td>
<td>31.2</td>
<td>52.6</td>
<td>26.9</td>
<td>-1.0</td>
<td>9.1</td>
<td>12.1</td>
</tr>
</tbody>
</table>

Source: Ministry of Finance Annual Statistics.

In current terms, in 1997 total out-of-pocket payments were equal to 4,714.53 million zloty³ (zl.). Total health expenditure was estimated at 15,429 million zl. According to official statistics, most of the out-of-pocket expenditure is in outpatient care (4,014.53 million zl.), as opposed to inpatient care (640.82 million zl.). The privatization process has been much faster for outpatient facilities than for hospitals. Hence, it is easier today for doctors to privately collect payments for outpatient services than for hospital services, which are supposedly free. Outpatient services are also used much more often. The out-of-pocket estimates above include all such payments for pharmaceuticals.

In focusing on the informal portion of payments we find, however, that the bulk of them seem to take place in inpatient settings. It is estimated by Chawla (forthcoming paper, 2000) that in 1997 484.28 million zl. were paid informally for hospital stays and only 77.3 million for outpatient visits. However, this figure probably underestimates the real amount of informal payments. According to the Health Care in Households Survey (Central Statistical Office, 1998), in 1997 about 78 percent of hospital stays were partially or totally paid for by patients. For 30 percent of those who paid, the fee was lower than 50 zl. Another 20 percent of patients paid more than 339 zl., and of these about 10 percent paid over 550 zl. For the period July 1997 through June 1998 it has been estimated that the median of payments for hospitalization was equal to 115 zl.. From 1990 to 1997 the percentage of the population reporting informal payments increased from 16 to 29 percent.

According to a public opinion survey conducted in 1998 [in Poland, each year the total value of bribes offered is at least 900 million zl. During a year each household receiving services spends at least 72 zl. on informal payments. The majority (42 percent) makes donations or buys shares on behalf of the hospital or ambulatory in which he/she is treated, the so-called “brick payments”. One also pays for a possibility of treatment by a selected specialist (10 percent) or for better medical care during a stay in hospital (9 percent); 8 percent of Poles express gratitude in financial form, whereas 3 percent confess that they offered bribes for admission into a hospital and 2 percent for quicker surgical intervention or medical examinations. (Center for Public Opinion Surveys, further CBOS,, March 1998).

³ Zloty is the Polish currency, equivalent to about 1/3 of the US$ as of 4/19/00. It will also be referred to in this paper as zl.
2.4. DEBATES ON THE SCOPE AND MECHANISMS OF INFORMAL PAYMENTS IN POLAND

The issue of informal payments has been debated and written about extensively by the media and other sources in Poland. The focus of this section is to review some of the writings on the issue and the way it has been debated in the country. The sources are mostly newspapers and the professional medical press. These writings in a number of cases make use of sociological studies and studies conducted by institutes of public opinion research.

According to one of the most reliable and respected Polish weeklies (D A. K.), “It is known that there are considerable payments within a ‘gray zone’. However, each subsequent management of the health ministry denies that bribes are a mass phenomenon, and some of them even state that bribes are occasional” (Majcherek, 1997).

The main reason for informal payments, as discussed in these articles, is to gain quicker access to surgical intervention or to a hospital. In this case "the initiative of payment comes from the providers' side, which means simple forcing of a bribe, and it is not the same as payments given by patients to physicians voluntarily" (Sienkiewicz, 1996 b). It can be estimated that about 1/7 of all those paying are forced by doctors to give bribes. More than half know the amount that is expected by the physician in advance (Sienkiewicz, above). There are three categories of doctors who receive informal payments for medical services: those allocating hospitals beds, those responsible for surgeries and those having access to expensive diagnostic facilities (Mozolowski, 1996 a). In the first group it is the ward head, or sometimes his deputy, who assigns beds. Equally important, of course, are the doctors responsible for planning and performing the surgery. The third group that can have some influence is the administration of specialized laboratories, equipped with expensive and hard-to-obtain diagnostic and therapeutic tools like: Cat Scan or MRI machines and lipotypers for crushing renal stones.

There are two informal ways for patients to ensure better medical care. The first is to precede a hospital stay with a visit to a doctor in private practice who is the head of the ward or has "his own beds"4 in the ward. It is estimated that for each 1,000 beds, half are informally at the disposal of ward heads and their deputies. The fee for making a bed available to a patient is 200-300 zl. (Januszewski and Kulik, 1997). However, one pays separately for surgery. The more complicated the operation, the higher the rate. During the medical consultation the physician sets the amount and receives payment from the patient, offering in exchange reliable medical care. The second way of ensuring good care occurs when a patient, unaware of the mechanisms existing in a ward, after many suggestions from hospital personnel, sends a member of his family to "settle for overdue arrears" (Mozolowski, 1996 a; Solska, 1994).

Another phenomenon related to payments outside legal channels is bogus distribution of prescription drugs. This illegal trade requires cooperation between pharmacy personnel and physicians writing out false prescriptions. With these prescriptions, both sides receive money from the health care budget (once the state budget and now the Health Fund budget), splitting it up between themselves. There are a number of other fraudulent uses of prescription drugs. The

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4 Some doctors (mainly heads of divisions of hospital) officially, either after consulting with the director of the hospital or without such consultation, reserve a couple of beds for their private patients. The fact that important and influential doctors have several beds reserved for their patients is an accepted and customary practice in Poland.
most common has been misuse of the so-called "green prescriptions", which entitled the patient to receive drugs free of charge.  

A payment that falls between formal and informal, although it is illegal, is the "shares" or “brick” payment described earlier, in which the patient or his/her family buys a brick that symbolizes a contribution to the health care facility. This is supposed to be a voluntary donation for the hospital, ambulatory, or medical equipment used. However, the voluntary character of the payment should in this case be interpreted as an informal dictate, because refusal to pay can result in denial or delay of services (Sienkiewicz, 1996 a; Fandrejewska, 1998).

In the opinion of some lawyers, various kinds of hospital or medical foundations are indicative of informal payments in the health service; their registration is an effective method of bypassing budget payment regulations (Fandrejewska, 1998). Doubts concerning legality of this kind of operation stem from the fact that the facilities, equipment and personnel used are all state property and employees. The only difference between a public facility and a foundation is the reception hours: "In the morning it is a public property, and in the afternoon it is leased out to a foundation.” The popularity of foundations should be attributed to the fact that patients are able to undergo specialized examinations and surgical treatments "quickly, in the afternoon” (Fandrejewska, 1998).

Other illegal procedures are unwritten contracts between funeral homes and health service personnel. It is essential for undertakers to have "connections" in medical facilities such as hospitals or emergency rooms, because the strategic moment for the funeral home is beating competitors to a "customer". When a death occurs informers are extremely useful, whether physicians, nurses, paramedics, or emergency dispatchers and drivers. In theory, selecting a funeral home is a decision of the family. Usually, however, the family will use the first funeral service that appears on the scene.

In the current debates in Poland, the main reasons mentioned for the existence of informal payments are the following:

- **Low wages.** Doctors emphasize that the pathological payment behavior results from lack of appreciation of their skills and the fact that their salaries are dramatically inadequate for the skilled work that they do (Majcherek, 1997; Januszewski, 1997).
- **Lack of awareness among patients about their rights.** In the opinion of surveyors of the Supreme Chamber of Control, patients do not have equal access to medical services, bribes are demanded from them and the patients themselves are treated like objects (Montgomery, 1997). “Observance of the patient’s rights in our country leaves much to be desired. In this respect we are one of the last places in Europe” (Karwat, 1998 b).
- **Patients’ desire for guarantees of higher-quality services.** Patients, having learned from their own or somebody else’s unpleasant experience, treat the bribe as a protection, a guarantee of quality or specialized medical care. Therefore the phenomenon of demanding money, not only for medical services, enjoys public acceptance. It is regarded as the only way of ensuring high-level care (Kirschner, 1995; Porada, 1997; Szcesny, 1999).

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5 There were some categories of people, usually older or with chronic illnesses, who were entitled to receive “green prescriptions”. However, these prescriptions have now been replaced by “white with a blue stripe” ones, which have far more stringent eligibility criteria. (See section on the nature of informal payments). Despite the greater restrictions, the new category of free prescriptions may be subject to some of the same abuses as the old one.
2.5 The Study

2.5.1 Study Objective

The main aims of the study are: (1) to identify the nature and extent of informal payments; (2) to understand why they occur and their general pervasiveness; (3) to understand their consequences, especially on access, perceived quality and gender- and age-specific issues; and (4) to suggest pragmatic and practical solutions for decreasing their occurrence and the problems they create.

2.5.2 Methodology

This qualitative study is intended to complement the exit survey undertaken concurrently in a number of health facilities. The main objective of the qualitative part was to enhance the quantitative part of the study by understanding in-depth the experiences and perspectives of users as well as providers of the health system—patients, doctors, nurses, administrators and some key informants—regarding the above objectives. (For more information on the methodology and site selection see Annex I.)

The main means of collecting information were in-depth interviews and focus groups. In addition, the existing literature on informal payments in Poland was reviewed for this study. In all, there were 185 participants in the study, living in two big cities, Gdansk (48 persons) and Wroclaw (48 persons) and in two small towns in the rural municipalities of Czluchów (46 persons) in the Pomeranian region and in Bielawa (43 persons) in the Lower Slesian region. The number of respondents was similar in each of the voivodships (Gdansk, Pomeranian voivodship, 96 persons, including 82 patients and 14 health service workers; Wroclaw, Lower Slesian voivodship, 89 persons, including 76 patients and 13 health service workers).

Out of the 185 people, 122 were interviewed through in-depth methods, including 95 patients and 27 health service workers in the same sites. In addition, 63 users participated in focus groups. It should be mentioned that even though 185 people were directly interviewed, since the research team asked about experiences not only of the respondents but also of those very close to them (their parents, children and siblings), the number of experiences reported was higher. (For more information on the characteristics of the sample see Annex I.)

2.5.3 Brief description of the sites

Gdansk. This is one of the biggest and most industrialized Polish cities. Its population is 458,355 (data as of June 30, 1999), and it has a relatively low unemployment rate (4.2 percent as compared to the 12 percent national average). However, the unemployment rate in the voivodship as a whole is high due to the closure of state farms after the transition. Gdansk is also relatively well developed compared to Polish cities in general and in terms of medical facilities. It has 5,550 consulting rooms (3,172 private doctors, 1,200 dentists and 1,178 doctors providing

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6 This number includes 10 respondents interviewed by the international consultants.

7 For detailed information about the sites see Annex I.
medical services for old age and disability pensioners), numerous outpatient clinics, 13 inpatient health care institutions of different levels of specialization and size and 3 highly specialized (tertiary care) hospitals. Gdansk has a very large catchment area as it is far from other big cities.

