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INFORMAL OUT-OF-POCKET PAYMENTS
For health care in Russia

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This book provides an overview of a study that was undertaken by Independent Institute for Social Policy in 2002 under financial support from the Moscow Public Science Foundation and the United States Agency for International Development (USAID) . Data generated in the course of face-to-face interviews with health care professionals in two Russian regions allows to make judgements about the prevalence of informal payments for health services made by patients at various health care institutions and units thereof. Authors argue that such payments have become a tool that patients and doctors use to adapt to realities of the transitional period. The book describes existing informal payment rules and schemes. Authors have analyzed personal and group norms regarding informal payments, as well as health professionals' attitudes towards their legalization. Data generated by the study has been used to assess the impact of legalization of informal payments for health services in Russia.

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Independent Economic Analysis Book Series

Independent Economic Analysis is a collection of books written by participants of the Strengthening Program for Economic Think Tanks in the Russian Federation. The series is designed to acquaint Russian and foreign readers with the scientific potential of Russia's non-governmental non-profit economic research centers' community. Most of such centers are very young, especially if compared with research institutions of the Russian Academy of Sciences or well-known sectoral institutes and economic schools. However, they already play a substantial role in public debates on such important issues of the economic policy as deregulation, development of socially responsible entrepreneurship, banking reform, fiscal policy, economic aspects of the social sphere, improvement of foreign trade, etc. Many members of this professional community provide advise to government bodies responsible for designing and implementing economic reforms in Russia. The community is evolving rapidly and comprises both well-known research institutions (e.g., Transitional Economy Institute, National "Social Contract" Project's Institute, Fiscal Policy Center, Leontyev Center, Urban Economics Institute, etc.) and centers that so far have been known only to a narrow circle of specialists.

Non-governmental non-profit applied economic research centers' social mission is to make professional economic expertise available to everyone who needs it. Without substituting academic institutions in the field of fundamental research or sectoral agencies' units that develop specific economic action plans, community of independent analysts is capable of independently forecast the impact of various decisions, recommend alternative solutions to stakeholders, project mid- and long-term trends and urge the public to take necessary actions. The community may be seen as an asset for political parties and movements oriented towards sound and needed reforms. Given that professional human resources in the regions are scarce, non-governmental non-profit applied economic research centers may be used as an efficient tool to improve the quality of decision making at both regional and municipal levels.

This book series provides an insight into capacities of Russia's economic analyst community as a whole, as well as to those of its most talented members who participated in the Strengthening Program for Economic Think Tanks in the Russian Federation in 1999-2002. The series contains both "narrow" topic-specific works (written in the genre of analytical note/"narrow" thematic report, the main type of product delivered by Program participants) united into compilations, and larger monographs (works written in this genre are intended to demonstrate that Program participants' professional competence is rooted in a solid scientific and methodological fundament).

The series does not pretend to be a complete collection of works produced by Program participants or represent all participating centers. However, publications of the series will serve as an important tool to disseminate Program outcomes. A formal presentation of the series is planned. The collection will be delivered to all interested organizations and agencies, leading Russian and American university libraries, and be made available through activities scheduled for Stage 2 of the Program implementation (years 2003-2005).

Editorial Board, Independent Economic Analysis Series

Strengthening Program for Economic Think Tanks in Russia

The Strengthening Program for Economic Think Tanks in the Russian Federation is sponsored by the United States Agency for International Development and implemented by the Moscow Public Science Foundation jointly with the Center for Institutional Reforms and Informal Sector at the University of Maryland (USA).

The program's goal is to facilitate development and strengthening of Russia's economic institutions and enhancement of their capacity for sound and independent economic analysis for the benefit of both government agencies responsible for economic policy development in Russia, and civil society organizations focusing on issues related to socio-economic development of the nation; to create a national network of economic think tanks and analysts; to mobilize internal intellectual and professional resources for resolution of Russia's economic challenges.

To attain its goals, the program holds grant competitions, provides technical support to the winners to assure their institutional development, assists in disseminating results of accomplished studies and developing networks of independent think tanks in Russia.

Some outcomes of Program implementation in 1999-2002

Ten grant competitions were held during Stage 1 of program implementation. The Program Board reviewed 588 applications and distributed 90 grants. The competition intensity – 6.5 submitted applications per 1 disbursed grant – demonstrates high level of research community's interest to the program. Thirty two percent of all grants were given to think tanks in the Russian regions (i.e. those located outside Moscow and St. Petersburg).

The program has supported creation of 11 new independent economic research centers (including 5 in the regions). As a result of the program-supported network development, an Economic Think Tanks Association was established. The association will focus on improving the quality of Russia's economic policy for sustainable economic development and public welfare, developing professional community, informing the general public and getting more people involved in discussing the various issues of Russia's economic development, as well as coordinating its members' efforts and advocating their interests before government and other bogies and organizations.

The program has supported creation of an open-access data base that contains information voluntarily provided by over 120 Russian economic research institutions. The base includes key contact information and analytical product samples. The data base introduces Russia's independent economic think tanks to potential consumers of analytical products, allows analysts to compare their works with those produced by their colleagues and serves as a tool that simplifies and facilitates communication within the expert community. The data base may be accessed via the program's web site (http://SETT.mpsf.org), as well as through MPSF's main page (www.mpsf.org).

Between 1999 and 2003, the program carried out 8 activities (e.g. conferences, workshops, "round table" meetings) dedicated to various aspects of the nation's economic policy. All in all, the program has provided an aegis for over 100 subject-specific discussions held by grantees.

The program and its participants pay special attention to target-oriented activities and measures to disseminate results of accomplished research projects. Materials produced under the program have been used by Administration of the RF President, Ministry of Economic Development and Trade, the RF Government Office, Analytical Section of the Federal Legislative Assembly's Council of the Federation, Ministry of Finance, Ministry of Agriculture, the Bank of Russia, federal Retirement Fund and other ministries and agencies. Program participants' works have been used as a reference in the course of public debates around such burning issues as deregulation of the country's economy (works produced by National "Social Contract" Project's Institute), alternative civil service (the Independent Institute for Social Policy), reform of Russia's retirement benefit system (Independent Actuary Information/Analytical Center) and many other topics. Regional participants of the program have made a substantial contribution to informing regional and local decision makers.

Implementation of the Program in 2003-2005

In 2003-2005, the emphasis will be made on providing support to the already existing independent economic think tanks in Russia that have earned their reputation by demonstrating high quality of the previous research and analytical products. Competition winners will be expected to carry out socially-important research, produce elaborated institutional development plans, generate sound proposals regarding communication of research findings to consumers of analytical products and the general public. The program intends to provide additional limited support to, and extend the timeframe of research projects. Along with that, requirements regarding the quality of submitted applications will become more demanding, and it will be somewhat more difficult for the applicants to win.

The program will become more focused on providing support to the regions and regional research centers. Small development grants will be made available to regional centers which, because to the lack of experience, will be unable to develop research and development programs without external support and, thus, demonstrate their true potential. The small grant program will allow each winner to obtain targeted counseling support, exchange knowledge with leading Russian and international analytical centers and be able to compete for the program's next regular (basic) grants.

The program will intensify technical assistance to analytical centers that will include provision of training in organizational management skills development, institutional capacity building, "centralized" activities to disseminate the findings generated through participants' research (complementing the latter's own efforts in the field), measures to introduce advanced international

experience in developing think tanks, network construction, encouragement of partnerships between the centers, intensified assistance with publishing grantees' works, as well as many other forms of additional assistance to participating centers.

Introduction

One of the main problems encountered by the Russian health care system is a substantial gap between the government's guarantees regarding free health care benefits, on the one hand, and scarce financial resources available to the system, on the other. According to the minimum estimates, amount of health care funding coming from public sources (i.e. public health care budgets of all levels plus financial resources of Russia's mandatory health insurance system) decreased by one third during the 1990s[1]. The growth in public health funding that started in 2000 has so far failed to compensate for the prior dramatic reduction. Meanwhile, state guarantees regarding provision of free health services that were established during the Soviet era, have not changed, whereas the cost of delivering such services has increased as a result of new cost-intensive medical technologies and pharmaceuticals. Insufficient public funding of the state-guaranteed health benefits has triggered the growth in both legal and informal patients' payments for health services and drugs and has made quality health services less accessible to the general public.

Data generated by numerous public surveys shows that informal (under-the-table) payments to health professionals have become very prevalent in Russia[2]. However, reliable information about the forms and rules of the "shadow" payments for health care remains scarce. So far, no research has been undertaken to investigate the correlation between the prevalence and types of informal payments, on the one hand, and formal rules governing such payments, on the other. Informal relations and social/psychological paradigms and health professionals' attitudes associated with the "shadow" revenues, as well as patients', health service providers' and social policy makers' attitudes towards possible legalization of informal payments deserve a more profound investigation. Valid data characterizing the aforesaid relations and paradigms will allow to make reliable judgements about alternative ways to eradicate informal payments through implementing various health care financing strategies.

This book presents results of a study that was undertaken in 2002 by the Independent Institute for Social Policy (IISP) and sponsored by Moscow Public Science Foundation and USAID within a project entitled "Analyzing implications of alternative health care funding options in Russia" (Grant No. 002/4-02).

This study opens a series of ISPI's research projects that will be implemented to investigate various aspects of interaction between formal and informal institutions that provide social services in Russia.

The study's goals were to:

- Assess the prevalence of informal payments for health care at various types of HC facilities;
- Describe informal payment rules and those used by health professionals to distribute informally-generated revenues;
- Identify personal and group norms that determine health professionals' behaviors associated with patients' "shadow" payments;
- Analyze health authorities', financiers' and facility administrators' awareness of, and attitude towards informal payment practices;
- Explore opportunities to control informal payment practices at and by various levels of health care management;
- Explore the possibility of transforming informal payments for health services and project the impact of their legalization.

Face-to-face interviews with health administrators, financiers (leaders of executive and representative branches of power, mandatory health insurance officers, leaders of health insurance companies, administrators [chief doctors] of health institutions) and health professionals (rank-and-file physicians/doctors and nurses) were held.

The study was conducted in two Russian regions. Since informal payments violate applicable Russian laws, respondents have agreed to provide information on condition of confidentiality. So, we could not disclose neither their identity, nor the names of the two regions in this book.

Authors would like to express their sincere gratitude to the Ministry of Health of the Russian Federation and health authorities of the two regions who expressed a great interest in the study and provided an invaluable organizational support. Also, many thanks to all health professionals, who took part in the study as respondents, for their support, information and opinions.

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[1] Shishkin S.V.: Health Care Financing Reform in Russia. Moscow, Teis, 2000 // www.iet.ru., p.93.

[2] Findings of the surveys are presented in Section 2.2

The survey tools have been developed by authors of this publication in cooperation with Mrs. T.M. Maleva and Mrs. L.N. Ovcharova (IISP).

Authors would like to extend their special thanks to Mr. A.I. Dontsov for analyzing the structured interview algorithm that was used by researchers to survey health professionals.

Section 1. State Guarantees and Population's Payments for Health Care

1.1. State regulation of economic conditions of health service provision

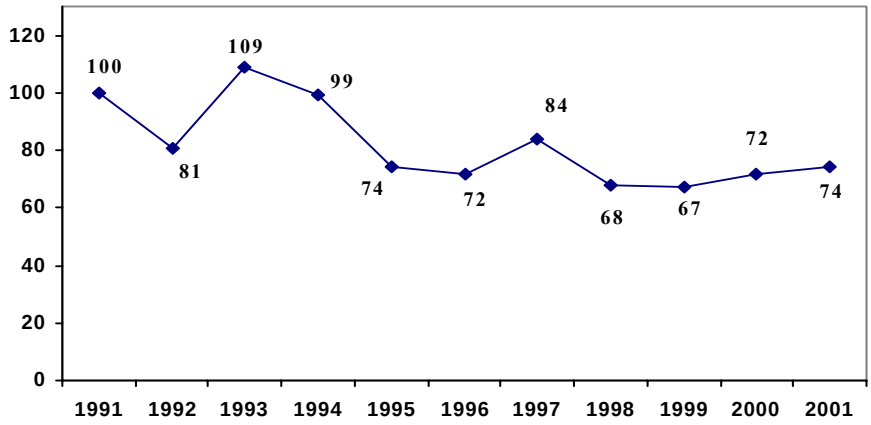
USSR was the first state in the world to guarantee a universal free access to health services to its citizens. However, Soviet legislation formulated these guarantees only in general terms. Article 42 of the Soviet Constitution (1977) established that the right of the Soviet citizens to protect their health "is provided for by free-of-charge qualified health care delivered by public health care institutions and expansion of a network of facilities providing treatment and health promotion services". Soviet laws did not specify services to which Soviet citizens were entitled. In fact, that meant that Soviet residents were entitled to free services in accessible health care facilities. However, the quality of services that people received depended on their social status and place of residence.

New Russian Constitution (1993) formulates the citizens' right to free health services in much the same way. Article 41 of the Constitution stipulates that "provision of health care at state and municipal health institutions shall be free of charge".

The nation's abilities to provide free health care to its citizens reduced dramatically during the transitional period (see Figure below). This has given an impetus to legal and informal payments for services. Health services, for which patients pay legally through cash registers, are referred to as "chargeable health services". Delivery of such services is governed by "Rules of chargeable health service provision by health care institutions", which were adopted Government Resolution # 27 as of 01.13.1996. According to that resolution, chargeable services may include preventative interventions, treatment, diagnostic services, orthopedic prosthesis and dental prosthesis services. State (federal and regional) and municipal health institutions may provide chargeable services only if they have a special permission from respective health authorities. Regional and municipal (local) authorities issue regulations that specify services, for which public health institutions may charge user fees, as well as conditions under which such services may be delivered.

Figure

Public* health expenditure (1991 = 100%)



Chargeable health services usually include:

* Health expenditures from state budget plus mandatory health insurance premiums. Source: calculations based on Goskomstat's [State Statistical Bureau] data that incorporate GDP deflation indices published in the end of each respective year (i.e. 1992 – 17.2; 1993 – 10.2; 1994 – 4.1; 1995 – 2.8; 1996 – 1.4; 1997 – 1.2; 1998 – 1.1; 1999 – 1.6; 2000 – 1.4; 2001 – 1.2).

- Medical examinations and tests that a patient needs to receive this or that formal certificate (e.g., to obtain a driver's license, regular occupational health screening certificate, certificate requested by prospective employer, etc.);
- Hotel/auxiliary services at hospitals (single or double room with a TV set, refrigerator, etc.);
- Medical interventions involving the use of advanced/modern technologies (e.g. endoscopy), as well as procedures performed by doctors at patients' request;
- Consultations by physician specialists;
- Diagnostic procedures, including those "bypassing the waiting list" or additionally requested by the patient;
- Additional treatments (acupuncture, massage);
- High-quality prosthesis;
- Personal nursing station;
- Cosmetic/plastic surgery.

Usually, prices for chargeable health services are set by public health institutions that provide such services, or – more rarely – by health authorities which, by law, act as founders of public health institutions. Whoever sets the prices, two federal regulations are used: "Calculation of health services production costs by health institutions: Technical Guidelines" (# 190-15/5, adopted by federal MoH on 11.26.1992) and "Instructions for calculating the cost of health services" (Doc. # 01-23/4-10, 01-02/41, adopted jointly by federal MoH and Russian Academy of Medical Sciences on 11.10.1999). Public health institutions (federal, regional and municipal) may use part of the money allocated to them from public health budgets and mandatory health insurance funds to indirectly cover some part of the costs associated with chargeable service provision[3].

1.2. **Residents' health care expenses (an overview of accomplished surveys)**

As recurrent public health budgets remain scarce, the burden of payments for health services is shifting towards the country's population and employers. It should be noted, that the government (i.e. its State Statistical Bureau [Goskomstat]) does not collect full information about health care funding from all existing sources. For example, there is no information about how much employers (corporations) spend to maintain their health care facilities. According to *Russian Health Care Foundation*, the share of HC funding from non-governmental/private sources increased from 14.0% in 1994 to 36.5% in 1999[4].

Official statistics indicate that amount of voluntary health insurance premiums paid by individuals and corporations has been increasing rapidly. Amount of chargeable services provided to the population has been growing likewise. However, voluntary health insurance (VHI) has not become the leading source of private health care funding. While in 1993-1994 total amount paid for chargeable health services exceeded that of VHI premiums by less than 100%, in 1998 this proportion was already 3 to1. In 2000, Russian residents paid 27,5 billion rubles for health services. That figure exceeded all VHI premiums collected during the same year by 100 percent (12,7 billion rubles) (see Table 1 below).

The share of chargeable health services in the overall amount of chargeable services (in monetary terms) increased from 1.7% to 4.6% between 1993 and 2001. This dramatic increase can hardly be explained only by growing demand for health care among high-income residents. However, it is difficult to draw any safe conclusions because of the lack of reliable official statistics. Moreover, officially reported data does not include informal ('under-the-table') payments made by patients directly to health professionals.

Table 1

Health Care Funding from Public and Private Sources (billion rubles)[*]

Year/Category	**1993**	**1994**	**1995**	**1996**	**1997**	**1998**	**1999**	**2000**	**2001**

[3] Kadyrov F.N. Price setting for medical and auxiliary services provided by health institutions. Moscow: Grant, 2001. Pp. 214-215

[4] Belyayeva N.V. Sources of financing in the system of Russia's health accounts. Health Economics Thematic Edition. Russia's Health Accounts. #7. 2001; p.59.

Recurrent public HC funding	6,38	23,9	51,3	72,1	98,5	88,0	137,7	199,3	241,0
Public HC funding as a % of GDP	3,7	3,9	2,9	3,1	3,4	3,1	2,9	2,6	2,8
Voluntary health insurance premiums	0,06	0,4	1,2	2,2	3,4	3,8	7,2	12,8	23,8
Chargeable health services	0,11	0,6	2,9	5,6	9,3	11,4	19,7	27,5	37,9
Populations' out-of-pocket payments for pharmaceuticals	N.a.	2,1	8,1	12,2	19,8	26,3	51,7	70,1	94,2

* Values before 1998 are given in denominated rubles.
Source: Russian Annual Statistical Magazine, 2000. Moscow: Goskomstat of Russia, 2001; Russian Annual Statistical Magazine, 2001. Moscow: Goskomstat of Russia, 2002

According to official data on the structure of household spending for final consumption[5], the share of household revenues spent for health care is increasing. In 1994, the share of health services and that of medical devices and personal hygiene items in the overall amount of household expenses was 0.4% and 2.5%, respectively. In 2000, these values increased to 0.9% and 3.5%, respectively. However, there is a substantial difference between households with high and low incomes. Comparison of the two opposite decile groups shows that the poorest households have to spend a larger proportion of their incomes for drugs, than the wealthiest families (4.1% vs. 3% in 2000). However, the wealthy spend a much higher share of their income for health services, than the poorest residents (1.8% vs. 0.2%).

Public surveys allow to make general judgements about the prevalence of out-of-pocket payments for health care, including 'shadow' payments (Table 2).

Table 2

Name of survey or organization	**Place and year of survey**	**Outpatient services**	**Diagnostic services**	**Dental care**	**Inpatient services**
Russian Academy of Sciences' Institute of Social and Economic Problems of Populationand Legal Sciences (ISEPP)	Taganrog, 1998	22			60
Kemerovo State University	Kemerovo, 1998	18-38	45	84	51
National Center for Public Opinion Studies (VCIOM)	National sample, 1999	4-20	44	80	34-37
Russian Health Care Foundation	Novgorod region, 2000	24			46
INDEM Foundation	National sample, 1999-2001	34			
Russia Longitudinal Monitoring Survey	National sample, 2001	10	21		15

[5] Household revenues, expenses and consumption in 2000. Moscow: Goskomstat/Russia, October 2001; pp. 34-38

Sources: Morozova Y.A., Ibragimova D., Krasilnikova M., Ovcharova L.: Russian residents' payments for health and educational services. // Public opinion monitoring: economic and social changes, 2000, # 2(46), p. 38. Kulibakin I.B.: "Urban health care systems": public survey findings. Kemerovo State University. Sociology Center. Kemerovo, 1998; Satarov G.: Diagnosis of the Russian corruption: sociological analysis (Report summary). Moscow, INDEM Foundation, 2002. Sidorina T.Y., Sergeyev N.V.: State social policy and Russians' health. Comments to the household health expenditure survey// "Russian World", #2, 2001; www.cpc.unc.sdu/rlms/

Detailed information about how much Russian families pay for health services and drugs was collected in the course of a household survey carried out by Institute for Social Studies (Moscow) and Boston University's School of Public Health in 1998-1999[6]. A survey of 3000 Russian households was carried out in January of 1998. Respondents were asked to provide information about payments they had made for health services and drugs during the month prior to the survey dates; 2200 households were asked to answer the same questions in January of 1999. The study has allowed to conclude that:

- Percentage of families' incomes spent on health services had been increasing;
- In a situation when people have to pay for services that are supposed to be free, low-income families and people residing outside large cities suffer more than families with medium and high incomes and residents of large administrative centers. They have to spend a higher share of their revenues for health services, and often refuse to get prescribed treatment or drugs;
- Amount of out-of-pocket payments for health care is comparable with that allocated from public (government) sources. The ratio between the two is estimated at 55 to 45[7].