**Wroclaw** is equally well developed in terms of industrialization. It has 637,294 inhabitants and its unemployment rate (5.2 percent) is well below the national average. The city has quite a broad medical infrastructure: 221 health service institutions, including numerous nonpublic ones. Twenty-one are hospitals of different levels of specialization and size, and 200 are outpatient health care facilities. Wroclaw is close to other urban centers and has a small catchment area.

**Bielawa** is a medium-size town situated within Dzieroniów administrative unit, in the Lower Slesian **Voivodship** (Województwo Dolnośląskie; Wroclaw is the capital). It is inhabited by 33,793 citizens. The unemployment rate considerably exceeds the national average. The city provides medical care for its inhabitants through 1 regional hospital, 2 outpatient clinics, and the ambulance service. Within the community there is also the State Administration for Children Preventoria (Panstwowy Zespół Prewentoriów Dzieciecych), which provides medical services for the population of the entire country.

**Człuchów** is a small town with only 16,000 inhabitants. It is situated in Chojnice administrative unit, in the Pomeranian **Voivodship** (Województwo Pomorskie; Gdansk is the capital). It is characterized by one of the highest unemployment rates in the country (1,404 persons—29.2 percent of the entire population). Człuchów has one community health center and two rural health centers (Wiejski Osrodek Zdrowia). The city provides in-patient medical care in a district hospital (basic medical service). Fifteen km from Człuchów is the city hospital in Chojnice, which offers medical service on the same level as the hospital in Człuchów. The nearest institution of high-standard hospital services (a specialized, or level of reference II hospital) is a clinic in Kosierzyna (90 km from Człuchów).8

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8 Level of reference refers to the level of specialization. There are three levels of hospitals (and of related inpatient care). The first level is hospitals with limited wards, mainly pediatric, internal medicine and gynecology wards. The second-level hospitals include at least four more specialized wards such as cardiology, neurology. The third level of reference comprises the most specialized hospitals, usually connected to a university.

9 For more information about sample selection and methodology in general, please see Annex I.
CHAPTER 3. INFORMAL PAYMENTS: THEIR NATURE AND MECHANISMS

3.1 INTRODUCTION

Informal payments can be cash, in-kind or gratuities. They are both paid voluntarily and asked for by the providers, implicitly or explicitly. Cash payments are given before or after treatment. In-kind payments are given before, after or even during the treatment in the form of supplies needed when patients are hospitalized, which may include sheets, syringes, bandages, food, and even medicines. In-kind can also include gifts to the staff of liquor and major food items, especially in rural areas, or of other items such as linens, given mostly after the treatment.

Cash and in-kind payments are not necessarily mutually exclusive. Patients may give some cash for admission, treatment or even referral and yet bring their sheets or medications to the hospital.

One of the difficulties in determining the exact nature of informal payments is the fine line that divides voluntary or gratuity payments from those that are coerced, whether explicitly or implicitly. In many ECA countries, including Poland, it is culturally acceptable to pay something to one’s own doctor or nurse. However, it is difficult to distinguish what is culturally accepted, that is, to what extent a payment is a true gift or something different. Gratuity payments are made most frequently after a visit to a doctor, when the patient is released from the hospital, or when a course of treatment by a doctor is finished.

Informal payment, according to this study, is minimal or nonexistent when a patient is admitted on an emergency basis. We heard of only one case where someone was denied emergency treatment, reported by a respondent whose child had appendicitis and was not referred to a specialist by his primary care doctor until payment was given.

In this chapter, the various informal payments are investigated, largely through the experiences reported by the respondents.

3.2. CASH PAYMENTS

3.2.1. Types of payment

Cash payments constitute the bulk of informal payments, and they seem to be highest for hospital treatment. However, this does not mean that the transfer takes place in the hospital; it could be paid in a doctor’s ambulatory office before or after the treatment. The majority of the respondents have paid cash for a service, sometimes combined with other means (in-kind and gift). Payment is generally provided before treatment, especially for surgical operations. Less frequently, it is given in installments during and after treatment.
Cash payments, by frequency and amount, are highest for chief surgeons, cardiologists, gynecologists, laryngologists, neurologists and orthopedists. In the case of gynecologists, a common opinion of the respondents is that "the best paid are gynecologists, through illegal abortions". On the other hand, pediatricians and general practitioners cannot earn much through informal pay. Experience and professional reputation are also important variables in determining the amount of informal payments. The sum paid varies also depending on the specific procedure. For instance, it may be between 1,000 to 4,000 zl. or even more for a general surgical intervention, 20,000 zl. for a heart transplant, 150 zl. to get a nurse for a sick child, and 50 zl for a prescribed week of sick leave or for a visit to a specialist without referral. The most frequent types of payment are:

**To individuals**: This may be either an envelope payment, handed directly to doctors and nurses, or an “open” payment for the private consultations necessary for getting access to public facilities (see below). Money is sometimes passed silently to a nurse. One said, “If it happens that parents want better care for their child, then they may slip 10 zl. into my pocket”.

**To the institution**. Another type of cash payment is made to the health care facility (‘brick’ payment). This is the most popular form of additional payments by patients. All respondents who had stayed in a hospital, or whose families or friends had, reported the necessity of this expense.

3.2.2. Why people pay

As we have seen, people make informal payments for a variety of reasons, among them to gain access to better care, to eliminate waiting or simply out of appreciation. These and a number of other reasons for paying informally are discussed below.

**Informal payments are made:**

*To guarantee access to a desired service and facility.* Respondents often reported visiting private offices of ward heads and specialists to give them an ‘advance’ payment as a guarantee of being admitted to the hospital. Usually this is also a way to secure care from a specific doctor or to be operated on by a specific surgeon.

One woman said: "When I was pregnant I used to go to a private doctor’s office for appointments; this doctor also worked in the hospital and I knew that during birth he would be there. I heard from my girl friends that if you don’t let a doctor earn some money before the birth you can’t count on getting proper care”. We were told by some doctors who were interviewed that sometimes a chief surgeon who is paid by a patient who expects him to do the operation will, in fact, call a younger doctor to perform the procedure.

Other respondents reported: “My mother had to pay DM 200 just for my father’s admission to the hospital in Walbrzych”. ‘I couldn’t get admitted to the hospital 3 years ago for eye surgery. I started to go for private visits to the head of the ward where the operation was to take place--my family paid for this, so I don’t know how much it cost.

*To ensure quality care and future care*: This is the most common reason, along with skipping queues, for paying cash. In many cases, payment is perceived as a sort of “insurance” premium
by patients who foresee using health services or the doctor in the near future. They feel that by paying they can secure attentive treatment, safe surgery and continuing care.

**To get additional services.** Some medications that are not absolutely necessary are denied to those who do not pay. For instance, according to a patient, if a woman after giving birth needs strong painkillers, she has to pay; otherwise she is refused the medication. Some of those interviewed could not afford to buy all the drugs they needed; therefore they had to prioritize. Checkups are not covered under the health plan and patients must pay for them directly.

A patient reported: “In the [state] clinic I paid additionally for filling a tooth with better material. It turns out to be cheaper than private treatment because I pay for the material, not for the visit”\(^\text{10}\).

**To skip waiting lists and save time:** Patients frequently reported that they paid to speed up the results of tests or avoid lines for specialist examinations or for admission to hospitals. For example one patient reported: ‘A friend was in hospital, the operation was delayed, and the doctor kept asking ‘Isn’t your family coming to see you?’ When the family came and gave money to the doctor a vacancy was suddenly found in the timetable for the operation”. A physician reported that if a patient demands speedy service, for instance for a cataract operation or crushing a renal stone, and does not want to wait he or she usually pays.

**To get services in state offices and hospitals without referral or without registering with the regional sickness fund.** This is not a type of informal payment in a strict sense. The patient needs a referral from his/her primary care doctor in order to get to specialists and specific (of his/her choice) inpatient care. This is a new constraint imposed by the 1999 reforms. Most respondents were discontented with the new referral system and tried to bypass it whenever they could, paying directly for services to which they are entitled free of charge. Other patients who are still not registered with their regional sickness fund also pay directly for services. One patient reported: “When I couldn’t get an appointment with the gynecologist (I was not registered as a resident in Wroclaw) I would go in without registration, and after the visit I would pay 50 zl. as if it were a private visit”.

**To get sick leave certificates.** Some users pay their doctors in order to get sick leave or for purposes such as disability certificates, which entitle the patient to disability payments. Sickness benefits are higher than unemployment benefits, and according to some of the respondents, workers who are afraid to losing their jobs buy a sickness certificate (which can last up to 9 months) to get a higher benefit during their unemployment period. The cost of such certificates varies, but on average it is about 10 zl for a day of sick leave and up to 3,000 zl. for a disability certificate. The latter is a riskier ploy, and there must be complete trust established between the doctor and the worker before such a certificate is requested or issued.

A patient reported: “It is possible to buy a sick leave from a doctor, the rate is per day. I don’t know what the prices are at the moment. There is always the risk that you can come across a

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\(^\text{10}\) Treatment of the four front teeth is free of charge and paid by the health insurance. The insurance fund also pays for basic tooth-filling procedures. The material available under health insurance for filling teeth, however, is not of high quality, according to users. Therefore, those who can afford it use a private dentist even for procedures to which they are entitled publicly. Or as in this case, they upgrade the free treatment they get in a public clinic by paying for better care.
doctor who doesn’t do such things”. Other patients, however, said: “One day of leave costs 10 zl. It’s known which doctor writes out such certificates”. “Everything can be bought; in Walbrzych a disability pension costs 2,000-3,000 zl., but you also have to know someone and be sure of them”.

To get a military exemption. We found evidence of this phenomenon in Gdansk, where a respondent said, “I know that in Gdansk you give a doctor 2,000 zl. and say that you want to arrange for military service (to have heart disease)”. Another respondent reported: “When I got conscripted for military service, I arranged a second examination in Oliwa (the respondent had already undergone the first examination to define his military "health" category). The visit took place, the doctor had already been informed, he didn’t even listen to what I had to say, just started to take notes at once”. By paying 2,000 zl. the respondent avoided military service. He estimated that this kind of "matter" currently costs from 3,000 to as much as 7,000 zl.

For pharmaceutical co-payment exemptions. Some patients paid to receive the so-called “green prescriptions”, which were highly subsidized. One respondent who was hospitalized and had paid her doctor informally received, in addition to excellent treatment in the hospital, a green prescription for pills that would otherwise have cost 100 zl. Prior to the health reform patients suffering from chronic illness had the right to green prescriptions for which they would pay a nominal fee; for instance if the medicine cost $500 they would pay only about $2. The main problem with green prescriptions was that there were no strict criteria (no legal bases) for determining what diseases or medicines were included in this category of entitlement. It was the doctor’s decision whether a particular illness was chronic and whether the patient could afford to pay. Green prescriptions have been replaced by “white with blue stripe” prescriptions, for which patients also pay very little. However, the rules under which one is entitled to such prescription are now much clearer.\footnote{After the reform "green prescriptions" were no longer used. Now there are 3 general categories of prescriptions:

- "White" or standard. For this type of prescription there is a small price reduction, from 1 or 2% up to 50% depending on the drug. Everyone is eligible for this.

- "White with a blue stripe ". This is close to what used to be called a green prescription and those eligible pay only a few zloty, no matter how much the drug costs. The rules on who is eligible and what types of disease are included are much clearer and stricter than before the reform. There is a list of diseases and drugs that give patients the right to receive such prescriptions (comprising 52 pages). However, not all drugs used for a particular disease, even if the illness is listed, are mentioned on this roster. Sometimes one drug is used for different diseases, and to get this drug prescribed a patient must suffer from one of the diseases on the ministerial list for which the drug is mentioned as a remedy.

- "Pink prescriptions" This is the category for controlled substances like morphine.

Free drugs are prescribed for disabled people and their families if the disabled person is the only bread-winner. The biggest controversy is connected with the ministerial list of diseases, which does not include all the chronic diseases; for instance, it does not list multiple sclerosis (MS).}
One of the falsifications reported is writing prescriptions for drugs in the categories exempted from co-payment for people not entitled to receive them. Some users reported that they had used the name of a relative who was disabled or was eligible for the green prescriptions to get drugs for themselves by paying the doctor a fee.

In big cities a new pattern is emerging: prescribing medicine in a way that, in the opinion of some of our respondents, suggests a connection between the physician and a pharmaceutical distribution company. Some patients were given a costly prescription for drugs and when they complained, pharmacists told them that the same medicine was available under a different brand for a much lower cost. (In one case, the user ended up paying 15 zl. instead of 35 zl. for an antibiotic prescribed for her son). Getting a new prescription for a cheaper brand, though, was not always a viable choice for the respondents because it entailed going back to their doctors and possibly paying more under-the-table money or wait a long time. In some cases it was not a viable choice because they needed the drug right away. One respondent described a situation in which the physician, at the end of a visit in a state consulting room, suggested she buy vitamins from him because it was cheaper than from a pharmacy.

It is worth pointing out that not all respondents give money for receiving care. One patient reported that her husband received good care without paying. He had cancer and was under treatment for quite a while and never had to pay anything. Another user said that he paid only because he wanted to, even though his doctor would have treated him anyway. It should also be noted that some of those who did not pay are very well educated and are well connected to doctors or other health employees.

### 3.2.3. Circumstances of payment

**Payment can be voluntary or coercive.** In most cases, doctors did not openly force informal payments. However, it is difficult to say whether payment was voluntary or forced. The boundary between the two types is blurred. This is true for both payments to individuals and to the “hospital”. For the latter category, the “brick” payments, a patient reported: "Bricks are legalized theft. They sound voluntary, but if patients want to get into a hospital or have surgery they have to pay. When my husband had surgery at a clinic in Katowice several years ago, it was ‘It would be kindly appreciated if you bought a brick.’ I bought one for 10 zl. and put it on the table by the bed so that the doctor visiting patients could see it”. At times the respondents tried to pinpoint the difference between voluntary and demand contributions: "When they give before, that’s a bribe; after, its an expression of gratitude".

The respondents emphasized strongly that coercion often takes the form of forcing a patient to use private services. Usually this happened when a doctor had a private practice while also working in a state-owned hospital or clinic. Coercion also took place when it was said straight-out that private service would guarantee more effective treatment or would considerably speed up scheduling of a procedure.

**Estimating the amount of payment.** Out-of-pocket prices for single procedures are in the majority of cases known in advance. Patients get their information on how much they should pay through different means. The most frequent include talking to friends, talking to other patients on the ward where they are admitted, asking nurses, or, in a few cases, directly asking doctors.
A patient reported to have figured out with his brother the amount of an informal payment that was necessary: “Doctors don’t say outright how much a procedure costs, unless they are desperate old mushrooms (old physicians). We agreed with my brother that 300 zl. would be enough for a referral to a specialist. I hope that this will be the end of it, but I can’t tell if this isn’t just the beginning”.

Others were guided by their own judgment. The likelihood of a bad assessment is very small, because the physician usually does not refuse an envelope if it is handed to him: “I estimate small procedures to be two to three times the cost of an ordinary visit,” one patient said.

It was surprising to find out how precise the knowledge about “prices” for different services was. Payments are supposedly illegal and consequently there is no public source of information; yet the vast majority of respondents knew the real cost of several different procedures, and the amount reported by different people tended to coincide. In a very few cases patients reported that it was the doctor who directly asked for the payment and set the fee. One patient reported: “Often the doctor in charge of the treatment, who refers to a hospital, hints how much his surgeon colleague expects to get”. Another patient reported: “A friend gave an envelope before the operation and the doctor took out the money, counted it and audaciously asked “Is this an advance?”.

3.2.4. Sources of funds for payments

**Savings.** In a number of cases, users reported that they used their savings to guarantee themselves better care. A woman pensioner with a rather large, visible hearing aid said that she used part of her savings to get it. She said that the one for free was even bigger and not very good, but for the one she was wearing she paid 1,100 zl. extra out of her savings (the insurance only reimburses 600 zl. for hearing aids). Another woman reported: “Five years ago my father was supposed to have serious heart surgery, and expecting additional costs he set aside 1,000 zl.”.

**Help from family, community or church.** Some patients who needed a long treatment or surgery asked their relatives for help. In one case, a married couple who were burn victims--a schoolteacher and a small businessman--said that their church collected money for them. Otherwise they would have had to sell their apartment, since payment for their treatment was very high. One reason was so they could have access to quality care. For instance, they wanted their wounds to be dressed with Johnson & Johnson dressings, which cost considerably more than the available domestic brand.

**Sale of assets.** Some patients sell their belongings to finance their health services. In one case, the family sold their car to pay for the implanting of two lenses for the mother.

**Loans.** Taking out bank loans or borrowing from relatives is another way some users afford out-of-pocket medical expenses. A patient reported: “They told me to gather 1,000 zl. overnight for an oxygen respirator for my father. I borrowed the money and paid, but my father died; they didn’t give us back the respirator so we couldn’t even request a refund”.

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3.3 In-kind Payments.

3.3.1 Types of payment

In-kind payments can also be made to both institutions and individual providers.

To the institution. As we have seen, a common form of in-kind payment is goods provided by patients—such as bedding, food, medical supplies, and medicine—that are used directly in treatment. The reports of such payments in Poland confirm previous evidence from the former Soviet Union (FSU). For example, Novak’s (1996) study of health expenditures in south Kazakhstan found that 25-30 percent of those who were hospitalized had to provide their own bedding, clean laundry and food. Direct in-kind payments based on these items are common also in Russia and in the Caucasus region.

To individual providers. In addition to traditional items such as chocolates and flowers, patients noted a number of other items that are given as in-kind to doctors. In-kind payment can also be services in return for services. Some influential patients, as their appreciation for special care, would tap into their network to do something for the doctor. One of the users interviewed in Wroclaw said that although her children paid the doctor who operated on her, her two sons, who were hunters, gave the doctor a number of games and facilitated a hunting license for him “Barter”, though, according to those interviewed, was much more prevalent in the 1980s and during the command economy. At present, most doctors prefer cash.

3.3.2 Gifts

It was much easier for the respondents to give small gifts to doctors and nurses than to give money, or to recommend the doctor to friends and family or offer various services in exchange. Respondents were much more willing to talk about this kind of informal payment, mainly because they perceive it as something natural and socially acceptable. The majority of respondents mentioned giving gifts to their doctors and nurses. The most common were cognac, coffee, chocolates and other sweets and cosmetic items (mentioned the least frequently). Other gifts directly depend on the profession of the patient. For example, one woman reported: “I gave bedding. I was working in a fabric factory and at the time one of the products was crepe bed linen”. Before 1990 users would give their doctors items that were not readily available. This still sometimes occurs. For instance one of the patients worked in a butcher shop and would give meat to her doctor: “In gratitude my father got half a pig—I don’t know whether the front or the back (the humorous respondent is the son of a doctor)”. In a few cases, patients said that doctors refused anything but small gifts: “I wanted to give an envelope to the ward head who operated on my husband. I told my husband to find out on the spot how much we had to give, but my husband said that this doctor didn’t take such gifts and may even feel offended. So I decided to give flowers, cognac and an envelope, but he didn’t want to take anything apart from the flowers”.

Doctors in general believed it was appropriate and not wrong for them to accept gift items from their patients. But there are also doctors who accept only cash: “I wanted to thank the doctor somehow for care, I gave him cologne, not too expensive because I can’t afford it, nicely packaged. After a while the doctor came back to me from the corridor and said that if I want to give him something, he’d prefer money”. Some nurses were weary of the gifts they received. One
said: “Sometimes somebody brings flowers, most often I get chocolates--there are periods when I cannot even look at sweets. Once I got deodorant but had to throw it away, as it had a terrible smell. Sometimes if they want to be nice and a box of chocolates is too expensive, they bring home-baked cakes. Or, when they bring something to eat for their relatives, they bring a piece of ham or some eggs or fruit for us as well. In the beginning I was embarrassed by this, but now I think it is a very nice gesture”.

Similarly, there are patients who prefer to give money, as this is a more effective way of achieving the goal they have in mind.

### 3.4 Other means to ensure access to quality care

#### 3.4.1 Social connections

Most respondents from rural areas emphasize that acquaintances are particularly useful for getting access to medical services; this is true of connections both with people linked directly or indirectly with the health services (such as politicians or entrepreneurs who have an influence on the development of the health center). “For several years I was a member of the Health Committee in the Gmina Council. There were also several doctors in it and when one of them saw me in the hospital he protested ‘You can’t lie in here in a ward’, and they moved me up to a floor where only one other patient, a priest, was lying”.

Connections do not necessarily mean access to free health care; at times, they ease the access, but the user may still pay. One of the nurses interviewed said “My mother was suspected of having cancer and had to have further tests as soon as possible. The waiting time for such tests was 3 weeks...I went to the head of our hospital and he said not to worry. And so after 2 days my mum was seen, only she first had to go for preliminary examination to the private consulting room of the surgeon who was to operate on her (it was a year ago, and the visit cost some 50 zł.). After that I came to both these doctors with flowers and brandy”.

Urban residents less frequently mention the usefulness of friends, although even there we found respondents who took advantage of acquaintances to get to medical services. One of the most striking cases was reported by a patient who said that 2 years earlier her grandmother, who at the time was 63 years old, had a brain tumor. Doctors said they could not operate on her because they only do that type of operation up to age 60. The respondents’ father (son of the patient) used his influence and connections, so they “made” her 58 years old so that she could receive the operation.