A survey conducted by ISELS in Taganrog in 1998 has shown that: 22% of respondents had to pay for some of the services they had obtained at district outpatient clinics. As for inpatient services, only 8% said that treatment at a hospital had been provided absolutely free; 28% of respondents called it "formally free", as they had had to buy gifts for medical personnel or pay directly for some services; 60% of respondents had to pay for inpatient drugs, dressings, etc. More than 90% of respondents said that they had made some payments associated with hospital stay. According to surveys in Taganrog, the share of patients who had to pay for health services in that city increased from 2% in 1981 to 10% in 1994 and 25% in 1998. Thus, the prevalence of out-of-pocket payments for health services is increasing dramatically.

A public survey carried out in March of 1998 in the city of Kemerovo shows that: between 1997 and 1998, 84% of patients had to pay for dental services, 51% made out-of-pocket payments in hospitals; 45% paid for diagnostic services; 18% of patients made payments at outpatient clinics (for being seen by their internist); 38% paid for being consulted by physician specialists[8].

According to the findings of a public survey conducted by VCIOM in June 1999 (a representative sample of 1600 adult respondents), 80% of patients had to pay for dental care; 34-37% - for services provided at hospitals; 44% - for diagnostic procedures, and 4 to 20 percent – for various outpatient services[9].

According to a survey of 450 households carried out by Russian Health Care Foundation in Novgorod region (April-June 2000), the share of patients who had to pay for services in the total number of respective service recipients was: 24% (outpatient services) and 46% (inpatient treatment). Amount of informal (under-the-table) payments accounted for 72% and 38.5% of the total amount spent for outpatient and inpatient services, respectively.

An analysis of HC funding from public sources (recurrent health budgets) was undertaken by Center for Social and Economic Studies in the fall-spring of 2000-20001. During the study, 562 residents of 6 Russian regions (Belgorod, Vologda, Samara, Chelyabinsk oblasts, Khabarovsk Krai and Republic of Chuvashia) were interviewed[10]. 40.6% of respondents reported to have used chargeable services at outpatient clinics sometime during 3 years prior to the survey; 8.1% had paid for treatment at hospitals. Out-of-pocket payments for health services during 30 days prior to survey were made by 21.3% of respondents (15% paid for services at outpatient clinics, 1.4% - for hospitalization and 4.9% -

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[6] Boikov V., Feeley F., Sheiman I., Shishkin S. Household health care and drug expenditure// Economic Issues, 1998, #10, pp. 101-117; Boikov V., Feeley F., Sheiman I., Shishkin S. Residents' payments for health services and drugs. // Health Care, 2000, #2, pp. 32-46; Boikov V., Feeley F., Sheiman I., Shishkin S. Participation of the population in health care financing. // Health Economics, 2000, #7, pp. 45-50.

[7] Shishkin S.V. Health care financing reform in Russia. Moscow: Teis, 2000 // www.iet.ru. p.143

[8] Morozova Y.A., Kulibakin Y.B. (1998): "Urban health care systems": public survey findings. Kemerovo State University. Sociology Center. Kemerovo, 1998

[9] Ibragimova D., Krasilnikova M., Ovcharova L.: Russian residents' payments for health and educational services. // Public opinion monitoring: economic and social changes, 2000, # 2(46), p. 38.

[10] Sidorina T.Y., Sergeyev N.V.: State social policy and Russians' health. Comments to the household health expenditure survey// "Russian World", #2, 2001;

to private practitioners). For 18.2% respondents, a visit to a health care facility resulted in an additional examination or procedure, for which 35.6% of such respondents had to pay for it separately. 47.8% of those who reported to have used hospital services during 3 months prior to survey date, had to make out-of-pocket payments for treatment, drugs and other services during their hospital stay. Payments for preventative examination were made by 27.1% of responders (11.3% of the sample).

INDEM Foundation estimates that "shadow" payments for health care may amount to 600 million dollars[11]. This estimate is based on face-to-face interviews with 2017 respondents conducted in the course of a study of corruption in Russia that was carried out by INDEM in 1999-2001. Out of 46% of respondents who reported to have used services at outpatient clinics, 34% said that they had made additional out-of-pocket payments, half of which were informal. Respondents were asked to describe situations in which they had made informal payments. The situations were then ranked in decreasing order of `their incidence (rank 1 – most frequent, rank 11 – least frequent). Informal payments are usually made in order to: resolve problems with traffic police (rank 1); get admitted to a university (2); evade military service (3); renovate apartment (at the expense of the government), obtain a state-owned apartment, get assistance from police (ranks 4, 5 and 6, respectively); get referred to a hospital and obtain an adequate treatment there (rank 7); undergo complex surgical operation (9). Treatment at an outpatient clinic ranked 7th in the list. However, in terms of amounts paid, payments made for outpatient and inpatient services rank 2nd and 3rd in the overall volume structure of bribes (the largest sums are paid to bribe university officials).

A *Russia Longitudinal Monitoring Survey* has been conducted annually since 1992 by RAS's Sociology Institute, RAMS' Institute of Nutrition and the University of North Carolina to examine the health and economic welfare of the Russian Federation. More than 7000 Russian households are surveyed each year to obtain data on their expenditures and consumption[12]. Data generated by the survey show that the share of health care and drug expenditures in the average Russian family's overall expenses is growing dramatically. Between 1992 and 2001 it increased from 0.9% to 4.6%. According to data collected in 2001, 10.1% of all outpatient care recipients had to pay for it, and only 49.7% of such payments were made officially (via cash-register). 55.8% of patients paid directly to health professionals or had to purchase gifts for the latter. In addition, 39.2% of those who had an appointment at an outpatient clinic were referred to additional tests or procedures, for which 21% of such patients had to pay. 70% of all payments were made legally, and the rest 30% can be classified as "under-the-table" payments. As far as hospital services are concerned, 15.3% of all hospitalized patients had to pay for treatment or other services: 65.3% of them paid through the cash register, while 51.3% gave money or gifts directly to medical personnel.

There is no consensus about the prevalence and scope of out-of-pocket payments for health services in Russia. However, available information allows to conclude that payments for supposedly-free-of-charge services have become a common practice in Russia.

Russia's shadow health care market was examined under a qualitative study of the country's shadow economy undertaken by I. Klyamkin and L. Timofeyev in 1999. Face-to-face interviews with health service consumers have allowed to conclude that informal payments can hardly be defined as extortion or corruption. Rather, they represent a special "form of cooperation between pauperized health care system and pauperized population in the efforts to retain at least some opportunities to provide and obtain treatment"[13]. Patients act as rational customers in the shadow health care market. This market's main distinctive feature is that relations between physicians and patients are not governed by any explicit or commonly recognized norms or principles. It should be noted, however, that our study has not confirmed the latter conclusion (see Section 3.1.).

[11] Satarov G.: Diagnosis of the Russian corruption: sociological analysis (Report summary). Moscow, INDEM Foundation, 2002

[12] www.cpc.unc.edu/rlms/

[13] I. Klyamkin and L. Timofeyev: The Shadow Russia. Socio-economic Survey. Moscow, Russian State Humanitarian University, 2000, p. 165.

Section 2. Types of Out-of-pocket Payments for Health Care

2.1. Rules governing out-of-pocket payments for health services: investigative tools used

Our study was designed to identify and formulate the rules that govern out-of-pocket payments for health services through interviewing health officials, representatives of health financing authorities, physicians and nurses.

As a rule, large-scale population-based surveys using questionnaires do not provide enough information to identify such rules or analyze the possibility of legalizing or transforming the out-of-pocket payments. In-depth interviews with health care consumers provide more reliable information about the rules and types of informal payments, but do not allow to make judgements as to how and to what extent can such payments be controlled by social policy-makers or health officials and, if they can be controlled, what control mechanisms are being formed or are already in place.

That is why we decided to interview people who act as key players in the shadow health care market (i.e., physicians and nurses), on the one hand, and health administrators and financiers, on the other, in order to collect information about new or ill-defined shadow practices in health care and answer the main question: can informal payments be reduced, and what immediate steps should be taken to do that.

Since our respondents were direct recipients of under-the-table payments, one might ask: to what extent they were honest with us, and how reliable can that sort of data be? That is why our questions had been formulated in a way that would allow respondents to "preserve their faces" and minimize temptation to distort or conceal the facts because of fear or embarrassment. We used a "flexible interviewing technique" which allowed moderators to adjust to each respondent's personality. The interview structure was intended as a tool that would make respondents openly reflect on their past experiences. It was designed not so much for getting unambiguous comparable answers for further quantification, but to make respondents talk as much as possible and trigger their own "mini-study" of the discussed problems. Although such methodology makes data processing difficult, it is a very useful tool when there is a need to collect as many perceptions and facts as possible. Discussion of possible ways to expand chargeable services or legalize patients' out-of-pocket payments was used as a motivation for our respondents.

The survey was carried out in two Russian regions that differed in the following characteristics:

- Region A: Recipient of federal subsidies with a fairly low per capita income and rural/urban population ratio close to the average national value;
- Region B: Donor of funds to the federal budget with a reasonably high level of per capita income and high proportion of urban population.

As was said above, we can not provide the regions' names, since practices that we examined are qualified as illegal in Russia.

Thirty five interviews with regional executive health officials and law-makers, heads of regional mandatory health insurance funds, health insurers, chief doctors (administrators) of various health institutions were conducted in February, March and April of 2002. Five of them were repeated to follow up interviews with rank-and-file physicians and nurses.

In April 2002, 136 interviews with health professionals in the two regions were carried out. The sample included deputy chief doctors, health institutions' unit heads, rank-and-file physicians/doctors and nurses. The interviews were conducted at the following locations:

1) regional state-owned teaching hospitals (2)
2) municipal teaching hospitals (4)
3) municipal urban outpatient clinics (2)
4) central district municipal hospitals (2)
5) district municipal hospitals located in rural settlements (2)
6) private health care facilities (2).

Thus, a total of 171 interviews were conducted.

In order to emphasize certain points or illustrate the reasoning behind authors' conclusions, we decided to include citations of respondents' most frequent answers or expressions of disagreement in the sections below.

2.2. Chargeable health services

There are four ways in which Russians pay for health services which are included in the guaranteed free health benefit package and, thus, are supposed to be provided at no charge to a patient:

1) voluntary health insurance premiums;
2) payment for services that are legally provided under fee-for-service arrangements ("chargeable health services");
3) payments for drugs and medical devices made by patients who obtain treatment at public health care facilities; and
4) informal out-of-pocket payments for health services.

Voluntary health insurance products are not in high demand in the two surveyed regions. Private health insurance industry in Russia is much better developed in Russia's largest cities and wealthiest regions. Physicians and even unit heads could not clearly say whether or not their institutions had any contracts with private health insurers and, if yes, how many VHI patients had been treated.

Chargeable health services in Russia are much more prevalent than voluntary health insurance. We should remind, that chargeable health services are those, for which patients pay legally through health institutions' cashier's desks.

The interviews allow to conclude that chargeable services are not provided by ambulance teams or emergency hospitals. The prevalence of chargeable services at outpatient settings is extremely low. According to surveyed physicians, only about 1% of patients at the surveyed outpatient clinics pay through the cash register. Rural hospitals – with rare exceptions – do not provide any services for which fees may be legally collected. Urban hospitals deal with paying patients much more often, but utilization of chargeable services varies across hospital units/wards. Therapy, cardiology, rheumatology, nephrology and gastroenterology departments provide chargeable services to only several percent of all their patients, while Pulmonology and Orthopedic Surgery charge 15% and 50% of patients, respectively.

Chargeable health services are more prevalent in Region B, probably because the average level of personal income in that region is higher.

What services do people legally pay for at public (state-owned) health institutions?

First of all, they pay for services that are provided in addition to "conventional" free services. These include medical examinations needed for obtaining a driver's license, health certificates requested by employers, etc., hospital hotel services (e.g. single room with amenities, TV, etc.), diagnostic procedures with the use of advanced technologies and other such services.

Secondly, they pay for services that could be obtained at no charge, but may as well be provided for fees with better quality and under better conditions (i.e. without patients being put on a waiting list, standing in lines, getting a referral, etc.).

One typical example of a situation when chargeable services are provided is that with a resident of a small town or rural settlement who travels to the regional center to obtain a diagnostic procedure or a specialist's consultation. If that patient is self-referred (i.e., has no referral from local physician), he/she will be charged for such services. Thus, there are patients who travel to the regional center without referral and pay for services which they can receive for free from their local provider. This shows that Russian residents do not trust "free-of-charge health care". Patients travel all the way to the regional center *"not because we can not provide these services. Many people believe that free services can only be of poor quality. They think that if they pay, high quality is guaranteed"* (doctor who works at a district hospital).

Thirdly, user fees are charged for services that comply with higher quality standards than those formally or informally set for the same services that are provided at no charge.

In reality, different quality standards have been set for the same service modality, depending on whether or not the patient can pay for it. The difference in quality may result from the use of drugs that have different cost and, therefore, clinical efficacy. Services provided by officially higher-qualified

physicians are also considered as those of higher quality. According to many respondents, the actual quality of free health services (in terms of treatment outcomes) has become low, if compared with quality standards set for the same services in the Soviet times. *"Sixteen years ago, when all health services were free, drugs were so abundant that and I had to spend all my time studying pharmaceutical reference manuals*" (pulmanologist of an urban hospital)[14]. Nowadays, state-owned health care institutions have an access to only a limited range of free drugs. A department head of a large hospital said: *"We always have a minimum necessary set of vital drugs in stock. Of course, they are the cheapest and least effective drugs"*.

The *de facto* standards of free services in some hospitals are so low, that a given patient with several exacerbated chronic concurrent conditions can obtain treatment only for one of them at any given time. In the past, a hospitalized patient could receive a comprehensive treatment for both primary diagnosis and concurrent conditions. Currently, he or she has to make separate payments for other specialists' consultations or diagnostic procedures associated with concurrent diseases. Here is what our respondents said on the matter: *"A patient with hernia and some concurrent conditions shows up. He came to me for hernia removal. I will refer him to an internist, because I will not treat those concurrent conditions myself. So, the patient will have to go to each relevant specialist and pay for counseling and treatment"*. Or, a doctor from a large urban hospital Pulmonology ward: *"Everything that goes beyond pulmonology has to be paid for by patients. If a patient has concurrent conditions, he or she has to pay for getting them treated"*.

Will health professionals benefit from further development of chargeable services?

First of all, it is administrators of health care facilities who are interested in further evolution of chargeable services, since the latter serve as an additional source of money that can be used to cover various hospital's expenses, as well as a legal source of additional personal income. Administrators of health care facilities receive some share of revenues generated through each chargeable service provision as an addition to their flat salaries.

However, the ways in which revenues from chargeable services are distributed make rank-and-file physicians and nurses less interested in increasing utilization of such services.

Under two above-mentioned MoH's cost calculation/price setting guidelines (see Section 1.1), health institution's personnel and units directly involved in chargeable service provision are entitled to only a tiny share of revenues generated from it. Theoretically, each public health institution's administration is empowered to increase that share. Decisions regarding distribution of revenues from chargeable services are made by institution's Economic Council, which includes that institution's Chief Doctor (director), his/her deputies, senior economist and heads of several units. Rank-and-file doctors and nurses are not in any way represented. The council's decisions must be discussed at a general meeting of the institution's staff. However, such discussions do not take place in every health institution. In some hospitals, even department heads know little or nothing about the way such revenues are distributed. As a result, revenues from chargeable service provision are retained by the health institution as a whole, while direct providers receive no more than 20% of the cost of each provided service.

Physicians realize that revenues from chargeable services should be shared between the entire institution and those who actually provide them. However, existing physician reimbursement arrangements are described by physicians as unfair and failing to take into account their actual contribution to the treatment process, in which *"40% depends on availability of diagnostic and treatment equipment, and 60% is a result of physician's knowledge, skills and qualification"* (a pulmonologist). *"A physician receives the money only for patients that he/she has actually treated, while administration, economist and accountant receive their share from all patients treated at the hospital.…With this scheme in place, the chief doctor's secretary gets more money than I do, although I provide actual services to patients"* (urban hospital's department head).

The situation is even worse in outpatient clinics, since officially-set costs/prices of their services are lower, than those in hospitals. *"The price a patient pays for my consultation is 21 rubles. I must examine the patient, fill out the chart and prescribe treatment. Repeated visit of the same patient is priced at 14 rubles. And I receive only 3 rubles from the total sum she paid"* (a gynecologist of an urban outpatient clinic).

Respondents said that direct providers of chargeable services should receive 30 to 60 percent of revenues generated through such services (50% was the most frequent answer).

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[14] "Urban hospital" here and below means a hospital located in a town or city, irrespective of its status or affiliation (it may a regional, district or municipal hospital).

2.3. Payments for drugs by patients obtaining services at public health care institutions

When obtaining diagnostic and treatment services at public outpatient clinics or hospitals, patients must receive all necessary drugs, materials and medical devices on a free-of-charge basis. A chronic shortage of public funding has resulted in a situation where state-owned health providers do not have enough money to purchase drugs and other items necessary for provision of free services to patients. A chief doctor of a central district hospital was very explicit: *"A guaranteed minimum stock of drugs is a science fiction, given our reality. … There are no drugs anyway"*. Sometimes there are not enough drugs even for patient who have already paid for their treatment.

Very often, drugs available at hospitals are obsolete and ineffective. Most of the hospitals do not have enough money to purchase modern evidence-based pharmaceuticals. Patients or their relatives have to buy "good" drugs in order to reduce the term of treatment, avoid adverse reactions and – when resuscitation is needed – to save the patient's life.

Various payment mechanisms are used. Sometimes attending physicians would offer assistance in purchasing the necessary drugs. In such cases, informal nature of payments is quite obvious: *"Current situation with drug supply encourages informal payments. There are different mechanisms: doctors may sell the same drugs that are available at the ward, but for 50% of their price*".

In other cases patients or their relatives buy required drugs at retail pharmacies. Those are legal payments. But, as a matter of fact, patients have to pay for what the government is supposed to be providing free-of-charge. Thus, such payments may be called "quasi-formal".

An explicit example of such payments was given by a head of one hospital's surgical department: *"A patient who is admitted for a planned surgery buys gloves (10 pairs for the team) and gauze. Like 30 square meters of gauze: 15 meters will be used for him, and 15 – for an emergency case"*.

Finally, patients can pay to an intermediary who assumes an obligation to provide all required drugs. A health insurance company may be that intermediary. We will discuss such payment mechanism in one of the sections below. Here we will just say, that such a payment can also be defined as quasi-formal. A patient pays an insurer on a legal basis, but the fact itself (i.e. out-of-pocket payment for drugs that are included in the free health care benefit package) is a violation of applicable Russian legislation.

The share of patients paying for supposedly free drugs was different in the two regions. It was larger in Region A, where most respondents estimated it at 70 to 80 percent, and only at one of the central district hospitals it did not exceed 20%. As one chief doctor of another central district hospital said, *"this proportion depends on how much money we actually receive from public sources"*. Department heads of some hospitals said that 90% of their patients had to pay for drugs. Free-of-charge drugs are provided to disabled people, war veterans, emergency cases and low-income residents ("mischiefs", "socially-inadapted people"). However, there have been cases when low-income emergency patients were asked to compensate the cost of disposable items and part of the drugs.

"Patients are explicitly divided into categories", said a department head of one of the hospitals, *"There are solvent and wealthy patients who never pay for anything, because they are recommended and referred by the regional government. Patients of the second category can not afford even simple drugs. The former do not want to pay, and the latter are unable to pay"*. Unlike most other people, high-ranking patients receive effective expensive drugs without paying for them. In fact, the cost of treatment for such people is covered through redistribution of public funds that constitute the facility's recurrent budget or, in some cases, from personal savings of the institution's staff: *"Sometimes high-ranking patients (big government officials) do not want to understand that we just don't have the necessary drugs in stock. In order to avoid scandals, medical staff collect the money and purchase the needed drug. They do whatever it takes to keep those patients' mouths shut. Just because that patient's son works in the State Duma [Russian congress] in Moscow. He was intimidating us. He said that we would be fired. Each of us contributed 20 rubles, then we went to a private retail pharmacy kiosk on the second floor and bought what he needed, just to make him stop it"*.

Free services may are also provided to people with high personal incomes: *"I was summoned to the chief doctor. He said: "This patient is a friend of Mr. X, and that patient is a friend of Mr. Y. You must hospitalize them, and no money charged*", said a deputy chief doctor of an urban hospital, *"May I at least ask them to pay for antibiotics that we do not have in stock?", I asked. "No way", the chief doctor said". "I have 15 or 20 incubation tubes, which I could use for low-income patients. And here you have patients who have a "hairy hand" somewhere and who never pay even for things that they can easily afford. Those who can pay always want to get everything for free"*.

Respondents from Region B estimated the share of inpatients paying for drugs at hospitals at 20 to 50 percent. They also noted that drug supply at hospitals had improved in the previous year (2001) as a result of substantial increase in the public drug funding, and remained sufficient in 2002. Prior to that, most of the inpatients had to purchase drugs for their own money.

The main cause of the aforesaid out-of-pocket payments for drugs is obvious. It is the lack of public funds allocated to public health care facilities for drug purchases. Our study has confirmed the correlation between these two variables.

However, administrators' and physicians' actions and attitudes can aggravate the situation with drug shortages even more. For example, administration of one hospital has preferred to invest available financial resources in development and expensive medical equipment, instead of purchasing sufficient quantities of simple and cheap drugs. As a result, even "patients with connections" had to purchase saline and dressings, let alone drugs. Moreover, that hospital's retail pharmacy kiosk was financially controlled by hospital administration.

In a situation like that, some health professionals may be concealing drugs purchased for public money and selling them to patients as "unique and rare" drugs. An interesting example was given by one of respondents: *"Nowadays, when a person comes to a hospital, they say: 'no drugs are available'. He buys drugs for his own money….. One of my friends is a public prosecutor. His wife was infertile. They ordered a drug and finally he bought it due to his connections. Then he became curious and traced the entire delivery chain. He found out that that drug originated in that very hospital where his wife was being treated. So, sometimes they have a free drug, but they prefer to sell it to patients"*.

There have been cases when physicians were selling prescription psychoactive drugs to patients. Physicians form a pool of strong psychoactive drugs through dispensing less effective substitutes to patients and concealing the former.

Some physicians who encourage their patients to purchase this or that drug from retail pharmacies, do it for selfish ends. There are several situations in which physicians benefit from their patients purchasing a specific drug or medical device:

1) Physician has an agreement with a pharmaceutical manufacturer of distributor, under which he or she gets commission for every given item sold. Physician may tend to prescribe a costly branded drug, because he receives remuneration from that drug's manufacturer or provider. However, in many cases a cheaper analog is enough to effectively treat a patient. Sometimes a cheaper generic drug may be more effective than its branded equivalent. *"Many firms advertise their absolutely useless expensive drugs. How can one control a physician who always prescribes expensive branded drugs? Often times physicians follow the indecent way. Patients' relatives are not supposed to have professional medical knowledge. Often they go: "This drug has such a beautiful name, and it is not cheap! It has got to be good". Manufacturers often play that card…. It is a very profitable business: many doctors cooperate with pharmaceutical companies…"* – said a doctor of an urban hospital. *"We receive money from manufacturers whose products we use during surgical interventions"* (head of surgery ward).

Commission to physicians may be paid legally or informally. In any case, however, the money comes from those physicians' patients.

2) Physicians ask patients to purchase prescribed drugs from a specific pharmacy (usually it is a private retail pharmacy kiosk in the hospital), which is often owned by hospital administrators or their relatives. If that is the case, virtually all patients are referred to that pharmacy: *"A patient gets transferred to his room. No one shows up the next one or two days. Then his attending doctor pops in and says: "You have this and that. Here is the list of drugs you will have to buy in a pharmacy on the ground floor of the hospital". And that pharmacy belongs to that hospital's chief doctor or his wife "* .

3) Prescribing physician offers the patient to purchase the drug from him, as he has "purchased it at the wholesale price without mark-ups". If this is the case, the physician acts as a retail distributor of drugs. Sometimes both parties benefit: physician gets his margin, and the patient purchases the drug at a lesser price than that offered by the pharmacy. One of our respondents said that he had been purchasing drugs at wholesale prices and selling them to his patients for the same price just to make sure that they could get an appropriate treatment. However, in most cases patients are talked into paying as much as they would have paid at a private pharmacy.

4) A health insurance company offers a contact to a patient, under which all his/her expenses associated with drug purchases during treatment at a given hospital will be covered. This scheme was introduced in September 2001 at a large teaching hospital in Region A, but was cancelled in October of the same year by regional government because of patients' complaints. However, this arrangement deserves a more detailed consideration.

Under the above scheme, hospital administrators would offer a patient to pay a certain sum as a VHI premium to cover the cost of the necessary drugs. Several payment options varying in size of the premium have been developed. Private insurance company would then draw respective contracts and,

after deducting a pre-agreed commission, transfer the money to the hospital's bank account. The hospital would then purchase all necessary drugs and provide them to the patient. Some part of the money was used by the hospital as an incentive pool for personnel. Due the scheme, the hospital was able to pay substantial bonuses to its doctors (up to 50% of their regular salary).

The hospital and the insurance company provided the following rationale for that scheme:

- patients pay less for the drugs than they would have at a retail outlet, because the hospital is purchasing them at wholesale prices;
- each participating patient can receive the necessary drug immediately when there is a need for it; he or his relatives do not have spend time searching for the drug;
- the scheme allows to reduce the cost to a patient and increase doctors' salaries;

However, health authorities and some doctors from that and other hospitals objected to the scheme, saying that:

- many patients had to pay more for their drugs than if they had bought them at retail pharmacies. Some of the patients complained that the cost of provided drugs was much less than the sum they had paid as a premium. It should be noted, however, that on several occasions the insurer returned the unspent part of the premium to the patients at their request;
- In many cases participating patients could not timely receive the needed drug, because it was not available at the hospital (it usually took more time to order and receive the drug through the hospital pharmacy than to just go to a retail pharmacy and purchase it);
- Some patients (or their relatives) still had to purchase necessary drugs at retail pharmacies outside the hospital for the above-mention reason.

Opponents of the scheme also argued that it could hardly be called an insurance product, since the contracts were signed with people who had already been hospitalized.

Obviously, this scheme contradicts the basic insurance principles. What is important, however, is that that innovation was an attempt to legalize patients' payments for health services which, in fact, violated applicable Russian laws governing free health service provision and health insurance industry. The scheme was cancelled, and patients continue to spend their money for inpatient drugs. Informal or quasi-formal out-of-pocket payments for drugs do not entail any administrative penalties against health providers who encourage or have to encourage them. However, as the practice has shown, an attempt to legalize such payments may trigger legal action against those who try make it.

2.4. Informal payments for health services

2.4.1. What do people pay for?

In hospitals, patients make "under-the-table" payments for:

- Diagnostic procedures and admission without being put on a waiting list (bypassing the line);
  - ❑ Examination and hospitalization of patients who do not have a formal referral to a given hospital issued by other health care provider or health authority;
  - ❑ Diagnostic examination performed out of patient's turn;
  - ❑ Reduced waiting time from referral to admission;
- Treatment as such;
- Diagnostic procedures;
- Counseling by specialist;
- Surgical interventions
  - ❑ Surgeon's work;
  - ❑ Anesthesiologists' services;
- Attending doctor's services not related to the operation (a better-than-usual patient management services);
- Auxiliary services:
  - ❑ Being transferred to a room with better conditions, e.g.: a room with less inmates, or a single or double room with better amenities (TV set, refrigerator, etc.);
  - ❑ Access to some items (e.g., a more comfortable bed, brand new blanket, etc.);
  - ❑ More frequent change of underwear or bed clothes;
- Various prescribed procedures, injections, etc.;
- Therapeutic massage;
- Bed-side nursing for immobilized patients.

Most frequent out-of-pocket payments in hospitals are those for surgical interventions, patient counseling by specialists and bed-side nursing. In some cases patients have to pay for all services provided by all specialist during their stay in hospital (admission area/emergency room – surgeon – anesthesiologist – resuscitation specialist – nurse/nurse's aide). Doctors most often charge for surgical interventions and consultations, while nurses and nurse's aides – for patient care. In some cases, when unit heads manage the entire process of service provision to a specific informally-paying patient, such patient may have to pay for the whole treatment, including diagnostic procedures, counseling, surgery/therapy, care and follow-up observation and treatment after discharge.

Employers' payments to hospitals for non-disclosure of occupational trauma cases among their employees deserves special attention: *"Factories pay a lot for our intended failure to officially report occupational trauma cases. Otherwise they would have to pay enormous sums. They pay for their employees' treatment and they also pay some substantial extra money. We use the latter to purchase equipment, renovate premises, etc."*. The money in question is transferred to the hospital on a legal basis (as official factory's payment for its employees' treatment). However, some part of that money is a payment for that hospital's participation in an illicit deal.

Out-of-pocket payments at outpatient settings are made for:

- Diagnostic examinations delivered out of turn (without waiting in line);
- Appointment with physician at a time convenient to the patient or after hours;
- Physician specialist's visit to a patient (for acupuncture, etc.);
- Referral to other health provider;
- Being put in a day hospital;
- Surgical intervention;
- Dental services;
- Massage;
- Physiotherapy;
- Issuance of a sickness leave certificate in the absence of medical indications;
- Issuance of "medical passports" and driver's health certificates;
- Accelerated issuance of papers needed for getting a voucher to a sanatorium/resort.

Most frequent informal out-of-pocket payments in outpatient clinics are those for the issuance of sickness leave and driver's health certificates, as well as for out-of-turn medical examinations.

Informal payments to laboratories are rare both in hospitals and outpatient facilities. Also, no monetary reimbursement is provided by patients to catchment area (community) internists, eve doctors and ENT physicians.

2.4.2. Causes of informal payments

Why do health professionals accept money from patients?

The reasons why health professionals take their patients' money are:

1. Low salaries
2. Unregistered cash is more attractive than what it left for physicians after patients pay for services legally (to a cashier);
3. Incoherence between officially-set prices for services and physicians' perception of their true costs;

1. Low salaries are recognized as the main cause of informal payments by most respondents. Here are some of the many statements on the matter: *"There is no other way out. We have to survive somehow. And you can not survive when your monthly salary is 2,000 rubles [$62.5]"* (a surgeon of an urban hospital).

Many respondents point out that informal payment practices emerged a long time ago as a response to low physician salaries - one of the fundamental principles of the Soviet health care system. Informal patients' payments "have been there since Semashko times. It is Semashko, the first Soviet Minister of Health, who said: "There is no need to pay good salaries to doctors, because doctors will always be able to provide for themselves". This sort of ideology was planted then, and it exists now, but in a slightly changed form". These Semashko's words were mentioned by many respondents. "This miserable salary is nothing but humiliation. My parents and grandparents were doctors. When I decided to apply to a medical university, my mother said: "Maybe a life of a Russian doctor will change for the better some day…" (Deputy chief doctor of an outpatient clinic). Most physicians feel humiliated and react strongly to accusations of accepting payments for services that are supposed to be provided free-of-charge.

Informal payments act as a tool that physicians use to compensate for what the government fails to pay and a means to level out the differences between the health professional community and better-paid categories of public employees. Physicians often compare themselves with: 1) poorly educated but overpaid young people; 2) public bus drivers and; 3) physicians who practice abroad.

"As soon as physicians start getting more or less decent salaries, informal patients' payments will become history, - said a department head of an urban hospital, - What is happening now is a shame. You study 6 years, then you do your post-graduate training, internship, become a Ph.D. Then you spend so many years in practice, and there comes a boy, who has just graduated from school, or even failed to finish school, and he receives a lot more money than you do". A unit head of a different hospital says the same: "We admit patients with mobile phones, and those patients are young boys…. I have been working as a surgeon for the last 20 years, and I can not afford a mobile phone… You ask you patient: *"You have a cellular phone. Where do you work?" He says: "I don's actually work anywhere. Sometimes, something, somewhere at the flea market…" I am sorry for our health professionals. I have nothing against a CEO of a huge factory getting a normal salary. But when a plumber or a loader at a brewery gets 10,000 rubles a month [$300], I start feeling that inferiority complex"*.

According to physicians, it is unfair that their salaries are lower than those paid to tram or bus drivers. *"When you see a notice in a tram inviting a tram car attendant with a monthly salary of 5,000 rubles, and compare that with 1,700 rubles you are getting after all these years in school and university… "* – complains an internist from a district hospital. *"Everything boils down to the salary. Judge for yourself: a bus driver gets 3-4 thousand rubles a month [$93-125], and an experienced physician's monthly salary is 4 or 5 thousand. But services they provide are so much different. That's it. This is what causes informal payments"* (a unit head of an urban hospital).

Some physicians compare their salaries with what is earned by their Western colleagues. *"When we are talking with our Western colleagues at international symposia, we feel embarrassed when they get to know how much money physicians make in Russia. A striking difference"*. It should be noted, however, that many other professional groups in Russia complain about low salaries, and that such complains can not be considered as a serious justification for informal (AKA illicit) payments. You can not expect a nation with a low per capita GDP level to pay the same salaries to its public employees, as are paid in a more prosperous country. It is important, however, that comparison with western colleagues tempts qualified Russian physicians to at least reduce that gap by way of accepting cash from patients.

2. Direct payments from patients are much more attractive than those made legally through a cash register. Lets consider an example given by one of our respondents. A patient who – for some reason – can not get a referral to a given hospital, or who does not want to wait for months on end for a free-of-charge surgery, but who can pay for immediate hospitalization, is sent by a doctor to the hospital's accountant's office. There they say that the cost/price of the needed treatment will be 10,000 rubles. Then, the surgeon who will be operating the patient, says frankly: *"If you decide to pay officially to the cashier, you will have to pay 10,000 rubles. If you decide to pay me directly, your expenses will be reduced to 5,000 rubles. Chose what's better for you…"*. If the patient is paying with his own money, he will certainly prefer the latter option. The surgeon, on the other hand, will receive more money than he would have received had the patient paid through the hospital's cash register. Moreover, the patient will be sure that not only he was lucky to save his personal money, but he also managed to get the surgeon interested in providing a better-than-average service. Thus, the informal out-of-pocket payment became a mutually-beneficial form of interaction between the patient and the doctor.

Informal payment practices are based on doctors' and patients' common interests. Doctors get too little money under official fee-for-service arrangements, and patients save their money by paying directly to doctors vs. paying legally – in accordance with the institution's formal price list - through the cashier's desk. Many doctors/physicians say that they take into account each patient's ability to pay. This is a compromise between underpaid health professionals and pauperized patients.

3. Informal out-of-pocket payments are made by a patient when this or that intervention involves the use of the latest technologies, and doctors believe that the price set for that intervention by hospital administration is much lower than its market price. Prices charged for the same services in Moscow or in the West are often used as a reference.

Informal additional incomes are viewed as:

- A way to decently reimburse high-qualified physicians/doctors;
- A source of funds to purchase new necessary instruments, equipment s and disposable materials;
- A source of funds for professional improvement (professional education/training, participation in conferences, workshops, etc.).

By and large, informal payments have become a forced measure for most health professionals who have to face realities of the transitional period. It would be a mistake to accuse health professionals of being the cause of the high prevalence of such payments in Russia. The main causes are: lack of public funding and patients' willingness to pay for more attention, less fear, etc.

Why do patients make "under-the-table" payments?

Why do patients prefer to give their money directly to health professionals, rather than paying through the cashier's office? Health professionals give the following answers:

1. Patients want to get services of a higher quality, or more services than are guaranteed by the government as the free health benefit package.
2. Patients want to get treatment at health care facilities and from physicians they trust more than those they are assigned to.
3. A patient may require a service that is not available neither for free, nor under legally-established fee-for-service arrangements.
4. Patients want to reduce the time from referral to procedure/hospitalization.
5. In some cases, an amount the patient pays to his doctor is less than what he would have to pay through the institution's cashier's office.
6. Patients want to thank doctors and nurses for successful treatment.

Let's discuss the 6 reasons in detail.

1. Informal payments are viewed by patients as a means to obtain sufficient amount of services of appropriate quality. According to respondents, *"many patients think that if services are free of charge, they must be of bad quality. They believe that payment is a kind of quality assurance"*. *"Nowadays, many patients think that free-of-charge treatment is a waste of time. Doctors make use of it"*.

Payments to doctors and nurses *"lift patients' concerns about the quality of free-of-charge health care"*. *"Patients pay because they expect that that will make their attending doctors be more attentive to them"*. It is a payment for more attention. *"Patients want doctors to care more about them, especially in hospitals"*.

Informal payments can also be made for a comprehensive set of additional (unplanned) diagnostic procedures.

2. A wish to get high-quality services makes patients go to health providers recommended to them by their friends, physicians, etc. However, the choice of public health care facilities that provide free-of-charge services is very limited for many patients. For example, regional teaching hospitals that, as a rule, have the best equipment and specialists, must admit and treat patients from rural areas (referred by district hospitals). On the contrary, residents of a region's capital who want to get inpatient treatment at the regional hospital, must either pay for it officially (through the hospital's cashier's office), or make an "under-the-table" deal with someone who can arrange for it. A patient who resides in the region's capital has to pay *for "getting entitled to treatment at the regional hospital. He could have obtained a referral to any other [lower-level] hospital. But he came here, to the regional hospital. And he want to be served here and by this specific surgeon. And the patient offers the money himself to get hospitalized"*.

"Any surgical intervention is fraught with death or serious complications. The risk is high. If I ever become a candidate for surgery, I will go to a doctor whom I know. And I will pay for being operated by a reputable doctor".

Informal payments exist because *"each patient a priori tends to go to "his" doctor. No surprise, that the whole world is shifting towards general practitioners/family doctors"*. Chronic patients pay, because *"they will have to spend a lot of time with their physicians. They know by experience that treatment effectiveness directly depends on how comfortable they feel with this or that doctor. They really become attached to good (as they think) doctors. They understand that the quality of medical service means much more than just doctor's professional skills and knowledge"*. Obviously, most patients do not have sufficient medical knowledge to objectively judge about the quality of treatment. However, the difference between the actual and perceived quality is not as important here as the fact that patients believe they can tell "good" service from "bad" service and are prepared and willing to pay for the former.

3. In some cases informal payments may be the only way to obtain this or that service. Care/bedside nursing for terminally ill or immobilized post-operative patients is a good example of that. Two interviewed surgeons made similar statements about care provision to a cancer patient: *"Our efforts and skills will be in vain, if that patient does not receive good care after the intervention. Naturally, his or her relatives ask us to help with that, and so we do"*. *"Who will be*

taking care of the patient after surgery? We do not have specially trained bedside nurses who can provide appropriate care to such patients". "Here … patient's relatives have to find a caretaker and make a deal with him".

4. Patients pay directly to a unit head or a nurse in charge of admission management in order to reduce the time from referral to admission. Also, patients are ready to reimburse relevant specialists in order to obtain a diagnostic procedure without being put on a waiting list.

5. Informal payment for treatment or diagnostic procedures is offered by a patient (or encouraged by a doctor), when, according to established rules, the patient can obtain respective services only by paying for them through the institution's cashier's office. For example, if a patient wants to undergo a diagnostic examination at a hospital without getting a referral from his/her catchment area outpatient clinic, he/she will have to pay for it through the hospital's cash register. However, since a doctor who will be providing the service will eventually get only a tiny portion of that money, he will try to talk the patient into paying a smaller amount directly to him. *"Patients pay through the cash register. But those who do the real work get none of that money. Doctors do not benefit from it in any way. Diagnostic examination costs 300 rubles. The patient will pay me 100 rubles without any cash receipts. It is good for him and it is good for me"*.

6. Finally, patients make informal payments to thank doctors and nurses. As a chief nurse of one of the clinics said: *"Those who are able to pay, will keep paying. When a person feels that they really care about him, he wants to say "thanks". He sees that our job is not an easy one, and he also sees the outcomes. That is why, a simple chocolate bar for a nurse … makes him and me feel good"*. Here is what one of the surgeons said: *"Patients often express gratitude not for a successful operation, but for your care and concern. A doctor who holds his patient's hand and listens without interrupting will get more gratitude than a high professional who demonstrates just a good technical performance"*.

2.5. Prevalence of informal payments for health services

2.5.1. Centers of informal payments in hospitals

Prevalence of informal payments varies across health institutions, departments and units thereof, and depends on a number of factors, including type/modality of service and doctors' professional qualification.