Another patient received excellent treatment when admitted to a hospital in Wroclaw after being in an accident. The accident happened outside Wroclaw and first she was taken to a smaller facility in a little town. But since her father knew the head of one of the hospitals in Wroclaw, she was transferred there and was given the best care.
CHAPTER 4. CAUSES OF INFORMAL PAYMENTS

4.1 INTRODUCTION

No systematic study has been conducted so far into the causes of informal payments in the ECA region. Boikov et al. (1998) suggest in their study of out-of-pocket payments in Russia that severe budget reductions lead medical personnel to demand payments—both because of shortages of critical materials and because of government failure to pay wages. Mays (1998) argues that doctors and hospitals in Georgia collect payments informally in order to avoid paying taxes. Such explanations are plausible. However, they do not fully cover or explain the range of causes of informal payments, which must be understood in order to generate solutions to the problem.

This study indicates that there are two powerful sets of forces causing and perpetuating informal payments in Poland. The first group influences the supply-side’s propensity to request or accept informal payments, and the second group contributes to the demand side’s acceptance or even encouragement of the phenomenon.

Two factors, among others, are prominent on the supply side. The first is insufficient funding and the second is an inefficient use of scarce resources, resulting in a chronic mismatch between demand and supply.

On the demand side, there is a culturally ingrained notion that one has to pay for quality services, including but not limited to medical care.

4.2 SUPPLY SIDE FACTORS

There are a number of conditions that lead to acceptance or demand of informal payments by health care providers, discussed below.

4.2.1 Insufficient funding of the public health system

One of the main problems, lamented by doctors and employees at the Kasa Chorych (the regional sickness or insurance fund, hereafter named “Kasa”), is underfunding. This qualitative study indicates that there is a discrepancy between what the health care system is mandated to do—provide universal and comprehensive coverage—and what it can achieve, partly due to low funding.

The share of public resources going to the health sector has been increasing in real terms in the last few years, roughly in line with GDP growth. The 1997 level of public spending is 32 percent higher in real terms than the 1990 level. However, per capita public health expenditure in Poland is only $219, compared with $735 in the Czech Republic and $1,573 in Austria (WHO, 1998). The 1999 reform has been accompanied by a contraction of the health budget, while the range of
services that the sickness funds were supposed to cover has been expanded, and this has made it very difficult to implement the changes successfully.

The minimum standard of service that the insurance pays for is so meager that in most cases people need to pay to get decent care. For instance, according to some of those interviewed, patients staying in the hospital are sometimes given only one main meal, and to get a second one they either need to have food brought in from home or pay for it. New band aids or dressings are given to those who pay and those who do not are given used, washed ones. Poorer patients sometimes are kept in their beds in the hallway, whereas those who pay get nice clean beds in the rooms.

Currently, the health system is financed by a 7.5 percent mandatory payroll tax. There has been discussion of increasing this rate to solve some of the existing problems. However, it is not advisable to extend it at this point. At present, the payroll tax also finances social security and its level is on a par with that in other OECD countries. From a macroeconomic point of view, in transition countries where the overall policy is to fuel growth and increase employment, high payroll taxes maybe counterproductive.

4.2.1.1. Low collection rates and poor prioritizing of expenditures

Even though most of the respondent providers pointed at underfunding of the system as the main problem, when one digs deeper problems with collecting the payroll tax and determining the allocation of funds come into the picture.

According to Preker et al. (forthcoming), all countries in the study, including Poland, experience difficulties in collecting their payroll tax revenues. In August 1999 about 400 companies in Poland were investigated regarding payment of their payroll premium. Of this 400, roughly 120 companies were reporting falsely low salaries for their employees in order to pay lower premiums and about 200 did not pay at all (interview with Dr. Christian Richner, health consultant). The sample may be biased, as the basis for selecting the companies for the investigation may have been that they were already suspected of not paying; the collection of premiums countrywide may not be as dire as the case of these companies indicates. Underpayment of insurance premium, however, seems to be an issue and it needs further investigation.

The problems of prioritizing the uses of public money and of efficiency are discussed later in this chapter. Here we would like to mention a problem that may not be relevant in quantitative terms, but that seems particularly felt among users and that may have an important symbolic value. Several patients complained that the Kasas are diverting scarce resources from health care, over and above what is justifiable. To be sure, these are only perceptions, but since they were shared among several users, it is worth mentioning them here. In Gdansk, there were many complaints about the new building the Kasa bought, which according to users was outrageously expensive (approximately 6 million zl.), in an area where even some basic services were denied to patients, at least in a timely manner. Some complaints were voiced by users in Wroclaw, who accused the Kasa of overexpenditures for its site and salaries: the salary of the head of the Insurance Fund and of hospital administrators is 10 times more than that of a highly qualified surgeon.
4.2.2. Bottlenecks in the supply system: demand and supply mismatch

Another impetus for informal payments, also related to underfunding, is the gap between what is paid under the insurance fund and what is demanded. The contradiction between the excess capacity mentioned in the literature on health care in Poland and the existence of informal payments was one of the more puzzling issues at the outset of the research. The existence of a large delivery system obviously exacerbates fiscal stress, as it leads to dividing the pie of public resources into thinner and thinner slices. As Table 2 shows, in Poland population-weighted averages for hospital beds and physicians per 1,000 people were lower than the corresponding averages for Western European countries and also lower than for other countries in the region with comparable levels of income. However, they exceeded the corresponding averages for other middle-income countries. Moreover, in the period 1990-1997 hospital beds were reduced by only 5.8 percent, while the number of physicians grew by 9.8 percent (Preker et al., forthcoming).

Table 2:
Hospital Beds and Physicians per 1,000 people in Poland and selected other OECD and East European countries (1995)

<table>
<thead>
<tr>
<th></th>
<th>Beds per thousand</th>
<th>Physicians per thousand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>6.30</td>
<td>2.31</td>
</tr>
<tr>
<td>Other East European Countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Czech Republic</td>
<td>9.00</td>
<td>2.92</td>
</tr>
<tr>
<td>Hungary</td>
<td>9.04</td>
<td>3.65</td>
</tr>
<tr>
<td>Romania</td>
<td>7.60</td>
<td>1.75</td>
</tr>
<tr>
<td>Slovakia</td>
<td>8.55</td>
<td>2.82</td>
</tr>
<tr>
<td>Slovenia</td>
<td>5.70</td>
<td>3.10</td>
</tr>
<tr>
<td>Former Soviet Union</td>
<td></td>
<td></td>
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<tr>
<td>Estonia</td>
<td>8.04</td>
<td>3.11</td>
</tr>
<tr>
<td>Latvia</td>
<td>11.00</td>
<td>2.92</td>
</tr>
<tr>
<td>Lithuania</td>
<td>12.19</td>
<td>3.51</td>
</tr>
<tr>
<td>Ukraine</td>
<td>9.89</td>
<td>4.51</td>
</tr>
<tr>
<td>Russian Fed.</td>
<td>12.51</td>
<td>4.42</td>
</tr>
<tr>
<td>Other middle Inc. countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Turkey</td>
<td>2.20</td>
<td>1.03</td>
</tr>
<tr>
<td>Korea</td>
<td>4.39</td>
<td>1.22</td>
</tr>
<tr>
<td>West European Countries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>9.30</td>
<td>2.60</td>
</tr>
<tr>
<td>France</td>
<td>9.30</td>
<td>2.80</td>
</tr>
<tr>
<td>Germany</td>
<td>8.89</td>
<td>3.30</td>
</tr>
<tr>
<td>Italy</td>
<td>6.40</td>
<td>2.30</td>
</tr>
<tr>
<td>Netherlands</td>
<td>11.30</td>
<td>2.50</td>
</tr>
<tr>
<td>Portugal</td>
<td>4.10</td>
<td>2.90</td>
</tr>
<tr>
<td>Sweden</td>
<td>6.30</td>
<td>3.10</td>
</tr>
<tr>
<td>UK</td>
<td>4.69</td>
<td>1.50</td>
</tr>
<tr>
<td>Other established market economies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>United States</td>
<td>4.10</td>
<td>2.50</td>
</tr>
<tr>
<td>Japan</td>
<td>16.20</td>
<td>1.80</td>
</tr>
<tr>
<td>Australia</td>
<td>8.90</td>
<td>2.20</td>
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<tr>
<td>Canada</td>
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<td>2.20</td>
</tr>
</tbody>
</table>

The contribution of excess capacity to informal payments, though, is not clearcut. If it is true that excess capacity in a situation of collapsing public finances generates pressure for medical personnel to seek resources elsewhere, it is also true that this overcapacity should limit the extent of informal payments through supply and demand mechanisms. But this is not happening. The question the research investigated was the following: “Is it a general problem of demand dependent upon supply (a source of market failure in the health sector, as investigated at length for the United States in the health economics literature\(^\text{12}\)), or is it simply the existence of bottlenecks in specific niches of the supply side (e.g., scarcity of general physicians or of some special treatments to which doctors have privileged access) that explains the relevance of informal payments in a context characterized by excess capacity?”

The second tentative explanation, the existence of niches of scarcity, is by and large more important. In fact, the Polish health system is certainly characterized by overemployment in some hospitals and excess supply of a few specialties, such as pediatrics. For example, in the academy hospital in Wroclaw, according to a surgeon working there, 3/4 of the pediatric ward is empty. This is due to demographic changes. However, queues seem to be significant in many other specialties, in most surgical specialties for example. So the existing delivery system is indeed excessive and unsustainable (at least in terms of acceptable standards) at the available level of public funding. However, there does not seem to be a generalized oversupply relative to the existing demand, but instead rather severe areas of demand-supply mismatch. Informal payments are larger precisely where there is short supply of a medical specialty or material relative to the existing demand.

Moreover, public facilities are actually delivering public services for just a few hours every day (usually in the morning, when surgical operations are performed and when doctors are visiting patients in the wards). Afterwards, they are either underutilized or become “foundations” or pseudo-private practices where services are fully paid for. So the actual volume of services that the public health system in fact supplies is much more limited than the existing capacity would suggest.

Equipment, especially, is insufficiently supplied. Thus even if there is no shortage of human capital in health care delivery (with the exception of a few highly specialized skills), supply bottlenecks exist. For example, for hip replacement the state provides roughly 60 artificial hips per year to the whole Lower Slesian (Wroclaw) region (2.8 million inhabitants). Even if there are enough doctors willing to perform hip-replacement operations, the actual number of these operations that can be performed under full state funding is very inadequate. All the others (roughly, from 300-350 per year) are done on patients able and willing to pay directly, not only for the artificial parts but also to the physician who performs the operation. These private procedures are done in public facilities after the 7 hours of work that doctors are obliged to perform for the state, or even during normal working hours and on the same premises where the doctors are supposed to do public work fulltime.