According to most respondents, there are certain units within health care facilities that serve as centers of informal out-of-pocket payments. There are also units, where informal payments are much less prevalent.

Informal out-of-pocket payments are most often made at urban hospitals, including:

- Large multi-specialty hospitals; and
- Emergency hospitals.

Percentage of patients who make informal payments at such hospitals ranges across locations and hospital departments. In the capital of Region A, 20 to 40 percent of patients hospitalized to surgery departments had to pay for services in an "under-the-table" manner. However, only 10% of all patients treated at Internal Medicine departments make informal payments.

In the capital city of Region B, the share of informally paying surgical patients is estimated at 10 to 70 percent. According to respondents, it is virtually impossible for an "ordinary" patient to obtain free services at some hospital departments (e.g. neurosurgery, vascular surgery, thoracic surgery, etc.). They have to pay either officially or informally. *"Our waiting list for free-of-charge surgery is a mere formality. We do provide free services, but only to our staff members, our relatives, our friends. Of course, sometimes such people do something to express their gratitude"*.

The lowest prevalence of informal payments is reported in district hospitals. Doctors in such hospitals also get reimbursed by patients, but such reimbursements are usually made in the form of in-kind contributions. Even the latter become less and less prevalent. *"Rural population is totally insolvent. There is nothing left even from an old Russian tradition to bring food to rural physicians"*. Only several percent of patients served at central district hospitals pay the actual money to physicians.

Informal payments in urban hospitals are most frequently made at several departments listed below:

- Surgery wards that perform non-emergency (planned) interventions and use the latest medical equipment and technologies;
- Neurosurgery and Vascular Surgery;
- Gynecology and delivery management;
- Proctology and Urology;

- STI units.

The lowest prevalence of informal out-of-pocket payments is registered in emergency surgery wards (except for cases when the latest technologies are used), therapy (except for some cardiology sub-specialties), pediatric wards, blood labs and some other units.

This substantial variation in the prevalence of informal payments should be taken into account in order to avoid biased assessments of the situation as a whole.

Informal payment centers: Surgery, Gynecology and Urology

Most respondents, including health care administrators and managers, agree with that informal payments are most frequently made in surgical wards. There is no consistent explanation for that, but majority of our respondents attribute it to patients' willingness to pay for visible and fast treatment outcomes. "the lion's share of informal payments are made in surgery … People are more willing to pay for surgery than for therapy" (a health official). Another respondent said that surgical intervention *"is perceived as a fast solution to your problem. The patient sees: an hour ago he had hernia, and now it is gone. A cardiologist or rheumatologist makes you swallow pills, but how much time will it take to get cured – only God knows. To this effect, surgery is a one-off thing: they remove something and sew you up. You have a broken leg – they just fix it. Russians have preserved this in-born feeling of gratitude to surgeons"*.

However, informal payments are not distributed evenly among various types and modalities of surgical services. Respondents note that emergency surgeons are less pampered by patients than their colleagues who perform planned interventions. That is why emergency surgeons are the poorest of all surgeons in Russia: *"This is true in any country. Emergency surgeons are the poorest surgeon class. An emergency surgery unit is a crazy place where patients deceive doctors. They promise to pay, but never actually do that, when the operation is over"* (a surgeon). Nevertheless, even emergency surgeons find ways to get some money from patients (e.g., for transferring a patient to a less populated room). However, solid cash is paid less frequently to emergency surgeons, since neither the patient, nor the surgeon have enough time for negotiations.

As far as distribution of illicit revenues among surgical team members is concerned, the smallest share usually goes to anesthesiologists (although it also depends on the surgeon's personality and behaviors practiced in each given team). One of respondents indicated that a new practice had been introduced by patients – to remunerate all surgical team members in order to minimize the risk of negligence. That opens new windows of opportunity for anesthesiologists: *" Anesthesiologists, resuscitation specialists and diagnosticians are the least pampered people in the team. They see a patient who had already been brainwashed and handled at all previous stages (at admission, then in a somatic department). Anesthesiologists believe that they are being deprived of their rightful share. The patient falls asleep on the operating table, then he wakes up in his room. Whom should he be grateful to? However, a new stereotype has emerged : "everyone should be reimbursed: surgeons, a unit head (for a decent room), anesthesiologists, etc."*

Informal payments are also very prevalent in Gynecology, Maternity, Urology and Proctology. Respondents attribute it to "tradition". However, payments in Gynecology may as well be caused by other reasons. Here is an explanation given by Head of Cardiology of an emergency hospital: *"Most patients in maternity hospitals or Gynecology departments are young women. The risk of complications is high. What would not you do for your beloved wife or fiancé? Surgeons in Gynecology or Maternity assume a lot of responsibility, and patients always have preoperative fear. I realize that myocardial infarction is not an easier thing, and hospital mortality rate is high. But fear of surgical intervention is stronger anyway. And that fear is probably justified. They want to be operated by the best surgeon, and you have to pay for choice"*.

STI and urology patients in Russia have always paid for treatment. This "tradition" is so old that it has never been broadly discussed. However, respondents admit that the frequency of informal payments for STI and urology services may be even higher than that for surgery. "*Venerology and urology have become even more commercialized than surgery. Maybe 20, 40 or 60 percent of all surgeons accept money from their patients. But if you take venerologists, you can be sure that no less than 98% of them charge patients directly. And the 2 percent are those whose professional level is so low that they do not have the guts to ask for money. Same is true for urologists, because they treat sexually transmitted diseases. No one doubts that treatment for such diseases should be paid for"*.

According to more than 50% of our respondents, informal payments are also concentrated in specialized or tertiary departments of large urban hospitals (e.g. Neurosurgery, Vascular Surgery, Trauma). *"Tertiary clinics are leaders in the shadow health care market. All urban hospitals, especially those that must admit both urban and rural patients, have specialized departments. Let's*

take hospital X with its Trauma. That department performs the most difficult operations. In that hospital, patients start paying as soon as they cross the threshold. They even have developed an unofficial price list for hospitalized patients. Informal payments are especially prevalent in hospitals where monopoly-type specialized or tertiary wards (like Thoracic Surgery, Neurosurgery and Cardiovascular Surgery) are located. Patients have no other choice but to go there. Most informal payments are made at surgical units".

Patients' preparedness to reimburse brain surgeons is explained not only by tradition, but, also, a better-than-average economic status of most patients who require brain surgery: *"From the top of my head, neurosurgery is the place where most of the money is accumulated. Most victims of street violence are wealthy people. The combination of trauma and ability to pay causes informal payments".*

Emergency orthopedic surgery also leaves room for out-of-pocket payments. *"Emergency orthopedic services differ"* – sass a surgeon – *"You can connect the broken bones using regular devices and materials. Or you can use some latest state-of-the-art devices. In the latter case it is not a shame to ask the patient to pay. Both interventions are defined as "emergency orthopedic surgery", but the second one is more attractive to the patient".*

Some respondents name Oncology as a center of informal patients' payments. They say that cancer patients have to pay not only for drugs, but for diagnostic and physician services as well. They also pay to get more of physicians' attention, as the fear of cancer is high.

About 25% of respondents believe that high prevalence of informal payments in hospitals is associated with patients' whish to reduce the time of treatment or to bypass the waiting list. *"The longer the patient has to wait for an operation or procedure, the more likely he or she will try to pay for being served out of turn. If you want to get served faster, you have to pay".*

Informal payment centers are a result of a range of factors, such as tradition, patients' preparedness and ability to pay, physicians' qualification and time considerations. Results of the study allow to conclude that preparedness of patients to pay depends directly from how much they fear for their lives. That is probably why patients more often tend to pay surgery vs. therapy.

Why therapists, cardiologists and pediatricians are poorer than other doctors?

Our research allows to safely assume that Internal Medicine (Therapy), Cardiology, Pulmonology and Pediatrics are hospital wards where informal payments are least prevalent, although doctors of these specialties do accept patients' gratitude in the form of candies, chocolate bars, a bottle of Champaign or wine.

Why is it that such important services have been passed by "new processes of health care commercialization"? First of all, ms most respondents insist that *"informal payments in therapy are rare"*. Interestingly, internists were almost unanimous in their explanations, while surgeons had sometimes opposite interpretations of the situation.

Interviews with internists demonstrate that they clearly understand all the drawbacks and deficiencies of the current situation in health care, but that does not seem to motivate them to "extort the money" from their patients. Some of the interviewed internists and pediatricians said that they did not want to charge patients, because they did not want to break a long-standing tradition, according to which physicians of those specialties had never been decently reimbursed for their work and had become accustomed to it, or found other ways to compensate for low salaries. In many cases, internists make their ends meet only due to their relatives and spouses: *"I have been working as an internist all my life, and I have never peeked into surgeons', urologists' or gynecologists' pockets"*, an experienced pulmonologist said, - *"There are people in my profession who live better than I do. But most of such people are supported by their spouses. I can afford to continue working in health care, because my husband is a railway official. Internists in this country have never had decent salaries. …But I would like to start getting more than I do now. All these sops humiliate physicians. I want the government to treat me with due respect "*.

Many respondents hope that the government will sooner or later start doing something to improve their financial situation. This shows that this professional group does not necessarily want to live under new unspoken laws that compel public employees to provide for themselves.

This protracted waiting for the government's help is complemented with adherence to moral and ethical norms demonstrated by overwhelming majority of internists: *"I have never accepted a penny from my patients, that is why I can not say what the prevalence of informal payments is. It is a matter of principle. I never take money from patients"*, - a therapist said, - *"I refuse even when they insist. This is the way I was brought up. Well, they do bring candies or flowers, and you can not refuse to accept such small gifts. I do not know, but I assume that physicians do accept money from patients.*

That depends, as I think, on a given doctor's personality. I do not blame other doctors for accepting informal payments. But I can not do that. This is how my mom taught me".

In addition to personal ethical paradigms, there are group norms that sound as follows: *"We are not accustomed to accepting payments from anyone"*. Moreover, altruistic motives among pediatricians, internists, cardiologists remain to be strong. Instead of asking patients to pay, some physicians even buy necessary drugs for patients for their personal money, when the situation becomes desperate: *"Before a took my current job at a private clinic, I was a head of department at a regional pediatric hospital",* - says a pediatrician, - *"we used to admit extremely poor people from rural areas. What could they offer to their doctors? Nothing. One of the reasons why I decided to quit and start working in the private sector was that my hospital was experiencing terrible shortages of everything. It was terrible. Our doctors had to buy drugs for severe pediatric cases".*

Many surveyed internists believe that the low prevalence of informal out-of-pocket payments in their field is as result of that majority of their patients are poor retired people, who – even without payments to physicians – are compelled to buy drugs, droppers, etc. there is no money left to reimburse physicians: *"Our patients can not pay anything to us, because they don't have the money. They spend a lot for drugs and other things, and there is nothing left to pay us. They have to buy everything: syringes, droppers, solutions, drugs, even aspirin and nitro, because we do not have any of those things in stock. We can only provide emergency services within the first 24 hours, Then patients have to pay for everything. We do not even have cotton and dressings. Patients have to pay a lot of money even without paying to us. We totally understand that, because we are poor people too".*

Interviews with internists and pediatricians show, that compassion for patients in this professional group remains one of the key factors driving physicians' behaviors. That is why we can trust our respondents when they say that the prevalence of informal patients' payments in Therapy wards is low, and that such payments are made by patients only when they really can pay: *"There are payments, but they are minimal. Most patients do not give bribes. Patients express their gratitude by giving us chocolate bars and candies. Payments are minimal. That's why there are no unspoken norms regarding such payments. If the patient wants to do something (pay money) to thank his physician, he goes and does it. But if he does not have the money, how he can "remunerate" his physician? A simple "thank you" is enough for my physicians. There are no established norms or rules for informal payments"* (a head of hospital department).

Internists say that there are three main reasons for the low prevalence of informal payment practices in their professional field:

1) insolvency of their patients;
2) tradition, a habit to "keep it low profile" and live a modest life;
3) unwillingness to take a risk of being caught;

Despite high ethical standards that exist in this physician group which allow them to say that "therapists are more decent people than surgeons", some respondents' statements indicate that internal ethical censors play an important, but not a decisive role. It may be assumed, that further evolution of informal payments is being impeded by patients' insolvency, rather than physicians' reluctance to accept such payments, although physicians' behavioral models (which will be discussed below) do play a certain role in this process.

A vague disappointment with the fact that patients do not realize that therapists also need to be paid could be heard in some respondents' statements. However, that slight disappointment would quickly give way to justifying reasoning: *"Our patients think that their hearts or lungs do not deserve serious attention. We say that asses cost more: they are prepared to pay a lot of money to get their piles treated, and they never pay to treat myocardial infarction. It may be that our patients are older people, and they do not realize how physicians live nowadays; they are used to getting everything for free. Moreover, all our physicians are women – no men at all".*

A unit head of a district pediatric hospital was more explicit in describing her feelings about ingratitude of her patients' parents: *"There can be no informal payments in my hospital. What are they supposed to pay for? No one even offers the money to us. We treat all our patients in the same way. We are responsible for all of them. They do give us chocolate bars sometimes. But rarely. Very rarely. When a child is being treated, everyone understands – he or she must be treated well without any gifts. On March the 8th [International Women's Day] I did not receive any chocolates at all. It is depressing, but what can you do? ".*

Does that mean that internists and pediatricians never accept money from patients? Analysis of respondents' answers shows that patients' payments for non-surgical services are often made in the form of "sponsor's assistance" (e.g. gifts to units and items for facility renovation). Moreover, such gifts are encouraged by hospital administrators and unit heads. One of our respondents said: *"I worked as an outpatient pediatrician for years, but patients have never offered me money. Then I joined a*

pediatric hospital. That hospital's director was caring so much about his hospital, that he would usually say to the parents of a hospitalized child: "I will do everything I can for your kid, but what can you do for the hospital? If you can donate flour or cereals, please do. Or you can give the hospital some money". This is normal, at least the hospital could function somehow". By the way, this fits the "paternalist expectations model" so often mentioned by respondents from this professional group. Maybe that is one of the reasons why they often complained about the lack of attention on the part of hospital administrators, saying that *"most hospital administrators are surgeons who just do not care about cardiology or internal medicine"*.

Nevertheless, administrators clearly realize that internists' incomes are miserable. However, according to the former, that is happening not because internists are too decent to accept patients' payments, but is a result of inertia and lack of flexibility that precludes them from getting even what they can get officially: *"The poorest people in hospitals are internists"* – says an urban hospital's chief physician (director), - *"There are two reasons for that. Internists are very inert. They can not or do not want to react to changes like surgeons do. … It is difficult to rock them. Most of them are women (except for a Therapy unit head). They go to work every day. They work one or two extra hours every day. They are very attentive to their patients. But they do not want on-call duties, night shifts or chargeable services. They want us to leave them alone. Probably, their husbands support them financially. They are satisfied with what they have. Sometimes patients give them flowers or a bottle of wine, and they think: "OK, that's enough for us, why bother changing anything"*.

However, the "effort minimization strategy" which the chief doctor is referring to, is not shared by all hospital-based internists. Rather, a stratum of physicians is being formed who believe that internal medicine is a *"mother of all sciences"*, and that internists should be guided by the same economic rules as those used by surgeons or gynecologists. Moreover, representatives of this newly-born group believe that patients do not pay therapists not because there is no such tradition, but because most therapists' professional qualification does not deserve any additional remuneration: *"My official salary in 1,800 rubles a month. But I actually get up to 10,000 rubles due to informal patients' payments. Knowledgeable clever internists are capable of making their ends meet by accepting cash from patients. When something starts aching, the patient goes to a generalist first. If he sees that the generalist is a good one, he tells his family and friends. And informal payments is such situation are justified, because we ought to start getting decent wages. My husband is an economist. Why should he get more than I do? Both of us are public employees with the same level of education. So, why should I receive less than him? I am charging patients for my professional qualification"*.

Thus, well-educated generalists start realizing what their true value is. And that realization makes them behave in a way that compels even patients with "limited financial abilities" to pay, thus breaking the long-standing norms. It can be assumed, that the days of non-payments in Therapy and Pediatrics are numbered. It is likely that 3 or 5 years from now free-market-oriented types of behavior will become very prevalent in internists' community, which will imply "everything has to be paid for". Non-market-driven practices will become rare or non-existent.

To summarize, the evolution of informal revenue-generating practices among internists and pediatricians is currently impeded by still-prevalent non-market behavioral stereotypes and low population's purchasing capacity. No interference with informal payment practices will allow to preserve the current situation for some time, but in 3 to 5 years, as physicians will be increasingly testing high risk behaviors, informal out-of-pocket payments in Therapy and Pediatrics will become as prevalent as they are in other specialties. Currently, patients may refuse to pay only because it is still possible. As soon as physicians offer new "free market norms", patients will have to start paying.

2.5.2. Informal payments in outpatient settings

According to available data, informal payments in outpatient settings are less prevalent than in hospitals. Only one respondent, a polyclinic-based diagnostician, estimated the share of informally paying outpatients at 10 to 20 percent. "Outpatient clinic is the poorest place", - exclaimed one of our respondents, and his opinion was shared by the majority of outpatient and hospital-based practitioners.

There are several reasons why informal payments in outpatient clinics are rare. First of all, municipal outpatient clinics mainly serve patients who are unable to pay. According to outpatient clinic staff, more than 50% of their patients are retired people, who can hardly afford to purchase vital drugs, let alone informal payments: *"People are pauperized. The level of personal income in my district is low. See for yourself: all the corridors are crowded with old women and men. Do you know what their retirement benefits are? What can you possibly take from them … Large central outpatient clinics have more patients who offer those envelopes with cash, because people who go to such clinics are generally*

wealthier. Some of our staff physicians would like to be reimbursed, but there is no way patients can afford it".

Patients with money do not like municipal polyclinics because of long lines, comparatively low professional level of physicians who work there and obsolete diagnostic equipment and prefer to go to private practitioners or private or public outpatient clinics that charge fees officially.

According to polyclinic administrators, most polyclinic-based physicians are people who - for some reasons - have failed to find better-paid jobs at more prestigious institutions and who are afraid of loosing their current jobs. Most of them are older people who sincerely believe that "it is too late for us to change our principles", that is why they tend to get small salaries and accept gifts from patients (candies, chocolates, bottles, etc.), but are unprepared to take the risk of loosing their reputation and job for additional revenues. This risk-evading strategy is intrinsic to most polyclinic-based physicians and municipal polyclinics in general. That does not mean, however, that internal limitations apply always and to all polyclinic-based practitioners.

According to both outpatient and hospital-based physicians, polyclinics also have "crystallization centers" of informal patients' payments. Like in hospitals, informal payments at polyclinics are mainly made in Surgery and Gynecology: "Surgery is the hottest place in the polyclinic. Out-of-pocket payments in Gynecology also exist, but they are less prevalent". Outpatients also pay for dental services, therapeutic massage and acupuncture. "Dental services in public outpatient clinics have never been controlled too much. That is why informal payments to polyclinic-based dentists have become a tradition". Outpatients can also be charged for diagnostic procedures.

2.5.3. Physicians' professional qualification and informal payments

The highest chances of being reimbursed by patients belong to:

- surgeons who have an access to unique technologies and have no serious competition;
- experienced doctors with the best track records;
- unit heads, professors, Ph.Ds and physicians with a "highest physician category" status;
- doctors who have good relations with hospital administration and respective unit heads;
- doctors good at negotiating with patients and building their own image;
- doctors who know how to "beat the money out of the patient".

All doctors accept payments from patients when the latter offer them. In the course of survey we encountered only one practitioner who had never accepted "patients' gratitude". She was a surgeon "of the highest category" and – according to her colleagues – an excellent specialist in the field with the monthly salary of 1,800 rubles. Single, no children. On one occasion she mailed the money given to her by one of her patients back to him. She also donated a microwave oven (presented to her by another patient) to her hospital. Her colleagues consider her "a strange person".

Young inexperienced doctors (except for those who know "how to behave with patients") have the lowest chances to be reimbursed by patients.

Do more experienced and better-qualified doctors receive money from their patients more often, than their less experienced colleagues? The answer is not as obvious as it might be. According to most respondents, a correlation between physician's professional level and his image does exist. A doctor who has managed to build his image, and who has an access to unique equipment and technologies, has more chances to get reimbursed by patients. Hospital administrators usually favor such specialists and are prepared to shut their eyes to the fact that money is being illicitly paid. Administrators reasonably believe that it is better "not to notice", than to loose an excellent and popular employee. Moreover, there must be someone capable of serving high-ranking patients (like regional and municipal officials and their relatives).