Another example relates to certain tests. Breast cancer is one of the leading causes of death among Polish women, killing 430 women each month (Amberheart Breast Cancer Foundation for Poland). Mortality rates due to breast cancer are twice as high as the average in Western industrialized countries and equal to nearly 60 percent of all diagnosed cases. The equipment

\(^{12}\) According to this explanation, doctors have a sort of target income and basically replace any shortage in salaries through increased revenue from patients, by demand if necessary.
used for cancer diagnostics is outdated and does not comply with any international technical standards, creating dangerous conditions for both patients and technicians.

Supposedly, the insurance funds should have provided for new preventive measures, including free yearly mammograms. However, there is a patient limit determined by the undersupply of reliable diagnostic equipment, and this is usually reached within a few months, according to patients who needed the procedures. For example, in February 1999 in Wroclaw it was announced on the radio that the quota for mammograms was filled, only 2 months after the announcement that the service was available. Those urgently needing the test had to wait as long as 4 months; as a result people who can afford it pay to avoid the delay. One of the women in our study, a school teacher who felt a lump in her breast after self-examination and who heard that she had to wait 3 months for a mammogram, paid 750 zl. and later paid the doctor to avoid waiting for her operation.

4.2.3. Doctors’ low salaries and wrong incentives

The low salary of physicians has been highlighted as the single most important cause of informal payments by previous studies in the ECA region. As Mauro (1997) noted, “When civil service pay is too low, civil servants may be obliged to use their positions to collect bribes as a way to make ends meet.” The earlier studies also indicated that medical payments in rural areas are higher because, in the context of greater austerity, informal fees are likely to be an especially critical source of income.

The low salaries of doctors can be a result of spreading the meager resources over an excessive roster of providers. According to a number of physicians interviewed, increasing providers’ salaries will reduce informal payments to a large extent. A doctor in Wroclaw said, “I am convinced, that 90 percent of those who accept bribes would stop doing it. In the case of the remaining 10 percent it is simply pathological and increase of salaries would fix nothing. A good Kasa Chorych should come up with its own control system for this phenomenon”. A household survey on health care in Krakow (Chawla, 1999) indicates that only the capitated primary care physicians did not charge additionally, namely, those physicians whose earnings were highest due to the adequacy of the per capita payment and the patterns of demand. Thus high earnings may offer a possible but partial solution, at least in some settings (Lewis, 2000).

We believe, however, that a main cause of informal payments lies with the previous system. The state's monopsony power during the Communist regime brought about informal payments. The prices for medical services were kept artificially low, leading to an equilibrium with excessive demand. In this situation, a black market is likely to develop in which the service is delivered at a price between the regulated price and the willingness of consumers to pay at the margin.

As the number of doctors per inhabitant grows, it is expected that the equilibrium price will fall. What actually happens, however, is that consumer expectations become more differentiated, and this is matched by greater diversity of services on the supply side. The state does not allow this to be reflected in an increase of reward differentials among physicians or of price variations across services. As a result, informal payments arise more frequently where the differential between "market" values and regulated prices is broader. It can then be argued that the problem cannot be solved through an across-the-board wage increase for doctors, but rather by allowing individualized pay raises more in line with the market value of the services provided.
Finally, the criteria according to which doctors are paid influence the extent of informal payments. The incentives for getting such payments differ greatly among GP doctors, who are reimbursed on a per capita basis, outpatient specialists, who are reimbursed on a fee-for-service basis or on the German “point system”\(^{13}\) and hospital employees, who are paid a fixed salary.

To explore this more fully, a brief description follows of the reform and of incentives that it may create for informal payments.

### 4.2.4 Consequences of the 1999 reform

The reform was very new at the time of this study (in place for less than a year), but so far it did not seem to have had a significant impact on informal payments. One doctor, expressing a widely shared feeling, said: “Nothing has changed with the reform, there is still the same mess and the same apathy of doctors. The outlays for health services are too low, which leads to discouragement among the staff. If this doesn’t change, the way the health services work won’t change either.”

The study next explores some of the incentives created or fueled by the way the reform operates and remunerates the providers.

#### 4.2.4.1. Incentives for hospital employees

Informal payments are more prevalent in hospitals. This is certainly due in part to the availability of private practices for outpatient care. Doctors can refer patients not urgently in need of hospitalization to their private clinics or ambulatories for visits rather than asking for informal payments in a public facility. However, the criteria for paying hospital doctors also stimulate informal payments. As one surgeon put it: “It is not important how many operations I will perform, 300 or 30--I’ll always get the same”.

Hospital doctors can earn officially through: (a) their fixed salaries, determined by hospital administrators within a range arrived at by collective bargaining at the national level and paid out of the pool of money that the hospital receives, mainly from the regional sickness funds\(^{14}\); (b) duties up to 24 hours a week, which include night shifts, emergency room duty, and working extra time over their 7 hours of required duty in the public sector (c) their own private practices; and (d) working in more than one health facility. These official sources of pay generally contribute to about one-third of physicians’ incomes. The rest comes from informal payments received in public facilities or from fees in private practice. Within the official sources of revenue, six duties a month can earn physicians as much as their salaries, and those who undertake 10-15 duties can earn about two-thirds of their official income this way.

As a result of the changes in reimbursement criteria for hospitals, the Kasa in both regions selected for this study stated that the reported number of patients visiting health facilities has increased by 40 percent since the introduction of the reforms. Hospitals are now paid on a cost-per-case basis, according to a very rough case-mix adjustment (there is a different reimbursement price for the various departments, but each admission within the same department is priced equally). The new payment system has caused a sharp increase in number of admissions for a

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\(^{13}\) According to the point system, each procedure is assigned a specific number of points. Specialists are entitled to use a certain number of points within a set period and can perform until they reach that number.

\(^{14}\) The rest of the funding comes from user fees, professional insurance funds and, for specialized hospitals, from the Ministry of Health.
variety of reasons. Among the most important are the urgency for hospital administrators to keep or increase revenues by admitting more patients and the increased use of hospital emergency wards by patients to skip the cumbersome referral system.

Doctors within the hospital, consequently, feel increasing pressure from the administration and from ward chiefs to increase the number of treatments. They may lose their jobs if they do not see more patients or fulfill the quotas set by the head of the department. In theory hospital doctors should not directly benefit from an increased number of patients because their salaries are fixed. The way they benefit, though, is through collecting more informal payments—the more patients, the more opportunity. Further, the greater the number of services provided, the more funding hospitals are able to claim from the Insurance Fund and the better equipped and more modernized they can become. This in turn helps doctors, who in many cases treat their private patients in the public hospitals.

There are also evidence that money collected informally could be shared with the higher level physicians. In Gdansk in a famous surgical department, one of the doctors interviewed said that the chief of the department dismissed a colleague, a doctor sought by many patients due to his professional reputation, because he refused to seek informal payments.

In summary, despite the low level of salaries, physicians still compete for positions in public hospitals for three main reasons: first, public hospitals are a source of informal payments. Second, the hospitals provide free infrastructure and materials that physicians can use to treat their own patients. Third, employment in public hospitals is a necessary step in building a private clientele.

4.2.4.2. Incentives for GPs

One aspect of the reform process that was highly criticized by the respondents was the new referral system. After January 1999, patients have needed a referral from a primary care doctor for any specialist visit or elective inpatient care. Individual primary care doctors contracted by the sickness funds receive a capitation funding proportional to the number of people enrolled with them. The per capita amount is slightly higher for people over 65 or under 5 years. With these funds, the GPs are financially responsible for referrals of patients to most outpatient specialists. In the absence of risk-pooling mechanisms (which could be assured by pooling the funds given to several primary care doctors), the concern is that the new referral system is creating a strong incentive for primary care doctors to undertreat and dump potentially costly patients. Almost all respondents—patients or doctors—were aware of this possibility. One physician explained very clearly: ‘People pay a 7.5 percent tax on their income for the Health Insurance Fund, and the Fund pays lump sums per patient, 60–70 zł. a year, to primary care doctors. In this case it’s not important whether the given person costs 15,000 or 150 zł. a year; the primary care doctor has a sum that is appropriated for treatment of that person in one year. Therefore a first-contact doctor with 60 patients has the amount of 3,600 to 4,200, which he cannot overstep during one year. Here the problem arises, since a first-contact doctor has various patients. If the majority are senior citizens, then the amount he has at his disposal is

15 At the time of the fieldwork, the primary health care doctors were responsible for paying some of the specialists, with the exception of gynaecologists, psychiatrists, or oncologists, who worked in the outpatient clinics for any referral they made. In other words, the money going to certain outpatient specialists came from the pool of money given to the primary healthcare providers. (We were told that soon all outpatient specialists would be paid out of the money going to primary health doctors.) Outpatient specialists are paid either according to the German point system or on a fee-for-service basis.
definitely too small in comparison with a doctor who has under his care mainly young people (who rarely visit doctors). It is therefore no wonder that such a doctor does not want to write out referrals for specialist treatment, since he simply cannot afford them”.

Another primary care doctor said: "Introducing the reform was not a very good idea, and first-contact doctors are paying for it. Every day patients come to me with smaller or bigger ailments. My job is to treat them or refer them to a specialist. With a certain pool of money at my disposal—60 zl. a year per patient—I am unable to properly treat a given person. Many of my patients are very sick and require specialist examinations. In general, it’s like this—not every person needing a referral to a specialist is given one. Those who can wait don’t get one for as long as 6 months. Some patients don’t wait and go to a private doctor. There they are examined without any problem, but they have to pay for it”.

People also complain about the lack of accessibility of their primary care doctors. According to many users, the referral system is creating new scope for informal payments to avoid the lines and see specialists. “I feel that a doctor doesn’t want to give me a referral to a specialist, giving the reason that it’s still too early but simply waiting for a bribe, because it’s obvious that in my case the earlier the better”.

There is a loophole in the reformed health care service through which patients can avoid the referral system: hospital admission on an emergency basis. In turn, hospitals that are now paid according to the number of procedures have an incentive to admit as many patients as possible. Consequently, the use of capitation funding for GPs, together with activity-based payment systems for inpatient care, seems to be causing a rapid increase in hospitalization (a 40-45 percent growth in volume over the previous year). Patients seek emergency care to bypass the cumbersome referral system and hospitals have an incentive to admit patients to increase their revenues. Primary care reform is intended to achieve exactly the opposite result.

4.2.4.3. Creating more bureaucracy

In addition to the incentives for continuing informal payments, the 1999 reform was criticized by both providers and users for having increased paperwork and bureaucracy.