As a rule, hospital unit heads recognize "the star's right to do more than is allowed to ordinary people" and can not control them. In most cases, such doctors have good relations with hospital administrators and are being patronized by the latter. One of such "unique" specialists said: *"As long as the head of my hospital needs me (and he needs me because I can do operations that other surgeons can not do), they (my colleagues, unit head, nurses and others) will keep their mouths shut"*.

More than 75% of all interviewed experienced doctors and unit heads are convinced that acceptance of informal payments by experienced and "unique" doctors is absolutely justified. *"Unique doctors are rare. They must maintain their skills all the time, because it is not easy to become a famous doctor. You have to earn your name and professional reputation. For example, surgeon X had to sweat a lot to become what he is now. Unlike other doctors, he would come to the hospital at 7 a.m. every day. He has received a large dose of radiation, because he has always performed X-ray examinations for patients himself. He never relied on anyone else, he would do everything himself. It took him a long time to learn things. He gradually achieved a certain level. Of course, now he has an access to*

expensive equipment. Once you get an access to a new technique, you start growing fast. All doctors who have an access to good medical equipment are very wealthy people. But it is the government who had contributed to their current economic status. Sometimes they forget it".

Surgeon X himself agrees with that highest-qualified doctors have the moral right to accept informal payments from patients, at least because someone should compensate them for work overload: *"You take money from your patient for a better-than-average performance. When I'm operating, I'm not looking at the patient – I'm looking at the monitor. I've been operating for the last ten years. I feel that my eyesight is deteriorating. Why should not I be paid decently for that? Why? Why should I suffer from providing good services to my patients? They should support me too. My health is a valuable thing. In theory, I can refuse to continue performing such operations. I do not think that there are surgeons who could be doing such operations for free…. The hazard should be somehow compensated for. The government does pay for hazardous extra work, but it pays a couple of miserable pennies. It is easier for me to do open surgery, but it is worse for the patient. And it is bad for me to look at that monitor all the time. Why is it that I must thing about the health of my patients all the time, and they do not think about mine?"*

Even when respondents speak about experienced doctors (not "super unique" ones), they justify patients' informal payments; Arguments for the latter look as follows:

- experienced doctors should receive a decent remuneration for their knowledge and skills, for using high-tech evidence-based techniques and for the fact that they have already earned their professional reputation;
- experienced doctors have sacrificed their health and a lot of effort for their patients;
- complications and adverse reactions are less prevalent in patients served by experienced doctors;
- experienced doctors do not often extort money from their patients.

Often times, experienced doctors have to rectify mistakes made by their younger and less experienced colleagues. It is that that patients' relatives are prepared and ready to pay for. However, younger doctors do not always ask patients to pay, even when they can do so: *"When there is a broken leg, you can just do a temporary bone reposition, or you can use Yelisarov device, but that will cost you. But only an experienced orthopedic surgeon can do it right. That is why experienced surgeons have more opportunities to earn patients' money, despite the fact that it is a public hospital that has taught them to use such technologies. Sometimes younger surgeons summon a more experienced colleague to do something for the patient for a fee"*.

As compared with their younger colleagues, experienced doctors have more means to form their own clientele, even when they get a new job and have to start almost everything from scratch: *"Even if a get transferred to another ward where most doctors are young people, that will not mean that I will start eating their share of the pie. At first, no one would be coming to me. But I will do everything to develop my own client base. Because experienced doctors always get more money than the young ones. Young doctors must be more active. Anyway, to start earning money you have to earn your own clientele. Young doctors have less connections and successfully treated patients who could recommend them to other people"*.

Most respondents agree that younger doctors have less opportunities to be paid by patients. Without experience and clientele, younger health professionals have to do something in order to improve their bleak financial situation. According to respondents, two opposite strategies are used by young doctors. Some of them are trying to compensate the lack of professionalism by actively extorting money from patients (at any price). Others tend to grow professionally in order to obtain the same unspoken right to charge for services, as more experienced doctors have.

The former strategy is more or less common and is strongly criticized by experienced doctors. *"Youngsters come in and want to get 5 or 10 thousand a month immediately. They say: look at how doctors live in America! But what can they provide in exchange?"* (a professor of medicine).

Most other respondents expressed similar views on the matter: *"If an inexperienced youngster slips in, performs an operation and gets money for that from the patient, I will smash him, or the Chief Trauma Specialist will. The only thing you get from such operations is complications"*.

However, some respondents said they could "understand the younger generation". It is younger practitioners and advocates of the they-have-to-learn strategy who said: *"Yes, young people are more active in asking patients to pay. That is because they do not believe that they will ever be adequately reimbursed for their knowledge and skills by the government. So, they prefer to extort the money in advance"*. Some of respondents believe that that sort of behavior is a result of the economic changes: *"Older doctors still don't know what to do in this new economy, but younger professionals know it perfectly well. They are not very well educated, but they know a lot about those new economic relations. Should we really blame them for that?"*

Younger doctors who prefer to grow professionally (according to respondents, about 50% of young doctors belong to that category), do everything to obtain professional skills which in the future will allow them to earn professional reputation. Moreover, young doctors try not to violate the norms accepted by most of their colleagues: *"We have a well-knit team of professionals in my department. Even young doctors who have been in practice less than 5 years want to learn and grow professionally. There are no young doctors in my team who could take money from their patients. Such things do happen among surgeons. Sometimes they do a simple thing and then ask the patient to pay an outrageous sum. Such things are not practiced by among my team members"* (urban hospital's deputy Chief Doctor).

Career-oriented younger doctors may also have a wish to accept informal payments, but are prepared to wait till their professional level will allow them to provide real value for patients' money: *"Many young doctors want to earn money as fast as possible. They do not have enough professional experience yet, but still accept informal payments from patients. Are they starving to death? Are they more hungry than their patients? The smartest ones realize that they must earn their reputation first. And they totally devote themselves to it. With time, such people grow into good professionals"*.

2.5.4. The size of health professionals' "shadow" incomes

Respondents were asked to provide their estimates of the ratio between officially-paid salaries and revenues generated from informal patients' payments in their or other hospital wards. Respondents who admitted to have received informal payments were also asked to provide information about amounts of such payments. Obviously, data provided by respondents can not be used to give reliable conclusions about the scope of illicitly-generated revenues. We will give one example:

Moderator: "One head of elective surgery department said that his total monthly revenues (including informal payments from patients) did not exceed 5,000 rubles (150$). Is that possible?"

Respondent: "Well… He has two cars. Some time ago one of his cars was stolen. Next day he went to a car dealer and bought a brand-new car of the same model".

However, available data allow to make general judgements about the order of figures involved. As the interviews have shown, the size of illicit payments varies substantially across specialties and doctors of the same specialty. One of our respondents said: *"There are surgeons and there are surgeons. One can get 1000 rubles and be grateful. His colleague may return 1000 dollars back to a patient and say: "Sorry, give me the real money". Some live in a dorm, some have big houses. Surgeons differ in ranks, titles, credentials and ability to advertise their services"*.

Amounts paid by patients to surgeons who have an access to unique equipment and have no competition may exceed the latter's official salaries 5 to 10 times or even more. Due to informal payments, hospital unit heads may receive 3 to 4 times more than what they are supposed to get from the government. Informal revenues of rank-and-file doctors in Surgery or Gynecology are 2 to 3 times higher than their formal wages. Ill-gotten revenues in other hospital departments exceed official salaries by 20 to 200 percent. Hospital nurses' actual incomes exceed their flat salaries by about the same figure. Physicians who work at urban outpatient clinics are capable of receiving 20 to 30 percent more than they are entitled to under the formal rate schedule. Community (visiting) nurses can earn even more than that.

Dentists' "shadow" revenue rates are very high (in comparison with formal salaries). Director of a private dental clinic said: *"When I want to hire a dentist who works at a public clinic, I start by saying: "What is your monthly salary?" – "One thousand rubles." – "How much do you actually get a month?" – "Seven thousand on the average""*.

Amounts paid by patients at rural hospitals are much smaller. According to a central district hospital director, *"we do have informal payments, but not too much of them. A surgeon would probably earn two or three times more than what the government gives him"*. A head of Surgery of a district hospital says: *"Informal payments are one-off things. They are rare and irregular. For the last 2 months I have been working alone, I did about 20 operations, and one of my patients gave me a bottle of vodka, thank God for that. But no money*".

SECTION 3. Rules Governing Informal Payments for Health Services

3.1. Informal payment models

There are five sets of rules governing informal payment provision which will be referred to as "informal payment models". They are:

1. Payments in accordance with unofficial price lists;
2. "Pay as much as you can afford"
3. Extortion
4. Uncoerced payments initiated by health professionals
5. Payments voluntarily offered by patients as an expression of gratitude

Payments in accordance with unofficial price lists

Patients have to make informal payments in accordance with existing "shadow" price lists. Under this model, patient gets informed about the price of required service, and has to decide, whether or not he is able or wants to pay. There is almost no negotiation between the purchaser and provider. The money may be transferred either before or after service provision.

As a rule, patients receive information about existing "shadow" prices from nurses or doctors. In some cases (e.g. in hospital units where informal revenue distribution is regulated) patients may receive price information from the unit head of chief nurse. According to a leader of a health insurance company, patients start receiving such news in a hospital's admission area/emergency ward: "A patient comes in. They tell him in the admission area*: "You will have to pay that much for drugs, treatment and surgery". This is usually said by physicians who work at admission/emergency departments or heads of hospital units"*.

Patients may also receive information about informal prices from other patients. If the patient is self-referred, he gets to know the price of treatment from former patients, who introduce him to the chosen doctor.

Informal price of a given service applies equally to all patients with a given diagnosis who were referred to a given doctor. As a diagnostician said: *"Even when I have to provide a specific service to one of my relatives, and I know that they are able to pay for it, I tell them the price. All my relatives and friends know that they will have to pay for services which are not provided for free"*.

As follows from respondents' answers, there are four ways in which fixed "shadow" rates are set.

First of all, a shadow price for a certain service in a given facility may be set based on that offered by "competitors" for the same service. According to a chief doctor of an urban hospital, *"Certainly, there are established informal prices for services. The level of such shadow prices is more or less the same in all hospitals. Everyone knows, how much will this or that intervention cost. If their price is higher than the average, the patient will go to a place that offers a better price. People know how much various services cost"*.

Also, there are established shadow prices for nursing services. Respondents in the two regions were unanimous in their estimate of the price that inpatients have to pay for a "personal nursing station": from 100 to 300 rubles per day. Nurses *"talk to each other and, thus, know how much does that service cost"*. The price depends on severity and amount of services required by a given patient (i.e., only care or additional procedures). As a unit head of an urban hospital said: *"Patients have to pay 150 rubles per day for a personal nurse in my unit. All of my patients are old people after hip replacement. They are totally immobilized. Our nurses can work both as nurses and babysitters for such patients on their days off. They usually earn about 150 rubles per 24 hours. Surgical nurses charge more – up to 300 rubles a day – if the patient is unconscious or in coma"*.

Informal fixed rates may also be set for other services. For example, patients in one of the districts had to pay a fee of 150 rubles for being referred to a regional hospital for examination or treatment.

Secondly, prices may be set on a competitive basis, but adjusted for facility's level, availability of equipment and physician's qualification. *"Unofficial prices range. They depend on how good the facility is and what equipment that facility has,* - says an insurance company director, - *doctors communicate with each other and know, how much their colleagues in various facilities charge for the same service. It is a more or less permanent circle of professionals, who compete with each other". "Informal rates do exist,* - said another respondent, - *and those rates vary. One doctor may charge X rubles for a procedure, and his colleague usually takes Y rubles for the same thing"*. A doctor from a central district hospital confessed: *"There is a price list for patients who want me to be their surgeon… Usually, a regular operation costs 3000 rubles"*.

Thirdly, informal prices may be set based on those set for officially provided chargeable services. As a rule, "shadow" prices are lower than those set officially.

Payments for endoscopic interventions will be a good example. A unit head of one of the hospitals said: *"A number of endoscopic procedures in my unit are provided for some fixed informal fees. Those fees are lower than the official prices"*. This shadow price-setting mechanism combines formal and informal rules: *"First you send the patient to the hospital's accountant's office. There they calculate the cost of required service. Then the patient can chose between paying half of that sum directly to me, or paying in full to the cashier. That's how we do it"* (a hospital unit head).

The same mechanism is applied to informal payments for patient counseling and diagnostic services.

Fourthly, a price may be set by a doctor based on his or her perception of what a decent remuneration for their service is. *"The price set by a given doctor will depend on his or her actual or desired economic status. They want to achieve or maintain that status (a decent apartment, a decent car, etc.). To do that, you have to have a certain level of income. The price is set based on such considerations"*.

Informal payments based on "shadow" rate schedules are common in all fields of medicine, but are more prevalent in surgery and gynecology. *"Maternity hospitals have unofficial price lists… different friends of mine delivered in two different hospitals, but both of them had to pay"* (unit head of an urban hospital).

Interestingly, this model of informal payments was more often mentioned by respondents in Region A.

"Pay as much as you can afford"

Under this model, the shadow price set by a health professional depends on the economic status of the patient or his/her relatives. The price for the same service is negotiated with each patient separately.

In some cases, the average shadow price, or that from the unofficial price list is used as a reference price, which then gets increased or reduced depending on the purchasing capacity of each given patient or his relatives. No fixed rates are used in this case. The price depends solely on the doctor's guess about the patient's ability to pay. That guess is based on information that the doctor receives from and about the patient (the way that patient looks, talks, the car he drives, the clothes he wears, etc.). *"When you talk to a person, you can tell who and what he or she is, - says a surgeon from a large hospital, - One surgeon said to me: "I can charge an outrageous sum for a minor intervention from one person. But when I see that my patient is a good man, I will take whatever he can pay for a complex operation"*. According to a hospital-based cardiologist, *"There are no fixed rates at all. We look at each person. One patient can give one sum, another one can afford a larger sum"*.

Doctors believe that patients from different walks of life should pay different prices. One of our respondents said: *"Imagine three patients in one room. One is a retired old man, the second is a public employee, and the third is a "gangsta". Two thousand rubles for an operation is a science fiction for the old man. The working guy will afford it. As for the gangster... Well, he goes to a casino and looses thousands of dollars there every day. That's why you can't charge the same price from all patients. You have to look at each patient. Or, take a school teacher… What can you take from him? They, teachers, are even poorer then doctors. At least doctors get some sops from time to time. So, the price of the same service must be different for different patients"*. According to another respondent, a doctor from a large hospital, *"… babushkas are served for free, as well as retired people, students, health professionals, people who work at day care centers.. It is only natural that we take money from patients who can pay. And we perfectly well know who can. It is those people who say that they are unemployed, but park their Mercedes-600s in front of the hospital. Why shouldn't they pay?"*.

This shadow payment model implies negotiations between the doctor and his patient about the price. The price may be set as follows: *"Everything depends on whom I'm dealing with. Sometimes I talk to people, and sometimes they talk to me : "will X rubles be enough?". If the patient offers a specific sum, I agree. You can't say something like "give me more". They pay what they can. Sometimes they ask: "how much do you need?" I say: "So and so". They say: "That is too much". Then I would say: "Then bring what you can. You can pay as much as you think your life costs". Then he pays like 50 or 30 percent of what I said in the beginning. However, it does not matter much to me"*.

A *pay-as-much-as-you-can* model is mainly used for out-of-pocket payments to surgeons, but was also mentioned by respondents in association with nurses' and nurse's aides' services. For example, *"… a patient is immobilized… Every time a nurse or nurse's aide takes away the bedpan, she gets 5 rubles from the patient. But I think that sums paid there are random and irregular. If he has 5 rubles, he pays, if he does not – he is not forced to pay"*.

The model in question is most frequently used in tertiary surgical departments, but was also reported in a cardiology ward of one of the urban hospitals.

The model was more often mentioned by hospital-based surgeons in Region B. That is probably a result of the higher average level of personal income and wider gap between the rich and the poor in that region.

Extortion

Patients or their relatives are forced to pay irrespectively of the actual amount and quality of obtained services or pseudo services.

First of all, extortion includes payments for services that must and can be provided free-of-charge. Examples include: payment for being hospitalized, although unoccupied beds are available; payment for being put in a room vs. corridor, although there are unoccupied beds in rooms, etc.

Demands to *"collect money for bulbs, mops, etc. for the hospital"* may also be defined as extortion.

Another form of extortion is making patients contribute to hospital's charitable fund.

Extortion may be combined with fraud. For example, a doctor may come in, ask patients to pay for services provided by other doctors and just leave with that money.

Uncoerced payments initiated by health professionals

The size of informal payment is not negotiated in advance. In some cases they can mention that the patient will be asked to pay at discharge, but they do not say how much. *"If you want to be treated at our facility/ward/unit, you are welcome. But you will need to do something to thank your doctors or the hospital"*. In most cases, an attending doctor or unit head or hospital director may allude to the need to pay, or ask the patient to pay at discharge. The exact sum may or may not be mentioned, or the patient may be asked to do something for the hospital.

Let's consider examples of this payment model: *"You will have your surgery done, and before you leave, they will ask you to pay this and that". "Everything that you see in my office has been purchased by patients, but you always have to ask or beg for it. They come in and ask for a consultation, I say that I have no time, then they offer something… ". "I have a good washing machine in my ward. It was paid for by one of our patients, a railroad official. He just asked:: "How much do I owe you?" I said "nothing, but we need a washing machine", and he just paid for it"*.

One of the model's distinctions is that a patient can refuse to pay for already provided services. The main reason why patients pay is that they want to maintain good relations with the hospital/doctors to be sure that in the future they will always be able to come to the same facility and be treated decently.

This model is mainly prevalent in large hospitals' surgical wards.

Payments voluntarily offered by patients as an expression of gratitude

The payment is offered and its size defined by patient himself. This sort of payment has two varieties: 1) patient pays before treatment starts in order to get more attention and minimize the risk of being neglected and; 2) patient pays retrospectively for already provided services. In the latter case a gift or money is given to attending doctor/surgeon as a gratitude for a well-done procedure/treatment and respectful attitude.

Payments for the same service may substantially differ in size. *"The same operation may be done for a chocolate bar, a pack of candies, a bottle of vodka or 10,000 rubles"*.

Some respondents reproached patients bringing "traditional" gifts: *"Patients' gifts are so primitive – flowers, wine, candies. We have abundance of all kinds of stuff in supermarkets these days. But they keep bringing candies. I do not eat candies,* - says a deputy Chief Doctor of an urban hospital,

- a small painting for my office would be a much better choice. Patients see it as a mere formality". A surgeon from a large hospital said: *"Each doctor in my ward throws those flowers out of the window. They blame patients for being so superficial. … Some time ago they started bringing cheap cognac. We call it "doctors' death". It is a Greek brand, but the cognac itself is a falsified stuff produced somewhere in Russia. I even saw posters in some hospitals saying: "Beware of cognac X. This cognac is dangerous"*. A unit head from another hospital tells his patients: *"You can do anything, but please do not buy this cognac. If you don't care about 200 rubles, give them to us, if 500 rubles is not a huge sum for you, you can donate that". Because all our refrigerators are totally stuffed with candy bars and bottles of adulterated cognac. We do not need any more of them, but people keep spending their money"*.

Patients who reside in rural areas usually give doctors food that they grow or make (sour cream, milk, eggs, meat, etc.).

The size of payments made by patients to express their gratitude reflects their economic status. However, unlike the pay-as-much-as-you-can-afford model, this model does not imply any negotiations between the patient and the doctor about the size of payment. *"I am convinced that a doctor may and must be remunerated by his patient for good work and human attitude*, - says a cardiologist from an urban hospital, - *there can be no price negotiations. A patient can only give what he or she can afford to give. I will never be able to say something like "you must pay 5 or 10 thousand. If you can's afford 10 thousand, pay 8" to a patient with acute myocardial infarction. I can not imagine myself negotiating like that. What if that patient will be dead in 24 hours?"* A head of Surgery of a large hospital said: *"We perform a lot of surgical interventions. One patient pays, another one does not… There are no preliminary negotiations about the price. You do you work, then patients who consider it possible pay, and those who do not want or can not afford do not pay". "Whether they express "gratitude" or not depends on their financial situation*, - said a head of Maternity of an urban hospital. *– For some people a bottle of champagne is an unaffordable thing. Some people can pay a lot without seriously damaging their family budget. It is interesting that people who earn a lot of money rarely say "thank you". A high-ranked government official will never give more than a bottle of champagne. Even when he is absolutely satisfied with the quality and outcomes"*.