The sickness funds require numerous forms to be filled out by both doctors and patients. The primary doctors complained that their work has increased because they have to complete piles of papers. According to one doctor working for the Gdansk sickness fund: “Frequently during a week it is necessary to change entire patient lists, and this requires an enormous amount of information. It is hard work to dig through all this, especially when every doctor has written out patients’ data in his own handwriting. Many times a doctor has gone back to a patient’s home to get more data because something that was not required in the beginning later turned out to be necessary”.

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16 Hospitals are paid by the sickness fund according to a cost-per-case payment system, with a unique price per procedure for all the interventions done within any department. For example, we visited a surgical department in an oncology hospital. They receive 1,682 zl. per operation, regardless of the type of intervention performed.
Such additional, cumbersome recording may be justified if it ultimately leads to better management and higher-quality services. This, according to our respondents, is not happening. Users also complained about excessive paperwork that cuts into the time that doctors can spend with patients. The paperwork also gives more excuses to doctors, according to a number of users, to stop seeing patients in a given day, claiming that they have filled their quota. A number of people employed in the sickness funds also complained about the burden imposed by the new recording method.

4.2.5. Lack of accountability and transparency

Lack of information and transparency is another reason for the existence of informal payments. Physicians refer to their “limits” in order to ask for payments from patients. They claim that they have seen the number of patients they were supposed to see in a given day, so that any extra service either has to be privately paid or patients have to wait. Some users said that there is no way to verify this. It is normal, for instance, to go a dentist with pain and be told that the dentist is over the day’s limit of patients and that the only choice is to see another dentist privately. Some doctors see their private patients and all those who pay during the hours in theory reserved for their public duties. Sometimes physicians tell patients they will have to wait even when waiting lists do not really exist.

One of the reasons for the lack of transparency is confusion in the health service about implementation of the reforms, creating a situation where nobody knows exactly who should take/make additional legal payments and for what. However, from the interviews with administrators and providers, it appears that nobody on the supply side is really interested in addressing the confusion, as it is precisely in the face of such uncertainty that those who want to take advantage of the system can thrive. Almost all the patients we interviewed said they would be willing to pay even more for health care in exchange for greater transparency. Users were strongly in favor of making out-of-pocket payments legal and somewhat publicly regulated.

Some GPs who have a contract with the Kasa have started to organize meetings with patients’ representatives to “make the Kasa closer to patients”. However, from what we heard in the study sites, we inferred that at this stage the Kasas cannot afford to make patients fully aware of their formal rights, since in reality there is a wide gap between the existing amount of public resources and the range of services that the Polish health service should supposedly provide free. This gap is likely to become wider as physicians’ salary expectations increase and as the need for more sophisticated equipment grows.

On the supply side, the fact that there is little professional sanction against informal payments and that physicians and nurses do not need to hide the practice from their colleagues helps to perpetuate it.

4.2.6. Role of the Kasas in rationalizing the system

Recently, the staff of the Kasas have been discussing ways to tighten contract enforcement. Some of the sickness fund employees interviewed said that the main task for the Kasas was to lead the rationalization of the delivery system. In a context characterized by excess supply, the sickness fund should allow “good providers” to be screened from “bad” ones. For example,

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17 As mentioned in footnote 10, the health insurance pays only for the front teeth and basic tooth filling. All other dental services are rendered privately.
through an activity-based reimbursement system, those providers that are able to attract more patients should receive more resources than those who do not.

For the time being the power of the Kasas to rationalize the system seems quite weak. The person we talked to in Gdansk Kasa was aware of only two cases (both dentists) whose contracts were terminated for violation of contract clauses with the sickness fund. Moreover, in Wroclaw one of the physicians said that so far no health facility has been closed for not having reached an agreement with the local sickness fund.

A reform being planned by the Gdansk’s Kasa Chorych is to divide specialists into two categories, first and second level. First-level specialists will be paid by GPs out of a fixed capitation budget, as some of them already are. Patients will be entitled to services from second-level specialists only if they are referred by first-level specialists. A second gatekeeper role will be thus added to that presently exercised by GPs in order to screen demand: first the GP, then the first-level specialist.

4.3 Demand Side Factors

After talking to users as well as providers, we can report that they unanimously agree that paying doctors is traditionally ingrained in Poland and that this goes back to the years of the command economy. Such payments were utilized regularly in the Communist period to gain access to rationed goods and to avoid lines. In general, there is a perception that unless one pays one does not get good results, and this goes beyond medical care to most services.

As we have seen, patients pay partly to buy future care. Many who pay will need repeated visits after their surgeries are performed. But even in cases where there is no need for continuing care, when a surgery is scheduled many who can afford it pay for the procedure in advance in the hope of “receiving good care”. Others pay because they consider it a token of gratitude for a surgeon who performed a difficult surgery. Still others give presents to the hospital staff because they were happy with their inpatient treatment.

Both users and providers pointed to the complacency of patients as a strong factor in the existence of informal payments: "The patients themselves got doctors accustomed to the idea that if someone doesn’t pay he is treated worse, that bribes are something quite normal, inseparably linked to the doctor’s work". "The patients force gifts on doctors--cognac or flowers, or they stick an envelope in the doctor’s pocket".

To some extent, users’ willingness to pay is associated with positive factors, as when payments express gratitude or are a signal of a close, personalized relationship between doctor and patient.

The acceptance of the phenomenon of informal pay shows how distant the Polish context still is from a culture based on the sense of individual rights and citizenship. The majority of those who were interviewed and had paid simply did not even contemplate the possibility that they could receive the same services otherwise. People generally do not perceive that through taxes and contributions they acquire the right to certain public services. In other words, public health services are not considered as a legitimate claim that is gained by paying taxes or by simply

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18 First-level specialists are categorized as those working mostly in outpatients clinics. Second-level specialists are surgeons and other high-level specialists working in the hospitals.
being members of a community. The services are rather perceived as a “favor”, dispensed because of personal connections or as a result of payment.

Overall, people’s attitudes towards informal payments can be grouped into three categories:

A. *Ambivalence*. Paying for health services is here understood to be a necessity. “You shouldn’t condemn doctors, it would be different if they had higher salaries. I am neither in favor nor against”. So most respondents, asked about their feelings when they give a bribe, say that it was initially uncomfortable for them and for the doctor, but that subsequently it got easier. One patient reported: “For the one who pays it’s a bit awkward, but you can get used to it; even if at the beginning the doctor resists, later on he’ll take it anyway”.

B. *Condemnation*. “I condemn not only taking but also giving of bribes, although I can’t say that if forced to it I wouldn’t also decide to give into my concern for someone close to me. Doctors should be forbidden to receive payments informally, they should have salaries large enough that they wouldn’t have to and could treat everybody equally. Another patient said: “Some doctors are the white Mafia. It’s criminal”.

C. *Open Acceptance*. A patient reported: “I feel that good doctors have to be rewarded somehow when they do the job well (in this case surgery); they studied hard so you shouldn’t skimp for them.”
CHAPTER 5. CONSEQUENCES OF INFORMAL PAYMENTS

5.1. INTRODUCTION

As pointed out in the introduction, informal payments are likely to lead to distortions in the health sector in terms of efficiency and equity.

Among the most important efficiency consequences are misallocation of resources, loss of tax revenue, bad incentives for health personnel that may lead to corruption, and opposition to reform. However our study, based mainly on qualitative interviews with patients, yielded evidence primarily about the equity consequences of informal payments.

Though discussion begins with the effects on efficiency, equity concerns will be predominant in this final chapter.

5.2. EFFICIENCY ISSUES

A phenomenon that could have important consequences for efficiency and that the study was able to highlight is the rapid growth of the private sector and its present strange symbiosis with the public sector. The private sector is not developing as an independent and competitive alternative to the public sector. Rather, the two are mutually sustaining, with the private sector profiting from the underfunding, lack of control and poor quality that characterize public services. For instance, private doctors make patient contacts in public facilities and use state equipment and beds in state hospitals. "If it shows that you have money, they suggest that it would be better to continue treatment in their private offices"; "The doctors not only send patients from the state services to their private offices, they also take bribes in the course of state visits for attentive care shown to the patient". But the relationship cuts both ways. State doctors send patients to private offices because of: shortages of medical supplies and specialists and long waiting times, using the private sector as a fallback.

The growth of the private sector is not a consequence of informal payments. Indeed, in the long run it could contribute to solving or at least reducing the problem of informal payments in the public sector, as fees are collected privately. However, it is another manifestation, like informal payments, of a pathological phenomenon: the use of public facilities as a tool for promoting private interest. This is pathological because it impedes healthy development of both the private and public sectors. Therefore, it is ultimately also against patients’ interests.

The chronic underfunding, coupled with the excess capacity of the health system (compared to the public resources available to support it), is the leading cause of the phenomenon. In the conclusion of this chapter, we will discuss possible remedies to the present situation, which, judging from our interviews, does not seem to be addressed by the 1999 reforms. It is vital to find remedies before those interests that are benefiting from the present pathological situation have time to consolidate and become too powerful.
5.3. EQUITY ISSUES

The relationship between informal payments and access to health services is complex. It may not make much difference to the poor whether high medical fees are official or unofficial. Such fees are obstacles to access in either case.

Problems of access seem to be particularly severe for pensioners. Certainly the frequency and character of contacts with health services, both in rural areas and large cities, are most affected by whether the person is post-productive (due to old age or a disability) or of productive age, i.e., working or attending a school or university. The former group has more-or-less regular contacts with the health service and the latter group more incidental ones. For this reason, it is no wonder that older people much more often speak of limitations in access to medical services, especially to the more specialized ones. They also lament being constrained by their low pensions from certain forms of medical help (such as effective but expensive drugs). Their limited budgets also restrict their access to private health services, which are more often used by younger people who are working. One senior citizen, expressing quite vehemently the concerns that many others shared, said: ‘Old people don’t have money, they don’t even buy medications, apart from the most essential. That’s why they rarely go to doctors. [Now, in addition, invalid groups are taken away continuously.]’. Some pensioner respondents saved for years to accumulate enough savings to be able to afford hearing devices, hip-replacement operations or other treatments.

Disabled people also feel discriminated against. One respondent with an amputated hand, who needed a special wheelchair she could drive with one hand, reported: ‘A disabled person used to be able to get a cheaper car. And now? I only want money for a wheelchair. I’ll get about 1,000 zl. from the Fund, and even a standard wheelchair costs 4,000-5,000 zl.

Many interviewees pointed out that people delay getting health care because of informal payments. They tend to utilize health facilities only when they are in acute need. Even then they are sometimes afraid to call an ambulance because “they’re afraid they will have to pay, and they don’t know what you have to pay for and what you don’t”. One of the respondents said “When my son had a broken leg his friends brought him home, afraid to call an ambulance. The boys (17 year olds) thought that they would have to pay”. Another respondent complained: ‘My father’s friend had a stroke, so an ambulance had to be called. The patient’s family wondered for a moment whether you can call an ambulance just like that and whether they would have to pay for it. But generally, with broken bones or such serious matters people know that doctors should be called”. Thus, urgent cases are generally dealt with even without payment, but there are exceptions.