Payment out of gratitude may take the form of a sponsor's assistance or barter. Services provided by a former patient at the expense of his/her organization are especially appreciated by doctors and hospital unit heads. Such services usually include renovation and equipment purchases. Best rooms and unit heads' offices we saw in the course of the survey had been renovated for patients' money.

For instance, renovation of one hospital was sponsored by one of its former patients, an owner of a large beer brewery. Recurrent annual health budget of town N increased many-fold after a mayor of that town had been discharged from hospital, and a piece of expensive medical equipment ($27,000) was purchased for a doctor who had been the mayor's surgeon.

Patients may also do personal favors to their doctors*: "Say, an operation costs 4,000. But I serve him for free. Why? Because for the last 3 years I have been parking my car in his car park. I'm getting a lot more than 4,000 rubles. Or I know that he will be repairing my car. Or it may be that he will be able to renovate my office"*.

Payments out of gratitude in the form of barter services are more prevalent in rural areas. According to a deputy chief doctor of a central district hospital, *"it is a "I do something for you, and you do something for me" principle. Those who do not understand that, have to pay cash. But that happens mainly in regional health institutions. Most of my patients can not pay me anything. But they can help me with something. For example, repair my car, or renovate my apartment, or take care of my kid*".

Patients' payments out of gratitude may be considered as the most prevalent model of informal payments for health care. They can be seen in all types of health institutions. In rural areas such payments usually take the form of in-kind contributions/barter. Pure money is rarely paid. In urban facilities – hospitals and outpatient settings - the model is most frequently used in Internal Medicine and Pediatrics.

Extortion deserves special discussion. Respondents used that word on many occasions to describe what they thought to be unfair/unjustified informal payment practices. Analysis of respondents' answers shows that providers apply the word to various situations, rather than specific payment models. All situations defined by respondents as "extortion of money from the patient" imply that the patient is forced to pay before health care can be provided, but the model of payment used by the doctor is not generally sanctioned by most of his/her colleagues.

Extortion *per se* is not openly supported by doctors. But the word "extortion" may be used by doctors to describe other informal payment models which in this book are defined otherwise. For

example, they may use the term "extortioner" to describe a doctor who compels his patient to pay a specific sum for an operation in advance, although most of his colleagues accept only what patients can offer. On the contrary, in a ward where informal rate-based payment model is commonly used, such doctor would not be seen as an extortioner (or would be called that by personnel of other wards where informal payments are less prevalent).

Do patients have to make additional informal payments after having paid via the cash register?

One of our objectives was to investigate a possible correlation between the prevalence of informal payments and the presence of official provider payment arrangements. According to the majority of respondents, a patient who has already paid through the institution's cash register or has purchased a voluntary health insurance coverage, does not make any informal payments for services. At best, such patients can offer small gifts to doctors (e.g., flowers, a bottle of cognac, a pack of candies, etc.). That is, a payment out of gratitude may complement official payments for services, such as cash payment via cashier's office or voluntary health insurance purchase.

A health insurance company CEO said: *"Sometimes they try to charge additional money from our insureds. But we are trying to curb such practices. We say to our clients: "If doctors try to make you pay for drugs or treatment, call us immediately or go to our representative at the hospital". And the conflict is usually resolved faster than the eye can flick. Sometimes doctors attempt to charge our clients because in some hospitals they do not receive anything from hospital administration for serving VHI" patients. Not all hospitals pay doctors for providing services to privately-insured patients.*

However, according to our respondents, informal payments in excess of what has already been paid officially are made by patients in the following cases:

- The price charged officially for a surgical intervention does not cover that intervention's actual cost; there are wards where *"officially-charged fees are always combined with additional informal payments for surgery"*. Informal rate-based and "pay as much as you can afford" models are usually used in such cases;
- A patient realizes that his doctor will receive nothing from the sum that he has paid officially, and offers him an additional informal remuneration as an expression of gratitude;
- Official payment through the cash register will entitle the patient to the same [poor] quality of service as no payment at all. Example: *"she paid officially for delivery management, but they put her in a room with "free-of-charge" patients, and no drugs are available neither for her, nor to them. If – Lord forbid – she has complications, she will have to pay for the necessary drug"*. If that is the case, all above-mentioned informal payment models may be used.;
- Payments for services that are provided in excess of those officially paid for (e.g. therapeutic massage).

Thus, legal payments for health services do not provide an ultimate protection against additional informal payments. As a head of Surgery at an urban hospital said: *"Currently, privately insured patients do not pay anything. But if doctors continue to receive miserable salaries, they will start forcing their patients to pay"*.

Doctors note that payments in excess of those officially made via the cash register are very common in Moscow*: "Many people who go to Moscow for treatment have to pay additional informal fees to doctors. Even if they have already made an official payment. And they have to pay a lot in Moscow. A friend of mine has had that sort of experience. He officially paid $2,500 for a vascular surgery. He said: "I'm lying in a post-operative ward. An anesthesiologist drops in. I pay him $150. Then I had to give some additional money to my surgeon and even to that nurse who would forget to change my towel…""*.

One can assume that informal payments do not exist in private health institutions, because doctors who work there are much better paid than their public colleagues, and because private facility owners are interested in eliminating such practices. However, informal payments were reported in all private clinics that we surveyed: *"Massage, acupuncture and dental services are uncontrollable"*.

What will a patient receive if he does not pay?

It can be assumed from the interviews, that only some part of patients make informal payments for health services in the surveyed regions. The share of paying patients varies across facilities, but never reaches 100 percent. The question is: do patients who pay to providers receive services of a better quality/quantity, then those who pay nothing?

The majority of our respondents assured us that the quality/quantity of services they provide does not depend on whether or not the patient pays. Here are several typical statements on the matter:

"I always do my job well, irrespective of whether they promise to pay or not. It does not matter if my patient pays 1000 rubles or nothing", - said a gynecologist who had been rarely reimbursed by her patients. *"I will provide treatment even without being paid for it*, - says a resuscitation specialist, - *I don't want to change. I can not just stand there and do nothing, just because the patient can not pay. Most of my colleagues feel that same. But other practices also exist". "A nurse treats all patients in the same way,* - says a hospital chief nurse, - *If a person is ill, you must treat him; if he has high temperature, you must give him an antipyretic, if he is bleeding, you must put him on the operating table and find the cause of that bleeding. It does not matter if he has paid to the hospital or not. In such minutes no one will even think about that"*.

However, respondents' answers to other questions imply that if a patient does not pay after being asked to do so, he or she is taking the risk of:

- not being hospitalized at all;
- being put in a overpopulated room;
- being left without necessary effective medications (the cheapest available drugs will be used);
- getting his surgery done with the use of obsolete techniques;
- getting his surgery done by the least experienced surgeon;
- receiving the cheapest available anesthetic with adverse/negative effects;
- being left without due attention from doctors and nurses.

Several typical answers may illustrate that. As one health official said, *"if a patient can not pay for surgery, there are always "free-of-charge surgeons" to serve him or her. Those surgeons are of low quality. Most of them are young, inexperienced surgeons without clientele. Or very old surgeons. Of course, the operation may be done well. But if not, a patient will pay with his own health. However, even if you pay, you are not protected against substandard performance or negligence". "I think that up-front payments make doctors assume more responsibility,* - says another respondent, - *you unconsciously tend to more for a patient who has reimbursed you in advance"*. One doctor described practices accepted in his hospital's Gynecology: *"A doctor will not give you a single spare minute if you do not pay. I know it, because my mother had to be hospitalized to that ward some time ago. They could not do a single thing for her, until I came to that ward and took the doctor to my mother's room. I know what gynecologists are like, because I am a doctor myself. In Surgery and Gynecology they have some long-standing behavioral norms, and they do not change them even when they have to treat their colleagues or friends"*. To summarize this section, we will give another aphoristic statement: *"If a doctor is forced to live only on his formal flat salary, he will not even come close to a patient"*.

3.2. Redistribution of informal revenues among medical staff

As our study demonstrates, revenues generated from informal out-of-pocket payments get distributed inside each given health institution. Schemes used in a health care setting for distributing such ill-gotten revenues vary and depend on behavioral norms accepted in that setting, level of trust and mutual understanding among the staff, as well as unit heads' and doctors' personal strategies.

3.2.1. Vertical redistribution of informal revenues: do physicians share with administrators?

Chief doctors' and unit heads' participation in informal revenue distribution can not be ruled out, but does not necessarily take place in all health care institutions. Chief doctors (AKA facility directors), their deputies and unit heads practice the following behavioral models:

- They do not interfere with what is going on the lower floors, but react to patients' complaints by penalizing staff members found guilty of taking money from patients;
- They partially govern the process by determining how many patients will be served for free, and how many should pay officially (knowing that a patient officially served at no charge is a potential source of informal payments). They personally manage admission of, and provision of services to every potential sponsor;
- They do not interfere with the process, but get some share of informal revenues on a regular basis.

Majority of our respondents believe that chief doctors do not benefit from patients' informal contributions, as they prefer to earn their share legally - from revenues generated through officially-provided chargeable services. *"Chief doctors have very good incomes due to legally-provided chargeable services. That is why they are not interested in getting their share of illicit revenues*, - said a regional health official, - *Maybe some of them do, but I've never heard of such cases. A chief doctor's actual income can be 3 to 5 times higher then his or her flat salary due to legal chargeable service*

provision. That's because 40% of a legally-generated revenue from chargeable services goes to doctors and nurses, and administrators get 10%. So, he or she does not need to take that additional risk" (one of respondents).

As a rule, chief doctors (CEOs) of large urban hospitals – due to their high social status and connections – own businesses or have their own patient clientele. Most of them are former surgeons, and that allows them to generate decent revenues of their own without making arguable deals with hospital unit heads. Some chief doctors own small businesses (e.g. small retail pharmacies), which allow them to be well-off people and avoid financial relations with their subordinates. However, respondents' answers do not allow to make unambiguous conclusions on the matter. *"Do unit heads share with the chief doctor or not, depends on each given chief doctor,* - says one of our respondents, - *but I know, that in order to become a hospital unit head, you have to pay $15,000 to the chief doctor. Every doctor wants to become a unit head, because that office gives you a good opportunity to earn money and power. As for Hospital N's chief doctor…. I do not think that he takes anything from unit heads. He has no time for that, because he has to make his own money. He owns saw-mills, pharmacies…. He is a busy businessman. He is very rich, and he can afford to act independently, like a very rich or very poor person. Even if he quits his career as a hospital CEO, he will not get lost. Other chief doctors do take their share. Take chief doctor Y: he has bought his CEO position, because his wife buys and sells things. Alliance between commerce and medicine is strong in my town. Everything can be bought. But still, chief doctors' main revenues come from sources other than their hospitals*".

Some respondents, however, believe that chief doctors always get their share of informal patients' payments. That does not make them effective opponents of such practices.

Unit heads also differ in their attitude towards informal payments and demonstrate various behavioral models listed below:

- A unit head takes all the money illicitly earned by his or her subordinates and redistributes it under a certain scheme;
- A unit head takes some share of the ill-gotten money from his or her subordinates without using any logical scheme;
- A unit head has his/her own informal revenues, but deducts some portion of his/her subordinates' illicit revenues to be used for the ward's needs.
- A unit head is against informal payments, as they may undermine his/her professional and personal reputation.

An effort-based scheme is one of the most frequently used vertical redistribution models. Under that scheme, an attending doctor/surgeon gets up to 50 percent of the sum paid informally by a patient. A unit head – even if he/she did not provide any services to that patient – gets 10% "for providing a cover". *"The unit head may even not be involved in the treatment process. But he will get 10%, because he is the boss…. But if something bad happens, he will be the scapegoat"*.

This is how a hospital-based internist describes the scheme: *"When I get something from my patient and everybody gets to know that, half of that sum goes to me, 10% goes to the head of my unit, and the rest of the money is distributed among nurses and nurse's aides. This is more or less fair. About 20% should go to the nurse who provides patient care. However, nurses work in shifts, and the 20% have to be divided among 5 nurses or so. Although the money patients pay us can not be even remotely compared with what they pay in Surgery, we do get something in addition to our salaries. I know that they have the same distribution scheme in Surgery. I talked to them before we introduced the same thing at our ward. However, they pay a lesser percentage to nurses, because the sums they charge are higher. Other hospitals in the city use the same type of arrangement. But that happens only if my colleagues know that I have received money from a given patient. If they don't, I do not share with anyone"*.

The scheme described above is broadly used in the surveyed urban hospitals. It is generally considered to be fair and just, since it takes into account the interests of all process participants. It may be assumed from respondents' answers that about 30% of all doctors who receive informal payments use this particular redistribution scheme.

Another income redistribution scheme is referred to by respondents as "slavery". Under that scheme, a unit head takes 100% of every other informal payment. Surgeons have to obey, because the unit head has enough power to cut off any subordinated surgeon's access to paying patients. *"Ten percent is fair enough,* - says a surgeon, - *they can do a much worse thing. If you do not give him 100% every other time you get paid by your patient, he can prohibit you from serving paying patients. So, 10% is a civilized approach"*.

We do not know exactly how prevalent this scheme is, but it may be assumed, that it is most frequently used in surgical wards, where unit heads are empowered to decide whether or not a particular surgeon will operate or not.

At the same time, the same, but slightly modified scheme may be used in Internal Medicine, if the unit head participates in service provision to a paying patient (e.g. provides counseling services to the patient's attending doctor): *"In such situation, the unit head and the doctor manage the case together, and the unit head is free to take as much as he/she wants from the received sum. If the unit head does not participate in the treatment, he/she will get 10%"*.

However, unit heads say that their control boils down to being aware of the facts of informal payments. According to them, they do not get their share of informal revenues, and they do it for two reasons: 1) they are afraid of being caught red-handed and; 2) they have opportunities to earn additional money even without being involved in anybody else's schemes. In the latter case a unit head does not interfere with his subordinates' money distribution arrangements, but sometimes steps in to make sure that nurses and nurse's aides "are not passed by", if he/she has no official ways to pay them bonuses.

There are many unit heads who never interfere with informal revenue distribution among their staff (*"we try not to notice that"*). Such unit heads keep working as active practitioners and use their professional authority to show that they don't need other people's money, but that each doctor's ability to earn depends on how good he or she is professionally: *"As a rule, doctors do not share with unit heads,* - a health official says, - *Why? Because a unit head is always one of the best in his/her field. The most complex surgical operations are usually done by a unit head, because patients want them. He/she can not do everything, so, something is left for rank-and-file surgeons. And this is the instrument he/she uses to influence doctors. If you work well – you will be operating. If you don't – sorry…"*.

Very often unit heads prefer to close their eves on their subordinates' informal revenue-generating practices, because they realize that it is virtually impossible to exist with such miserable salaries. However, unit heads do realize the possible consequences of such practices: *"Some unit heads know about informal payments in their units, some do not,* - says one of our respondents. – *Our unit head does not want us to live in poverty, and I think that he does not forget about himself as well. At least, he has his own ways to earn money, and he does not rob us. We do not have a clear-cut system or hierarchy in terms of revenue distribution"*.

Not only an actively practicing surgery unit head may refuse to take his commission from doctors, but he would sometimes give part of his informal revenues to his chief nurse and other nurses in order to avoid unnecessary conflicts: *"A unit head can have a money sharing agreement with his chief nurse. They have common interests. It is easier for him to pay some part of his revenues to the nurse than to watch out for unpleasant tricks on her part all the time"* (a health official). If that is the case, the cash flow starts moving from (vs. towards) the unit head, who does it in order to preserve stability/tranquility within his team.

Thus, unit heads use various revenue distribution models, starting with fixed share-based scheme and ending with the non-interference strategy. This diversity is a result of numerous factors, the combination of which has to bring stability to each team and is unique for each setting.

3.2.2. Horizontal redistribution of informal revenues: do surgeons share with their team members and nurses?

A rule, according to which informal revenues must be shared between the doctor and his/her nurse, has become a commonly-recognized norm among *"decent doctors"*. "Like other doctors, I do not understand when someone in a ward gets those informal payments and does not share with his or her colleagues. Because services are provided by a team of people, but some members of that team can get paid by the patient, and others can not. The money must be distributed among all tam members, but in accordance with each member's actual contribution. That will be fair".

When explaining the need to share, doctors mention two sides of the issue- ethical and pragmatic, although sometimes these two motivators act simultaneously: *"Surgeons usually share with an anesthesiologists, surgical nurses and assistants, because it is impossible to conceal your interest from them. So, you get your team members interested too"* (a surgeon).

According to most of our respondents, the sharing approach is especially justified in ethical and – especially – pragmatic terms, when treatment outcomes depend on how well the team works: *"When a hypothetical patient brings money to a hypothetical doctor, the latter must remember that he/she never does anything without other team members. When doctor comes into the operating room – he has an assistant waiting there; that assistant is also a human being. And he is not a low outcast – he is a doctor who has been earning his daily bread by working hard. So, the doctor must share. Then, much depends on how the team anesthesiologist works. Then there are surgical nurses. Our instruments are of terribly low quality. You can get those incredibly bad instruments, if you do not*

share with the nurse who can get better-quality scalpels and stuff. So, if the patients pays a certain sum, divide it by two at once, because you should share with tour team. Otherwise the team will die: people will find an excuse to say "no" to you (like "I do not feel very well", "my tooth is aching", etc.). And you will have to use bad instruments (vs. good ones that could be provided by nurses, because nurses always know where good supplies live). That can happen in any facility. If you a front man and a money generator, you should care about people who help you generate that money. Then you can be sure that your team will never fail you".

The more urgent the operation is, the more the surgeon will tend to share his revenues from it, as he gets more interested in getting the specific best people to work in his/her team: *"There are cases when surgeons do not share with anyone. And there are cases when surgeons share with all their team members, including a nurse and nurse/s aids. The latter is more likely to happen when there is an extremely urgent operation to be done. In such a case, a surgeon will rush into the room to get the team together and say: "I'm paying". They never refuse… "* (chief surgery nurse).

Most of our respondents defined revenue-sharing practices as fair. However, one should not think that all informally-received revenues get shared. Rather, only some portion of the total sum is divided among the staff, while the rest of it is concealed by primary recipients. That may be assumed from some respondents' statements in support of such practices. About one third of doctors prefer not to share their informal revenues with other colleagues.

The forms of revenue distribution

Informal revenue-sharing practices may be influenced by various rules and take various forms. The following forms are most prevalent:

- Fixed *pro rata* distribution;
- A "melting pot" for the needs of the entire ward;
- Floating share-based distribution;
- In-kind remuneration.

Informally-generated revenues may be shared among surgical team members or among all people in a given ward who contributed to the treatment/care provided to a paying patient.

Fixed pro rata distribution: the money is shared between team members based on a subjective perception of how much effort each of them has contributed to the treatment process. This is how it happens with respect to a surgical team: *"Being an honest man, a surgeon gives part of the money to his anesthesiologist, nurse, nurse's aide and the unit head, that is, to all people who have made their contribution. But he does it in a fair manner, as opposed to the way they do it at the hospital's accountant's office, where they pay only 30% of the sum to him. He is a surgeon and deserves 70%, because he has found the patient and he has done the operation"*. Where there is a well-knit team, a "melting pot scheme" is used: informal revenues are summed up to be later divided among doctors, nurses and auxiliary staff who provided various services to the paying patient.

This is how a unit head commented on the scheme: *"We have a set of unspoken rules in my ward. They help us to distribute the money based on certain percentages. A surgeon gets 40%, an anesthesiologist receives 15%, an anesthesiology nurse – 5%, surgical nurses get 10% each, the unit head also gets 10%, and even nurse's aides get a certain percent of what has been paid by the patient… We developed that distribution scheme together"*.

Cash payments from the melting pot may be done in order of priority. For example, nurses get paid first, when the total accumulated sum reaches a value equal to the projected monthly/quarterly nurses' share of informal revenues. All other cash payments that get into the pot before the end of that period get divided among doctors. One of our respondents gave the following description of the scheme: *"This is how we always do it: you get paid for an operation – you contribute that sum to the ward's melting pot (it's not like you get the money for an operation and run away with it). We are a sort of a commune. For instance, X percent should go to nurses. We put everything we earn informally in a melting pot, then – when there are 10,000 in the pot, we pay nurses. Anything that goes into the pot after that (but before a certain date) will then be shared by doctors"*.

Sometimes (but not always) the melting pot money is divided in a more or less objective performance-based way: *"There was one case. A severe patient was admitted. They gave us money and said: "Do everything you can. If you fix him, you will get more. All our team members received that money. But we looked at each other's actual performance. Doctors received higher, but more or less equal sums, and nurses got smaller amounts. But everyone was eager to stay for a night shift. We saved that patient. People were getting some catheters out of their pockets, everyone was excited. We would get 100-200 rubles per person per day for 2 weeks. Then doctors received additional 500 rubles each (including the surgeon). And we put all that money in a melting pot. We liked the idea"*.

A "melting pot" for the needs of the entire ward: Informal revenues are consolidated and used to cover the ward's expenses. There are many cases when doctors save up informal revenues from patients' payments and sponsors' contributions and then use them to renovate the ward or purchase expensive furniture. One of our respondents, a unit/ward head, says: "We do as follows. One patient pays 5000 rubles, another one pays 5000, the third one pays the same. We transfer all of that money to a construction company that also does renovations. They give us a receipt. When total amount reaches 50,000 rubles, they renovate our ward. Or it may de done in a different way – we give them an invoice, and they pay. Well, the financial side of it is not overly legal, but at least we do not use that money for our personal needs".

Floating share-based / contingent distribution: percentage of informal revenue shared by that revenue recipient with other team members depends on the size of patient's payment. The less money is paid by a given patient, the greater share of it is retained by the doctor: *"How much the doctor gives to his/her team will depend on how much he or she gets from each patient. If there are no established rules in the team as to what percentage of any received sum goes to whom, the doctor - if he receives 1000 rubles - may give away one sum, but if he receives 2000 rubles, he can give away a larger share"*, - says a deputy chief doctor, OB/GYN.

If patients' payments are very small, the distribution practices become even more discretionary*: "Most of our surgical services are provided for officially-charged fees. However, sometimes we provide free-of-charge services. In that case some patients pay us 500 or 1000 rubles – whatever they can. That money is then divided among the team members, but there are no fixed percentages or shares"*.

In-kind remuneration: Instead of getting some percentage of out-of-pocket patients' payments, a nurse or nurse's aide may receive an in-kind equivalent of her share from a doctor (e.g. services or access to services). For example, a nurse's relative may be admitted to the hospital without being put on a waiting list and get served for free: *"I have never refused to provide assistance to my staff when they or their relatives needed treatment or hospitalization. If my ward is overcrowded, I will say: "Come to my office tomorrow at 6 p.m. and I will certainly help you with your problem". This rule applies to all staff members, including nurses and nurse/s aides. They are always the first ones whom I help out with their problems"* (a unit head).

According to data generated from the interviews, pro rated and contingent distribution are the two most prevalent models used in health care facilities to distribute patients' informal payments (the former is mainly used to distribute the money only among surgical team members). Any given hospital ward usually has its "favorite" distribution model. That does not mean, however, that all surgeons in the ward always stick to it. Nevertheless, to be able to break the rules, a surgeon must earn his professional name and clientele first.

There are probably more than just four income-sharing practices. However, the four examples allow to get a general understanding of how diverse and complex such practices are. The fact that informal out-of-pocket payments are illegal and, thus, are often concealed, allows diverse revenue distribution schemes to exist. Which of them are used in each specific ward will depend on how well-knit the team is, what norms are practiced, and what strategies are used by that ward's unit head and doctors.

Unit heads – if they have enough power and respect - play a key role in making their subordinates accept or abandon this or that scheme or practice. As a rule, unit heads do not refuse to regulate the ward's "melting pot" replenishment and distribution. However, they become less capable of controlling the cash distribution when other models are used. Personal preference-driven cash distribution leads to "quite" conflicts between doctors and unit heads. Some doctors do not share with colleagues, or do it sporadically, and that does not make such doctors overly popular among the staff. By and large, specific patterns of informal revenue distribution practices depend on the prevalence and size of informal out-of-pocket payments made by patients in a given unit or institution. The more prevalent such payments are, the higher the probability is that fixed share-based (pro rate) distribution scheme will used.

Situations in which informal revenues are not shared among the staff

As noted above, about 30 percent of our respondents insist that ill-gotten revenues are not shared at all or are shared only rarely, and that that causes conflicts between doctors and nurses. "Each man for himself" continues to be the main principle*: "We have a chat in a tea-room and then everyone goes about their business. There are no group agreements, everyone plays for himself"*. There are hospital wards where cash-sharing between doctors and nurses has never been a common practice, and nurses are not allowed to discuss doctors' practices and decisions regarding informal patients'

payments: *"there is a rule in my ward: it does not matter who of doctors earn money that way and how much do they earn. We, nurses, have nothing to do with it. It is none of our business. Although some doctors do discuss informal payments as such, they never will be able to cross the line and start sharing with us"* (a chief nurse).

Some of our respondents believe that doctors who share their informal incomes pamper or "spoil" their nurses: *"I do not want to spoil my nurses by giving them money. Why should I do that? They may start quarreling with each other (i.e. who should get the bigger share). I can help them in other ways. For example, I can help my nurse to find a decent apartment using my connections. Not all of them like it, but those who do not like it can leave. I will find a replacement fast"* (a "superstar" surgeon).

According to our respondents, there are surgeons who never share neither with nurses, nor with anesthesiologists. As a result, each surgical team member starts providing for himself: *"Surgeons and anesthesiologists do not contact in monetary terms, although they operate together. "Every man for himself". Anesthesiologists and resuscitation specialists play an important role during surgery, but surgeons do not bother sharing with them"*, - says one of the interviewees.

Separate payments to doctors and nurses also take place when patients' relatives want nurses to be more attentive and are prepared to pay for it. That often happens in trauma, burn, resuscitation, cardiology units and in other cases when a "severe" patient needs a special, better-than-usual care.

Data generated in the course of interviews allow to conclude that the absence of cash-sharing practices is often a result of that nurses and doctors receive informal payments via two separate channels. However, doctors often overestimate nurses' revenue-generating opportunities or even block them, thus cultivating tension in the team. *"Everything related to patient care is done by a nurse. A nurse/s aid can just take away a bedpan. The rest of the job is done by a nurse. Washing the patient, treating sutures, everything. A nurse is up to her ears in that. A doctor who takes everything, explains to the patient that everything has been paid for. But nurses get nothing from that money. Doctors share with nurses only in two wards of our hospital. That is why nurses are strongly dissatisfied and often talk about that among themselves"* (hospital chief nurse).

Are there conflicts over informal revenue distribution?

Nurses' dissatisfaction with doctors' failure to share informal revenues makes them go to superior managers "for truth". However, administrators are not always capable of influencing the situation. *"Patients rarely complain to me. It is nurses who often come and complain about doctors, when they know that doctors get money from patients for surgery. Imagine a nurse who asks a patient to pay, and the patient says: "I have already paid to the doctor". Then the nurse goes to the chief doctor, to hospital administrators and starts complaining: "We also provide services to patients. Why is it that nothing is left for us?!" That leads to conflicts between doctors and nurses. There are no conflicts in the wards where such problems are settled. Everybody is satisfied"*. (a health official).

Nurses are determined to make informal revenue-generating/distributing practices more transparent and clear-cut. This shows that many open and hidden conflicts are a result of nurses' dissatisfaction with the fact that doctors do not share with them, or do that without any account taken of each team member's actual effort/contribution. This leads to situations where unit heads have to redistribute legally-generated revenues from chargeable services in favor of the mid-level staff in order to create at least an appearance of performance/effort-based remuneration of nurses and nurse/s aides.

Nurses and nurse's aides strongly support a "performance-based payment approach" and some of them are trying to exert pressure on doctors in order to make them distribute informal revenues in a more fair way. Sometimes it leads to nurses' demands to be paid for providing patient care and procedures: *"There are wards in which nurses demand that doctors share with them. When informal payments are not very prevalent, nurses somehow tolerate doctors' failure to share. But when virtually all patients are paying, they stand up for their rights. This is because their contribution to the overall treatment outcome is significant"*. However, most of our respondents say that it is not very often that a nurse would aggressively demand money from doctors, because *"nurses are not spoiled with money and are glad when they get anything at all in addition to their flat salaries"*.

There is no single opinion as to how much conflict is there with respect to informal revenue distribution. Most of our respondents believe that there are almost no open conflicts over informal payments, because the latter are "a very covered-up practice". *"I have never heard about conflicts over money-sharing arrangements. At least, not about serious conflicts, - says a health official, - I am sure that nurses are not satisfied with what doctors pay them, but this dissatisfaction never goes out. Nurses never openly demand that doctors pay them"*.

It is likely that the lack of open conflicts between doctors and nurses around informal patients' payments is a result of many factors, one of which is an unspoken rule "not to make your dissatisfaction visible to doctors". Nurses say: *"we do discuss our resentment among ourselves, but it is sort of inadmissible to share it with doctors"*.

However, available data allow to assume that this is not a universal rule. More than 30% of our respondents admit that minor or even high-intensity conflicts over informal payments do occur. Most of such conflicts are caused by nurses' dissatisfaction with the way informal revenues are distributed among the staff. However, given that hospital chief doctors (administrators) tend to use tough measures against those who participate in such conflicts, many wards prefer not to "advertise" the conflicts and try to settle them before they become known to hospital administrators.

Some of our respondents indicated that there are doctors who intentionally incite patients against nurses to avoid sharing with them and/or reduce nurses' opportunities to get paid by patients directly. *"A nurse does not have as many opportunities as a doctor to show that she is a true professional. She does what doctors tell her to do. Whatever patients pay is good for her. Sometimes patients do not trust the nurse and ask "what are you giving me?" That is due to the doctor who – in order to prove that he cares about the patient – keeps writing notes, where he indicates an exact time (in hours and minutes) for injections. Why indicating minutes? The doctor is building his good image and makes the nurse look like a clumsy fool. And that doctor keeps bothering the nurse all the time. That is why nurses are dissatisfied. It is easy for a doctor: he operates, then he prescribes treatment and sees his patient only once a day during the morning round. The rest of the job is done by the nurse. Who – if not she – will change a bedpan, do an injection, etc.? But the doctor does not notice that. He does his thing and leaves. Then he comes in once a day to demonstrate how he cares about the patient. The nurse does everything, but doctors do not want to notice that. Some of them even incite patients against nurses"*.

It should be admitted that conflict and no-conflict practices coexist, but domination of this of that practice may be achieved by various means. It may be assumed that professional teams where monetary conflicts are absent are using some clear-cut rules with respect to informal revenue distribution. As follows from the interviews, fixed share-based distribution or other arrangements accepted by all players serve as the most effective tools to eliminate conflicts over cash distribution. *"There are different rules governing informal revenue distribution. Somewhere people share, and somewhere they don't,* - says a health official. – *In some institutions doctors share with nurses, in some facilities they don't. Where there is no agreement, they have to face conflicts"*.

An important role in lifting such conflicts belongs to unit heads. A unit head may interfere in cash distribution practices, but may not be brave enough to force an actively resisting doctor to start sharing with nurses. Such is the case with high-class surgeons who earn popularity for their institutions and can allow themselves to behave the way they want.

Miserable official salaries encourage health professionals to accept payments from patients. However, group norms and rules regarding informal payments are lagging behind rapidly evolving informal practices, which are strongly influenced by personal attitudes and strategies. It is noticeable that many "unique" world-class doctors do not comply with rules set by their unit heads. They prefer to set their own rules and impose them on other staff members. However, rules imposed by force are very unstable and usually cause a lot of resistance.

3.2.3. Regulation of informal payments distribution among mid-level and junior medical staff

Along with doctor-nurse revenue-sharing arrangements, there are nurse-nurse and nurse-nurse's aide cash distribution schemes. As a rule, group norms regarding revenue sharing among nurses exist in health care settings where nurses and nurse/s aides get separate payments from patients or patients' relatives. Examples include Cardiology, Trauma, Burn centers, etc.

Craving for justice is strong among mid-level staff. Cash-sharing rules used within nursing community are generally tougher then those regulating monetary settlements among doctors or between doctors and nurses. Nurses tend to use fixed share-based or "melting pot" arrangements.

According to our respondents, informal revenue distribution in some settings may be regulated by chief nurses. Such is the case in a ward or unit where the chief nurse does not prohibit informal revenue-generating practices among nurses and nurse's aides. Very often, it is a chief nurse who decides as to who of her staff will be given an opportunity to serve as a "personal nurse" for a paying patient. However, we could not get any information about whether or not nurses have to share with the chief nurse for getting revenue-bearing assignments. Various scenarios may be considered.

If a chief nurse is not getting her share of informal revenues from her unit head, it is very possible that she gets paid by nurses for granting them an access to informal payments. If she is getting

her share from the unit head, decision about whether or not to take the money from nurses will depend on her personality.

Cash distribution schemes used by nurses in a given ward are usually copied from those used in that ward. Paradoxically, but it is nurses who sometimes manage negotiations with patients regarding payments to doctors: Doctors may discuss monetary issues with nurses and then entrust them with making a deal with a patients. *"It is difficult to conceal informal payments from nurses, because many patients consult with nurses about how much should they pay to a doctor"*.

More than 50% of our respondents believe that nurses have their own separate channels of informal income. However, their revenues from out-pocket-payments are incomparable with what patients pay to doctors. Moreover, patients' payments to nurses are rare. One exception is payments for "personal nursing stations", which are perceived by most nurses as a source of legal income, since they work as personal nurses on their days-off and, thus, can not be accused of giving too much time to one patient at the expense of others.

Conflicts among nurses over informal revenues do exist, but most of them are a result of injustice on the part of doctors. A typical conflict between nurses is triggered by the fact that a nurse is giving too much of her time to one [paying] patient, thus making other nurses do part of her job. This is not welcome by other nurses and a unit head, who often interferes in informal payment practices in order to prevent nurses from abusing patient relatives' kindness. *"These informal incomes corrupt nurses. After being paid 100 or 150 rubles in cash for an off-schedule night shift, a nurse will not be performing the way she is supposed to during her regular (non-privately-reimbursed) shift. She spends a night near the patient's room, then in the morning she gets her 100-150 rubles from the patient or his relatives. You know, she gets a small flat monthly salary (once a month) for her regular work, and if you divide that salary by total number of regular shifts… Well, 150 rubles is not a big money for sitting with a patient and feeding him from a tea spoon, but she is not a nurse's aide – she is a professional nurse. But if she gets cash immediately after serving the patient, that will corrupt her. I prohibit such things. But I think that such practices do exist in my ward"* (head of a hospital ward).

Sometimes conflicts around informal payments break out spontaneously as a result of nurse's aides' or nurses' resentment that someone (another nurse or nurse's aide) has received more money from a paying patient than they have (e.g. a night-shift nurse vs. a day-shift nurse): *"It is OK when the money is shared evenly. But if only two or three people in a ward get it all, other staff reproach them. Generally, everything that is somehow related to money causes hatred: "Why is it that it all goes to her? She gets more, because she works during a day, and I work at night. But I provide the same services to patients, and I deserve the same level of income". That's how it starts. But there is no one to blame. To pay or not to pay is decided by patients. But everyone is ready to take money from patients. Otherwise it will be impossible to survive"*, said a chief nurse of a large hospital.

Uneven distribution of "shadow" incomes in a situation when official salaries are very low cultivates jealousy and suspicions among nurse's aides and makes them support revenue-sharing schemes based on pro rata distribution or the "melting pot" principle.

Revenue-sharing practices among nurses

Revenue-sharing arrangements among nurses may summarized as follows:

- Everything that patients give goes to a "melting pot" (including candies, chocolates and cakes);
- Distribution based on each nurse's effort, under "fixed pro rata" or contingency schemes, depending on amounts paid by patients;
- Distribution based on "what your conscience tells you";
- No sharing of small individual payments

When distributing informal revenues, nurses are trying to act fairly and make sure that patients' payments or contributions made for services provided by more than one nurse go into one joint "melting pot", especially if patients donate food stuffs: *"I can assure you that everything that one nurse gets goes to our "joint pool" or "melting pot"*. - a chief nurse of Cardiology says, - *When a doctor gets something, he then carries it to his cave. It is different among nurses. Nurses are a well-knit mighty team. If one team member is weak, everyone suffers. If you act like a rat (e.g. conceal the money), no one will help you when you have problems. It is natural: I do not have too many patients in my room, and my colleague is overloaded with job. So, go and help her out. But if you know that she has received something from her patients and has not shared with you… Next time no one will come to help. That is why nurses always share with each other. Whatever is given by patients during a shift is shared by the entire team"*.

A fixed pro rata distribution model applies to payments that nurses receive from doctors. As a rule, those are small sums, which can hardly satisfy most of the nurses.

The fact that some hospital wards have introduced "fair distribution" schemes was confirmed by one of our respondents, a chief nurse: *"There were cases when patients relatives would give 300 rubles per day. And we would buy something for the entire staff. There were times when we could not receive our salaries for months on end. Then we would share that money among us – 10-12 rubles per person. For public transportation, just to get back home"*.

Nurse/s aides can also be paid by patients separately. But such payments are so irregular and small, that they do not get shared with other staff. Nurses, however, share with nurse's aides sometimes, but that depends on *"what their conscience tells them"*.

Despite tough horizontal control, the no-sharing practices do exist, but nurses do not talk much about them, since people who do not share their informal incomes with colleagues are reproached. By all accounts, nurses conceal 50 to 70 percent of what they get from patients. This shows how difficult it is to control all informal cash flows, even when there are people who are deeply interested in exerting such control. Requirements regarding money sharing may be less tough with respect to divorced nurses who have many children, or who do not have any opportunities to earn any additional money outside her institution (e.g., do injections or provide to her neighbors, etc.).

By and large, surgical and anesthesiology nurses who get cash directly from patients or surgeons are less dependent on unspoken rules, as compared to other nurses, who have to live under tough control most of the time.

SECTION 4. HEALTH PROFESSIONALS' ATTITUDES TOWARDS INFORMAL PAYMENTS

4.1. Physicians' and nurses' attitudes towards informal payments

4.1.1. Physician groups with different attitudes towards informal payments

There is no single opinion among doctors regarding patients' informal payments. There were both consistent supporters and militant opponents of such payments among our respondents. Between the two extremes are "forced supporters" and "those regretting" who could have joined supporters, but do not actually receive informal incomes.

Consistent supporters

This group comprises doctors/physicians who feel good in the free-market environment and believe that professionalism should have its market price. They do not look embarrassed when talking openly about their views, as they –like most other doctors – think that informal out-of-pocket payments are a result of the government's ignorance and negligence: *"Generally, a patient's gratitude is a normal thing. They thank doctors all over the world. In America – if you trust those books – they do it too"* – says one of informal revenue supporters. As a rule, doctors strongly criticize existing official provider reimbursement system, due to which doctors are considered to be one of the lowest-income professional groups in Russia.

Doctors from this group view informal incomes as a good motivator for professional growth: *"When informal out-of-pocket payment goes directly to a doctor, he knows what he is working for. If there is a need, he can spend all night at the patient's bed (like a nurse's aide), or he can leave his home number to patient's relatives, so that they can call him in case of emergency – and he will come immediately. Nobody will do that for 13, 20 or 40 rubles"* (a unit head).

Sometimes "supporters" refer to informal payments as a resource for recreating their own health. Some of them say that patients who can pay should do it for ethical reasons, since the government has abandoned doctors (*"just forgot about them"*).

Very often doctors justify informal incomes by the need to maintain professional level, purchase new equipment and instruments, or by the fact that patients offer the money voluntarily (which is probably true).

Doctors in this group are especially sensitive to the type of payment and tend to reproach "standard gifts", which are usually incoherent with the doctors' actual effort and demonstrate patients' disrespect: *"Who do they think we are? Plumbers or alcoholics? I discharged 8 patients after difficult surgical interventions. They brought me a bottle of vodka, a bottle of cognac and those *!*!** candies. Do they think I'm an alcoholic? But they think that that is an adequate way to say "thank you" to a doctor. They keep bringing booze. This is a shame! I operated one patient. Then he brought me a big pack of cigarettes.. He says: "It is a Marlboro". I say: "I gave up a year ago". He says: "But you can give it to someone as a gift". I say: "Thank you". And that was after a serious plastic surgery. I gave those cigarettes to my smoking colleagues. Of course, extortion and corruption must be eradicated. But "saying thanks" to your doctor is a long-standing tradition. It dates back to Stalin times"*.

As a rule, high-qualified doctors are strongly against categorical requests to pay. On the contrary, patients' payments made out of gratitude are always welcome.

It should be admitted, however, that this group is very heterogeneous and includes the following sub-groups:

- Active supporters
- "Superstars" (celestials)
- Moderate supporters

Active supporters are doctors who see informal incomes as their main goal and who sometimes exert pressure on their patients: *"When patients give you money out of their own free will, this is OK. But now we have an army of doctors, for whom such revenues have become the meaning of life. And*

they think that it is good. Those who devoted their lives to money-making live decently. And it is such doctors who throw away flowers that patients bring. Because they want only one thing - money".