At other times, payment is really forced upon the patient because the quality of free public facilities is so low that paying becomes a matter of life and death. A man reported his mother’s experience: “A year and a half ago, she was going to have thyroid surgery. Her condition was serious. Then the doctor who led her treatment proposed two solutions: either he would do this in the standard way (i.e., to do it easy way with the risk to make my mother an invalid for the rest of her life or would do it in such a way that there would be no complications, for only 6,000 zl.”. One of the most extreme cases was that of an elderly user. Her sister had cancer and went to a GP and received a referral, but she had to wait 3 months for the treatment and died in the meanwhile.
5.3.1 Social status and perceptions of health services

Social or economic status of users does not seem to be a factor in paying informally. Those doctors who ask for money in general ask most of their patients, regardless of their ability to pay, and the rest do not ask even from rich patients.

Other studies have found evidence of a graduated asking price among doctors. In some cases, as Ensor and Savelyeva (1998: 47) note, “Providers may price-discriminate so that the rich are charged more than the poor.” In support of this assertion, Novack (1996) showed that the richest quartile of the sample pays significantly more for medicine than average in South Kazakhstan. Similarly, Balabanova’s (1998) survey in Bulgaria indicated that the rich pay more for health care than do the poor. The problem with these results, however, is that it is not clear whether the rich were simply paying more for more service or for equivalent service. The results of the present study do not clearly show a pro-poor attitude on the part of doctors, with the exception of a few isolated cases.

The solutions to the problem of informal payments that poor and rich offer is also similar, ranging from “pay more and expect more” to “punish harder”. The only difference is in the extent of the connections that rich and poor users have within the health system, which influences the probability of having to pay for public services and whether the private sector is perceived as an alternative.

Practically all our respondents, from small towns as well as big cities, had a much better opinion of the quality of services obtained in private practices. Not everyone, though, agreed on the need for more far-reaching privatization of state health institutions. Such solutions are more accepted among younger people of higher social strata, while older people in lower social positions (physical laborers, unemployed persons, farmers) approach such ideas with greater caution, because their incomes are not high enough to cover the costs of paid public health services. In fact, we should add that very few people, even those with the highest financial standing, wanted a totally privatized system. They would be willing to pay, but only to an extent. The great majority of respondents did not radically depart from the principle that public health services ought to be financed in compliance with the principles of social solidarity, which they considered a foundation of the social security of citizens.

5.4. REGIONAL DIFFERENCES IN ACCESS

Being from rural versus urban areas had an impact on access to quality health care, even among those who could afford to pay. Those living in rural areas in Czlucho and Bielawa have fewer qualified specialists and well-equipped facilities at their disposal. As a result, for people in rural areas access to higher-quality care requires not only paying for such services but also traveling.

Rural residents also have a better opinion of the health services in big cities, even when similar services are available closer to home. They are also particularly easily exploited by doctors in the city.

We do not, however, have sufficient grounds to say that there is a specific character of informal payments in the health services related to urban or rural environments. In both environments there are many similarities in the situations in which payments are demanded and in the forms of expressing "gratitude".
5.5. RECOMMENDATIONS

Compared to other parts of the interviews about the nature and mechanisms of informal payments, the responses regarding possible remedies were less assured and detailed. The different suggestions by administrators, doctors and users for dealing with the problem of informal payments can be summarized by the slogan, “Pay more and punish harder”. Being that the interviews were almost exclusively directed at patients, and given the relative unawareness of service users of the causes of the phenomenon, this was an expected outcome. However, an analysis of the main findings of the study leads to some recommendations more specific than increasing doctors’ and nurses’ salaries and implementing more rigid control mechanisms.

Since the issue of informal payments is a complex and multidimensional one, it is very important to note that any approach to regulating or reducing it needs to be holistic. If informal payments are more a symptom than a cause of the existing imbalances characterizing the Polish health system, a real solution to the problem ought to address those deeper causes. Finally, any solution needs to include reforming and strengthening the institutions in related sectors. For instance, for any solution to be effective, there must be a judiciary system that can regulate, enforce and prosecute; a tax system that is effective in collecting taxes, and consumer groups willing to stand up and be part of the solution. Against that background, the findings lead to the following recommendations:

*Rationalize the delivery system*

The prime problems to be addressed are inefficiency and misallocation of resources. In Fall 1999 when the fieldwork for this study was being completed, the government considered raising the payroll tax rate from 7.5 percent to about 11 percent. Although we believe that the problem of underfunding strongly contributes to informal payments, we would not recommend as a first step that the payroll tax be further increased. Without real change, any additional money poured into the Polish health system may just increase some providers’ rent, without really improving the quality and availability of services. To increase efficiency, the Polish health service needs further rationalization of the delivery system and a new management culture, patient-oriented and based on performance. Informal payments are particularly widespread for those services that are in short supply, such as specialized surgical procedures or diagnostic tests. The rigidity of the system does not allow relocating resources away from the services in excess supply to those in short supply. Thus, the first step is to increase the flexibility of the system and to make it more responsive to demand. As a start, staff management ought to be much more decentralized, handled at the individual facility level.

*Strengthen funding*

At present, the Polish health system appears severely underfunded, and this contributes to the practice of informal payments. This is partly due to the excess capacity now in place, especially in terms of human resources, and the problem can therefore be partially solved simply by reducing capacity where it exceeds demand. However, per capita public health expenditure in Poland is only $219 per year, compared with $735 in the Czech Republic and $1,573 in Austria (WHO, 1998), for a public health care system that still promises comprehensive coverage to the whole population. The 1999 reforms further expanded the range of services that the state is supposed to provide for free (primary care services were added to the list), whilst the public funds for health were contracted in real terms. Thus, there is a need to make the level of funding
more coherent with the responsibilities in terms of delivery of health services that the state assumes. Until 1999, the amount of public resources going to the health sector has been roughly increasing in line with GDP growth\(^\text{19}\) and this seems the maximum affordable for Poland.

Two issues related to funding are important. The first concerns the most efficient way to finance public expenditures and the second concerns the best mechanisms for garnering supplementary private funds into the health system.

Regarding the first issue, at present almost the entire burden for health care funding falls on the payroll tax. The payroll tax works best in economies with high formal employment rates and relative economic stability. The present economic situation of Poland seems pointed in exactly the opposite direction. The Polish economy is characterized by thriving small-to-medium enterprises whose major competitive advantage, from an international perspective, is still cheap labor. Higher payroll tax rates may therefore simply encourage new enterprises to go underground. The growth-thwarting impact of health and social security contributions are likely to become even larger as the process of economic integration within the EU advances. To remedy this, alternative means of financing can be strengthened. First, there is the possibility of expanding general budget transfers for the nonproductive segments of the population. If health is really a priority for the Polish government, as it claims, budget allocations should reflect the preeminence of health care. Second, for many services there is scope for further private funding, in the form of user fees (see below). These means of funding already exist, though they are unregulated.

As for the second issue, getting private funds for the health system, the only way to promote risk-pooling mechanisms other than that presently provided by the state is to develop voluntary health insurance. The addition of private insurance, however, raises complex conceptual as well as implementation issues—ones that are still unsolved, and not only in Poland, and that go beyond the scope of this work. For example: Should private health insurance be supplementary or substitutive of public insurance? To what extent should tax benefits be introduced to promote the purchase of private health insurance? These are strategic political issues. Implementation issues are equally important; it is particularly difficult to define and enforce the regulatory framework needed for private health insurance to succeed. The greater the role assigned to private insurance in health funding, the more important it is that such a framework be in place. *Legalize co-payments, while ensuring the access of those who cannot afford to pay*

A system of co-payments or additional payments for medical services, if accompanied by greater transparency and higher quality of services, was accepted by most respondents and can be included as a recommendation. However, the state should ensure basic medical care by clearly defining the range of services offered free and those services and users who are exempted from co-payments. Unfortunately, there are no off-the-shelf, internationally accepted standards for defining such exemptions. Cost-effectiveness, availability and protection of disadvantaged groups (such as old and chronically ill individuals and children) are all criteria that should be considered in designing the basic package of free services and exemptions. A first step would be to articulate a new regulatory framework, more in line with existing conditions of delivery and fiscal constraints. Such a regulations should entail, among other things:

\(^{19}\) The 1997 level of public spending is 32% higher in real terms than the 1990 level.
• Legalizing and auditing of out-of-pocket contributions;
• Encouraging medical-expense reporting by patients by making this necessary for some forms of favorable tax treatment (e.g., an income tax deduction for expenses for catastrophic illness); and
• Giving tax benefits and deductions to hospitals for revenues reinvested in capital maintenance and improvements.

**Improve transparency regarding the benefits provided by the public health system and increase patients’ information about their rights**

The government needs to make rationing decisions in a more transparent way, clearly informing patients of the criteria for choosing among competing claims. The most demoralizing strategy is to raise public expectations and then frustrate them as the services promised are not delivered or are severely rationed. Information can be given to patients through booklets distributed to all those registered under the health insurance funds. At the time of the study, the regional sickness funds were handing out such booklets to users; however, the number of booklets was far lower than the number of those insured. To help promote transparency and information, the organization of consumer groups should be encouraged.

**Pressure doctors to observe a mutually binding code of ethics**

This thrust could begin with a public awareness campaign to inform patients—probably through the booklets--of their rights and of what they can legitimately expect to receive free. It will probably take a long time for a new culture, based on respect for patients’ rights, to become widespread among doctors and other medical employees. To promote such attitudes among doctors, it is important that ethics become a vital part of medical training. It is also important that initiatives for sharing activities and concerns be fostered among all personnel working on hospital wards.

**Establish an effective channel for user complaints**

There is a need to strengthen channels for patients’ grievances with regard to a given provider. This also implies the possibility of lawsuits. Right now, even though there is a section for complaints in the health insurance funds, hardly any cases are taken up or followed. Users do not have faith in this mechanism and seldom try to use it.

**Improve the transparency of the way the public health system and its levels are administered**

Users and local providers need a clearer definition of responsibilities at the different levels of the system, from the central government down to local governments, health insurance funds, and health care facilities. Getting this information together would require better data collection on current operations, and once assembled, it could be disseminated through means such as the user booklets mentioned above.
I. 1. REMARKS ON METHODOLOGY AND ORGANIZATIONAL PROBLEMS

1. The study encountered some organizational difficulties. The main one was selecting an appropriate research sample of patients, which consists of inhabitants from two cities (Gdansk and Wroclaw) and two rural municipalities belonging to the cities of related voivodships (Pomeranian and Lower Silesian). The local team did not receive, either from the employer or the relevant Health Funds (kasa chorych) in Gdansk and Wroclaw, any data that would be useful for constructing the two research samples. The organization of the samples (selecting respondents for interviews) was the task of the research team, which was comprised of three sociologists from Nicolas Copernicus University and four sociology students from a training course on qualitative methodology. This lack of data complicated the organizational side of the research, necessitating both more time for selecting respondents and multiple adjustments to the structure of the research sample. However, it had a positive impact on the methodological standards of the study and, as a result, on the quality of the empirical material obtained.

2. The selection of the research sample—for both in-depth and focus interviews—was in no way influenced by institutions of the health service system (such as health funds, hospitals, first aid rooms, and health service personnel). Likewise, patients did not influence selection of health service representatives. Thus, in accordance with a basic principle of sociological research, influence of the institutions and persons whose work was the subject of the study has been limited regarding the choice of respondents.

3. Independent selection of the research sample also increased the anonymity of the research. The respondents had no reason to connect interviewers with the administration of the health funds, or with employees of other institutions checking on irregularities in health service activities. In asking those selected to answer questions or to participate in the focus interviews, the team could present itself as absolutely independent of local structures of medical administration. The team was able to introduce itself as employees of a scientific institution, Nicholas Copernicus University, who worked in another city and who were performing an independent study of health services in the context of the recent reform. This way the team made sure that the information obtained and the respondent’s data would not fall into the hands of local physicians, nurses or health service administrators, either through formal channels (records of interviews and reports) or informally (through private conversations). This increased the level of mutual confidence, which is important in handling sensitive issues.

4. The team kept the need for anonymity in mind when arranging interviews with patients (in-depth and focus) outside of health service establishments; these were held in private flats and in settings provided by various institutions (the University of Gdansk, the Non-public Primary School in Wroclaw, the head office of the Forestry Administration in Wroclaw, and municipality offices in Bielawa and Czluchów). These sites were chosen to enhance the privacy
aspect of the research and make respondents more confident in sharing their experiences. In general, interviews carried out in a neutral place yield more candid and accurate information.

5. The way the research sample was organized should be described as less than optimal. As mentioned, the local team did not use any official list of patients of a particular health facility or of those employed there (e.g., physicians or nurses). Instead, it selected the respondents, both users and providers, through private informal channels, in regions of the study where team members were acquainted with sociologists and educators, through personal contacts (relatives, acquaintances, acquaintances of acquaintances) and through graduates of the Sociology Department of Torun University working in both rural regions. However, the criteria for selection (such as age, gender, employment status, and a recent hospital treatment) were always taken into account.

6. Selection of respondents through a third person made the conversations easier, increased the level of mutual confidence, and enabled the team to obtain answers to even the most sensitive questions. However, the method of selection made it difficult to compose a quasi-representative sample, that is one with a proportion of individuals from the basic social-professional categories typical for a big city or a rural region. Although in a qualitative study such representation is less essential than reliable, multidimensional information, nevertheless the information should be obtained from a socially diversified group of respondents. Lack of such diversification necessitates multiple "weighting" of a sample, namely of a special selection of respondents in successive stages of the research process, in order to eliminate the most glaring incommensurability of distribution of traits such as--in the case of this study--sex, age, education, and profession. However, this would significantly prolong the collection of empirical material. Since both rural and urban areas were selected for this study, and within them groups of people based on age, income, employment status, education and so on, even though the sample cannot be generalized to the entire population the team feels that the cases studied here are a reasonable microcosm of the national distribution.

7. For the sites, Gdansk and Wroclaw were selected. Wroclaw, in the lower Silesia region, was chosen because it is urban and close to other urban centers. It has a small catchment area, low unemployment, and many open and closed mines. Gdansk and the other two cities close to it, Gdyma and Sopot, are on the seaside, have high unemployment and are poorer, have very large catchment areas and are far from other big cities. The agricultural patterns of the sites are also very different. In Gdansk the closing of large farms that operated under Communism has caused high unemployment. In Wroclaw small subsistence farms still exist. Close to Wroclaw is Katowice, with the largest number of health facilities in Poland, whereas no facilities are close to Gdansk.

8. The first criterion for selecting the rural areas was economic situation. Those selected have a high unemployment rate, significantly greater than the average rates for both
voivodships and for Gdansk and Wroclaw, and thus significant areas of poverty. In Bielawa\textsuperscript{20} (Wroclaw region) this situation has been caused first of all by bankruptcies of the local textile industry, which under socialism provided jobs for 60 percent of the population of the municipality. In Czluchów\textsuperscript{21} (Gdansk region) economic difficulties caused by the political transformation make the problems of workers of the former state farms much more acute. These people have for many years lived on social benefits financed from, among other sources, the municipality’s own means. The team assumes that the very difficult economic position of the two rural municipalities would have an influence on both access to the health care system.

9. In selecting both small cities, the team was also guided by an organizational criterion: Graduates students of Torun University work in the self-government offices of both municipalities, which greatly facilitated the research in difficult rural areas.

10. In sum, it can be said that some difficulties the team encountered, resulting from lack of organizational support from regional health funds, turned out to increase the quality of the information obtained. In the case of patients, the team considers the information to be highly objective. The information obtained from medical personnel is much more vague, which is not particularly surprising. It would be naive to assume that persons who are incumbents of the informal and illegitimate payment system in health service would give extensive and accurate information on such a sensitive subject. However, in both the pilot phase and during the study, a number of physicians agreed to talk to us, since they were introduced to us by people known both to us and to them, and gave us insightful information on how informal payments work. Moreover, the World Bank team was able to talk to a number of physicians working for the Health Insurance Fund in both cities who gave highly useful information on the subject.

\textbf{I.2. Structure of the Research Samples}

11. In the qualitative phase of the research two techniques were used: in-depth interviews and focus interviews. As mentioned earlier, the subjects of the research were patients as well as health service personnel, but the latter were examined by means of in-depth interviews exclusively. The two patient groups--those interviewed individually and those who participated in the group discussion--were examined independently of each other.

12. In all, conversations were held with 175 people living in two big cities: Gdansk (43 subjects), Wroclaw (43 subjects); and in two small towns, where the local administration of the

\textsuperscript{20}Bielawa is a medium-size town situated within Dzierzoniów administrative unit, in the Lower Pomeranian Voivodship, with a population of 33,793. The unemployment rate considerably exceeds the national average. The city provides medical care for inhabitants on level of reference I, thanks to the work of the Health Care Administration (providing a regional hospital and 2 outpatient clinics) and Ambulance Service. Within the community there is also the State Administration for Children Preventoria (Panstwowy Zespól Prewentoriów Dzieciecyh), which provides medical services for the population of the entire country.

\textsuperscript{21}Czluchów is a small town (16,000 inhabitants) situated in Chojnice administrative unit in the Pomeranian Voivodship. It is characterized by one of the highest unemployment rates in the country (1,404 persons—29.2 %). The city has one community health center. Furthermore, in the community of Czluchów there are two rural health centers (Wiejski Osrodek Zdrowia). The city provides medical service in an in-patient medical service institution on the level of reference I (basic medical service), in a district hospital.. Fifteen km from Czluchów, the City Hospital in Chojnice offers medical service on the same level as the hospital in Czluchów. The nearest institution of high-standard hospital service (level of reference II) is a clinic in Kosciierzyna (90 km from Czluchów).
rural municipality council would typically be located: Człuchów (46 subjects) and Bielawa (43 subjects). In each of the voivodships similar numbers of people were interviewed (in Gdansk, Pomeranian voivodship, 89, including 79 patients and 10 health service workers; in Wrocław, Lower Silesian voivodship, 86, including 76 patients and 10 health service workers).

13. All together 112 people were interviewed individually, including 92 patients and 20 health service workers. The locality and essential features of the social position of the patients are presented in Table 1.

### Table 1.
Social structure of the in-depth interview participants

<table>
<thead>
<tr>
<th>General Category</th>
<th>Specific Category</th>
<th>Bielawa</th>
<th>Człuchów</th>
<th>Rural areas</th>
<th>Wrocław</th>
<th>Gdańsk</th>
<th>Urban areas</th>
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<td>22</td>
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14. Focus group interviews (8 meetings, 2 in each site) covered a smaller group (63 people). In each of the focus groups 7 to 8 people took part, and essential features of their social position are compiled in Table 2, divided by region.

### Table 2.
Social structure of the focus interview participants

<table>
<thead>
<tr>
<th>General category</th>
<th>Specific Category</th>
<th>Bielawa</th>
<th>Człuchów</th>
<th>Rural areas</th>
<th>Wrocław</th>
<th>Gdańsk</th>
<th>Urban areas</th>
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<td>32</td>
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</table>

15. In principle, in qualitative studies a research sample is not required that exactly reflects the social-professional structure of the group from which the sample has been selected. However, diversification of the sample with respect to its social composition (females and males and people of different ages, educational levels, professions, and so on) considerably extends the possibilities for interpretation. The controlled selection of respondents for both in-depth and focus group interviews permitted the analysis to take into account the quasi-representative nature of the sample well beyond expectations, as follows:

i. In both patient groups (in-depth and focus interviews) the team had to deal with the assumed imbalance of genders (significant overrepresentation of women). However, it was also assumed that women may use medical care more often than men and more often bring children to the doctor.

ii. In the "in-depth" group a majority (over 50%) of persons interviewed were within the so-called productive age (36 - 60 years), which is consistent with the structure of the society as a whole. Within the focus group the number of pensioners and annuitants was larger than in the greater society, based on the research assumption that one of the focus groups in each of the examined cities, voivodships and municipalities should first of all include people of post-productive age.

iii. The level of education in both groups of patients (in-depth and focus interviewees) should be recognized as slightly higher than in the entire society, in spite of corrective measures undertaken to have more diverse groups in this respect. However, over-representation of people with higher and secondary education in comparison to the proportions typical for the whole society greatly facilitated obtaining more extensive (and often deeper) information about informal payment mechanisms in the health service. From the people of lower educational level, represented in both samples at a level exceeding 30 percent.

iv. The team believes--in conformity with the circumstances of qualitative studies--this study’s representation of each of eight social-professional classes (physical workers, laborers, lower white collar workers, higher white collar workers, entrepreneurs, farmers, students, pensioners, and unemployed) to be sufficient. The representations offer a possibility of investigating the specific contact of these groups with the health service.

16. In summary it can be said that the material obtained, both in terms of volume (over 300 pages of records concerning patients and doctors), and merit (many very extensive
interviews enabled us to investigate the mechanisms behind the phenomena described) makes it possible to draw qualified conclusions about the nature and occurrences of informal payments in the health service, especially when one looks at the phenomena from a patient’s viewpoint.
Institutional Issues in Informal Health Payments in Poland

Report on the Qualitative Part of the Study

Shahriari H, P Belli and M Lewis

February 2001