Such doctors do everything to get to patients' money: refuse to hospitalize patients (for non-existent good reasons) who do not promise to pay; announce the "shadow" price of treatment in advance; tell patients and their relatives that no quality may be guaranteed without informal payments; intimidate patients by promising to give then over to an inexperienced doctor, etc.

Active supporters may be divided into two age groups: young doctors and older doctors. Young doctors believe that a patient has to pay for his health. Most of such doctors are not the best specialists in their fields, but tend to conceal the lack of experience by using a pseudo-scientific language, prescribing the most expensive branded drugs and trying to get paid for everything imaginable. Their older colleagues reproach them, as they believe that "youngsters get more than they actually deserve". Older "active supporters" may not necessarily be best specialists. Some of them have an access to informal out-of-pocket payments due to their ranks, positions, connections, etc. They often advertise themselves in the mass media as *"impregnable luminaries"*.

Active supporters of informal payments are usually treated by their colleagues with understanding, respect and – sometimes - envy. They get reproached by other doctors only if they do something that can not be described in terms other than "racket" or "bare extortion".

"Superstars" or "celestial luminaries" work only when high reimbursement – official or informal - is guaranteed. "Superstar" doctors have a unique know-how, technologies and equipment and have no competitors, at least in their region. Most of them are surgeons, who almost never work without being paid "big money", as they believe that "free-of-charge" patients can and should be served by other – less qualified – doctors. Sometimes, however, they can take a rare or complex case for free because of professional interest or *"not to loose skills"*. They do not make hints and they never ask for money. Patients pay out of their own free will, and they pay a lot more than they do to other doctors. Despite their indisputable popularity in Russia, such doctors very often use mass media (including the Internet) to advertise their services. As a rule, they are admired and/or envied by colleagues.

Moderate supporters are consistent supporters of informal payments who are not as highly qualified as the "superstars" and can not be as active as the latter in generating informal revenues.

About 20 to 25 percent of our respondents can be defined as "consistent supporters": 10-15% are active supporters; about 3% are "stars", and 5 to 10 percent are moderate supporters of informal payment practices.

Forced supporters

A larger share of our respondents may be classified as "forced supporters" of informal payment practices. These doctors demonstrate a combination of old Soviet-type paradigms and new "capitalist/individualist" values. The two opposite ideologies bubble and collide, which leads to internal conflicts and sufferings. Doctors in this group realize that patients do not have to pay for services that are supposed to be provided free of charge, but do not refuse such payments as they believe that they are fair and justified: "Well, by and large, patients should not pay. When I accept money from my patients, I feel bad. But then I stark thinking: "I have done so much, and I have spent so much of my time. Why should I work night and day for nothing? I do suffer because I have to accept money from patients. But doctor's official flat salary set by the government is so miserable. It is humiliating".

Some of the "forced supporters" blame the government for indirectly forcing the doctors to accept money from their patients and for the lack of "civilized" provider payment arrangements: *"Informal patients' payments are perceived by most of my colleagues as an unpleasant thing. May be other countries have a long-standing tradition of charging cash from patients. But Russian medicine is not like that: medicine has never been treated here as a for-profit corporation. I will be glad if those informal payments stop. But health insurance schemes (as they exist today) do not work, and the government has so far failed to invent anything else. That's why it is difficult to blame doctors who accept money from patients. My wife is also a doctor. We have a child (he was born when we were university students). But when we were medical students we thought : "Soon we will graduate, then gain experience, and everything will be great". Both of us spent years as clinical residents. That was difficult, given the small child. But we kept thinking: "It will be better soon…". Now I am 40, and nothing has changed. That is why informal payments will be very difficult to eliminate. Doctors have to survive you know. Nothing will change unless the government does something about our salaries"*.

The level of self-respect is high in this group. And it is self-respect that may strongly influence informal revenue-generating practices among such doctors: *"Most doctors want to be appreciated and*

respected. – said one of the chief doctors, - *It takes a lot of nerve to extort money from patients. Sometimes a simple "thank you" costs a lot more than money. And when they are giving you a banknote with disgust, you have an irresistible desire to throw it back to them"*.

Most doctors in this cohort see informal payments as a means to survive and, thus, justify them: "All doctors will benefit from any government's moves to make our life better. We need a decent salary, and we should not think about how to feed our children. We are just forced to take money from patients". "Payment out of gratitude" is perceived by majority of such doctors as the most acceptable "shadow" payment model.

"Forced supporters" are usually good specialists in their fields who use a "take whatever they give" principle and almost never compel their patients to make monetary or in-kinds payments. They are especially good at building good relationships with patients and relatives thereof. As a rule - and like most doctors - they expect their patients to reimburse them: *"if I really made a difference, and if the patient can afford to pay"*. If the patient does not pay, they do not react strongly, nor do they try to *"squeeze the money out of him"* or start treating him worse. Part of them can refuse to accept money from a patient, when they think that *"that patient is too poor"*. However, such doctors' attitude to a given patient may *a priori* depend on the latter's ability to pay. Some of them a "super careful" and prefer to accept money only from someone they know or from friends of someone they know to avoid publicity and the risk of loosing reputation. "Forced supporters" belong to all age groups and – as a rule – have friendly relations with colleagues.

About 45 to 50 percent of our respondents belong to that category. Most of them work at urban hospitals. Outpatient settings, central district and district (AKA rural) hospitals have less doctors of that cohort among their staff.

"Those who regret that they can't do it"

This group includes doctors/physicians who would like to be paid by patients, but never actually get anything: "It would gladly accept, but they never give".

This cohort includes:

- Doctors at rural community hospitals where patients never pay because they are too poor;
- Young inexperienced doctors;
- Doctors who are not very good at building good relationships with patients and/or patients' relatives;
- Outpatient clinic-based physicians;
- Pediatricians and internists who work at urban hospitals.

As a rule, such doctors/physicians serve patients who can not afford to buy necessary drugs, let alone other services. Most of "those regretting" are needy people who lead a modest life. They are prepared and willing to accept informal payments, but their patients are not able to pay: *"Sometimes I do receive some money for services that I provide to my friends' friends. Sometimes they ask me to go to a distant rural settlement, examine someone there and prescribe treatment. But that does not improve my financial status much. That's why many of us have to grow vegetables and stuff. So, the only informal payments I get is those made by someone I know. But if my patient offers me money, I will take it. I will never refuse"*, - says a doctor of a central district hospital doctor.

A chief doctor of a district (rural) hospital also confirmed that rural residents are not accustomed to make payments at community hospitals: *"Paying money to doctors is not a widely-spread practice. Although that would be better. I could buy everything I want for those 10 rubles [$0.3]"*.

There are doctors in this group who explain their refusal to accept cash from patients by two reasons: 1) the risk of being caught red-handed and; 2) inability of rural residents to pay: *"There is a temptation. But first, it is a risky thing, and, second, as the proverb goes, "I would take, but they won't give". Rural population is pauperized"*.

Doctors of this category prefer to keep it low profile and are happy to accept whatever patients give to them: *"They talk too much about "shadow payments" these days. This is an exaggerated problem. First, rich people do not fall ill that often. And if they don't, who is supposed to be making all those informal payments? The poor? The poor can not pay. Sometimes they do something to thank you. I remember one woman who brought me a jar of strawberry jam and two apples. I took it all home, and me and my wife discussed it over a cup of tea and the strawberry jam. If a patient wants to something for you to say "thanks", he does it even if he can not give much. But even that makes you feel happy. However, our salaries are so small, that we would love to be thanked with big money instead of jam"* (a rural doctor).

Doctors/physicians from this group often work at more than two health institutions or do something else to earn additional money. Most of such doctors are unsatisfied with their current status,

but have managed to reconcile themselves with it. The only way out they see is assistance from the government. They are victims of the transitional period who do not want to live the old way, but are unable to change it. Unfortunately, they are doomed to eternal waiting and incidental earnings with growing dissatisfaction with their work at the background. Most of those who envy more prosperous colleagues and start conflicts come from this group. However, in rural areas their dissatisfaction is to some extent mitigated by the fact that most rural doctors live the same way.

About 10-15 percent of our respondents may be assigned to this group.

Opponents of informal patients' payments

This is a very heterogeneous group. It includes doctors/physicians who do not want to accept patients' informal payments for various reasons. Doctors who belong to this cohort:

- Do not want to take the risk of loosing their job ("low profilers");
- Are afraid that they will loose respect and professional reputation ("mild opponents");
- Do not want to violate personal ethical standards for the sake of money ("consistent opponents");
- Do not want to depend on patients' "sops" and uncertain chances ("the independent")

Low profilers. This subgroup comprises doctors who work at private clinics and are satisfied with their social and economic status and do not want to run unnecessary risks: *"I feel easier without under-the-table payments. I am satisfied with my share of the clinic's revenues. I have a good contract. Excessive risk does not pay off. Do I actually need problems with the Tax Inspection?"* – says a doctor from a private clinic.

Doctors who share this opinion can be found at outpatient clinics, diagnostic facilities and central district hospitals. They value their current job positions, respect themselves and tend to comply with their institutions' by-laws and policies. When they breach them, they feel a certain discomfort which can hardly be compensated for by what they illicitly get from patients: *"One patient will pay and go. Another one will go and complain. I really care about my job. I will never get involved in a deal like that"*, - said one of our respondents. *"Do not make me stand in line, I'll pay you for that". I hear this every day. I do not know who that patient is and whether he is bugged or not. I have earned my reputation, and I don't want to loose it"* – says another respondent.

Mild opponents. As a rule, this subgroup group includes old doctors who have achieved a harmony between themselves and the outside world, which they do not want to destroy: *"Think for yourself: money is dangerous. I'm 62 now. What if you take that money and get caught? It 's a shame and disgrace. Do I need it? Ok, I will take that sum. But will I remain a decent man after that? I'm trying to imagine: I take money from a patient and start distributing it among my doctors: you take 500 rubles, and you take 200… And how much shall retain? This is too difficult and too contradictory. You do it once, and then you forget who and what you are. A devil himself might stumble…"* (an old-aged hospital unit head).

This subgroup also includes doctors who care about what their colleagues and patients think of them. This especially matters to doctors who work in small cities and rural settlements. Being located so close to patients - geographically and psychologically – makes doctors think twice about what they do and how they do it: *"I feel embarrassed when I prescribe many drugs and have to say that the patient has to buy them for her own money. She starts looking at me as if I'm putting that money in my pocket. I live here and I do care about what people say about me. Sometimes patients do not give you anything, but then say too many things about you"* – says a Chief of OB/GYN of a central district hospital located in a small town.

Consistent opponents. These doctors are poor, but never take money from patients for ethical reasons. Their attitude towards informal payments may be defined as "active disgust". They do not want to change their values and principle for money.

As a rule, they are old doctors who have somehow failed to earn high ranks and titles and, thus, are not very ambitious, or they are "hereditary" doctors. Here are statements made by doctors who are against informal payments for ethical reasons: *"I was brought up in a different system. I can not step over principles that my parents taught me. I prefer to do everything for free, but to keep my soul in peace. No one can say that I did something wrong. Honestly. This is the way I've been brought up"*. – one of our respondents said. *"This is abnormal. Such practices must become extinct, I'm telling you. Even if I become a beggar, I will never do it. I feel embarrassed even when I just hear it"* (another respondent). *"This is incompatible with medical profession. To take money from patients is filthy. My upbringing will never let me do that. My parents and grandparents were doctors. They could not allow themselves to take even a candy from their patient"* (a "hereditary" doctor).

Sometimes proponents of the *"it is better to be poor but good"* principle can be found among world-class specialists. As a rule, they get small salaries, but never accept money or gifts from patients, even when the latter insist. They say that they *"are not accustomed to it" or "it was not an acceptable thing in the past"* or *"we have been taught to act differently"*, *"our teachers would not do that"*, or *"this is not what they taught us to do"*. It is certain that these people feel proud to "act as our hearts tell us" and not to be *like "the majority who have traded their conscience for money"*. Some of them emphasize their attitude by returning patients' gifts in public or buying drugs for lonely poor people, orphans and bums.

In the latter case the word ***"altruists"*** would be most appropriate. They prefer "giving" to "taking". It is doctors-altruists who are trying to employ all possible opportunities (including personal savings) to help everybody who needs their assistance. They are prepared to give their last penny to save a patient. Most of them are middle-aged or older people with a very well-developed sense of compassion professional duty.

It is possible that what respondents said may differ from what is taking place in real life, but we do not have reasons not to believe them. It may be safely assumed, that in most of such people – given their strong adherence to conservative values and a lack of flexibility - those values were not transformed under pressures of the market place. Rather, "free market forces" have hardened them.

Doctors who avoid dependency and uncertainty. Representatives of this subgroup tend to gravitate to some inviolable solid rules. This is so important to them, that even unstable "shadow" incomes may be perceived as an element of uncertainty, which can hardly be tolerated (especially if the level of self-respect is high): *"The current system annoys me. I want to work and get what I really deserve for that work. I do not want someone to bring me that money, I do not want to feel sorry for myself or for any of my patients. I do not want to be afraid to say something that I'm not supposed to say. All I want is to come to my clinic, do my job right, get my salary and do whatever I want with it. Like go to the theater or buy a new dress, etc. I want things to be stable and predictable. I want to be sure that tomorrow I will get 2,000. Why must I humiliate myself begging? I am a doctor. My intellectual level does not allow me to beg from patients. I am working for the government"*.

Some doctors are strongly against any dependency. This makes them do everything to minimize the possibility of getting paid by patients. They are very sensitive to how informal payments are made, what patients think when they are handing the money over to them, and how patients' behavior changes after the payment is done: *"I hate when they are giving me money with that look ("Ok, take it, you've kind of earned it). I will take that money and give it back to the patient. Patients must know; a doctor is an intelligent and creative person, and you can not just buy those qualities. It is a pleasure to give back the money to that kind of person. Moreover, another two or three thousand rubles will not make my life better"*.

Ten to fifteen percent of our respondents may be defined as opponents of informal patients' payments. The question is: do they always turn down such payments, or is that an image that they want to preserve at any price. Some of the opponents' statements allow to conclude that sometimes they do accept cash from patients, but they do it less frequently than opportunities allow. They always reserve the right to refuse. The rest of doctors are more dependent on such opportunities, and have less internal motivations not to accept the "shadow" cash from patients.

Thus, it would be inappropriate to use a "one-dimensional" approach to informal payment practices and doctors' attitude to them. Russia's health professional community demonstrates a whole range of [sometimes contradicting] attitudes towards patients' out-of-pocket payments. That should make us avoid indiscriminate conclusions and estimates that are not based on the actual practices and specific studies.

4.1.2. How do physicians justify informal payments

In addition to identifying doctors' and nurses' attitudes towards informal payments, we also wanted to investigate health professional's internal restrictions preventing them from accepting out-of-pocket payments, as well as arguments they give to justify or reproach informal payment practices. The interviews allow to assume that most doctors justify informal payments. Only 5 percent of respondents say that informal payments can never be justified, no matter what the situation is.

The strongest argument doctors give to justify informal payments is that their official salaries are too low. As a result, doctors are unable to lead a more or less decent way of life, support their families, bring up and educate children, transfer important values to younger generation: *"I personally justify informal patients' payments. It is impossible to survive with my official salary. Non-medical professionals do not believe when I tell them how much money I make officially. A worker at a mechanical plant will never work for that kind of money. It is embarrassing. It is difficult to prove to*

your own children that "your cause is just", that that is what a man should do, that you have to study, then work from early a.m. till late p.m., work at night shifts… My son says: You do all that and you only earn those miserable 3,000 rubles? I don't believe you!" This is not right. Doctors should live differently. This is not fair. How can someone with such salary bring up children and prove to them that decency pays off?".

An overwhelming majority of our respondents consider patients' payments out of gratitude for already provided services as the most acceptable payment model. When doctors become patients, they never fail to "express their gratitude" to colleagues, thus demonstrating that their norms and expectations regarding patients' payments apply to themselves as well: *"I am not against patients expressing their gratitude. If the patient wants to thank his doctor, this is his decision. In any form. I have relatives, and sometimes I arrange for their treatment at other hospitals. And I myself do something to thank other doctors. But I can not give them money. I can't explain why. I usually buy a pack of candies or a bottle of wine. That is absolutely normal. But they rarely accept gifts from me, because I'm a medical worker just like them. But I can not fail to thank"*.

While approving of patients' voluntary payments, doctors often reproach colleagues who extort money from their patients: *"Payments are justified when they are initiated by patients who feel that their doctors have really helped them. You do not ask for anything. The patient just comes in and gives you a pack of chocolate bars. If he wants to thank you in a different way, he is free to do it". "Any payments to doctors are justified, but only if patients make them of their own free will. If there is no racket. If a patient is satisfied with treatment outcomes and if he is able to pay, such practices are acceptable"*. Patients' gratitude is a powerful motivator for doctors, and they are prepared to do much to actually deserve it.

According to our respondents, surgeons deserve patients' gratitude more than other doctors: *"I think that it is surgical services that must be rewarded first of all, as well as postoperative care. Any surgical intervention can result in death or serious complications. The risk is high. So, when outcomes are good, and there are no complications, and they haven't given him hepatitis, and there is no abscess – why should not that patient pay?"* – said a chief nurse of a large general hospital.

Doctors who do not justify informal payments believe, that those who accept such payments are violating doctors' ethical norms which may never be violated, no matter what the motivation is. They also believe that the fact of payment does not influence the quality of services provided to the patient: *"I do not see a situation where informal payments could be justified*, - says on of the surgeons. – *Patients are making a mistake thinking that if they pay they will get better services. In fact, money does not influence the quality of treatment. One patient gave 1000 to the unit head. He thought that that was just because he was a unit head. And he never returned back to her. He thought that she had paid for a more or less decent room. And she thought that those 1000 rubles would make him do something for her. How to justify such payments – I don't know*".

In addition to appealing to ethical norms, respondents of this cohort believe that informal payments shall never be accepted, because it is the government who must pay decent salaries to doctors: *"A patient shall not pay for anything, just because he is a patient. It is the government who should pay for his treatment"* (a unit head).

Doctors who accept and approve of patients' payments are convinced that *"if the government is unable to reimburse doctors decently, someone has to do that for the government"*. Doctors who justify informal payments often refer to the quality and effectiveness treatment. In this case, patients' payments serve as reimbursement for doctors' knowledge and skills.

Perceived injustice makes doctors firmly believe that *"you can not do without informal payments"*. However, analysis of such arguments demonstrates that informal payments are considered by most doctors as a bonus for a better-than-average performance: *"If you do your job well, it must be rewarded adequately. If an obstetrician travels all the way to his hospital on his day off and delivers a baby without complications, he must be reimbursed accordingly. But there cases when they make a deal with the doctor, and he comes in when the woman is already in labor. This is a kind of fraud and indecency. In a situation like that there is nothing to pay for"* (a unit head of a maternity hospital).

Some doctors believe that a patient may be asked to pay for an opportunity to choose this or that doctor, for additional examinations or better-quality drugs offered by doctors: *"If a patient wants to be treated by a specific doctor, the payment is justified. That is his choice. He wants to be served by a more experienced doctor, and he has to pay for the right to choose"* (an OB/GYN doctor).

Doctors who work at private clinics believe that a patient may be charged an additional fee when treatment outcomes exceed that patient's expectations or are unique: *"I do not even know how can additional (informal) payments be justified. Maybe if the outcome has exceeded all expectations, or when it is a unique case. When you can say "I did it!" and you feel so proud of yourself. Only in a case*

like that – maybe. But generally I do not think that all patients should always pay" (a resuscitation specialist who works at a private clinic).

Doctors also believe that informal payments make them assume more responsibility for the paying patients and encourage professional development: *"Such payments make you feel more responsible. You become more responsive to the patient's needs. Not only you observe him after surgery, but also provide counseling, correct errors made by your predecessors, etc. You become more disciplined"*.

Very often doctors say that patients save money, rather than spend it, by paying directly to doctors, when both sides are satisfied and no one looses anything: *"The payment is justified when we kind of find each other: the patient has an opportunity to pay less for the same quality, and I have a chance to get more, than if I could if the money goes to the cashier. Say, if the patient pays through the cash register, I will get 270 rubles. When he pays directly to me, he pays less than he could have, but I get 1,500 rubles in cash. So, everybody is happy. He knows that I/m the best surgeon in town. He comes to me and says: "The operation officially costs 4,000 rubles, and I can only pay 2,000, but directly to you". So, we make a deal. I always agree to help people"* (Head of Surgery).

It can be concluded that most doctors do not see informal payments as something shameful or inadmissible. Many doctors perceive what they accept from patients as a fair reimbursement for their good work and an opportunity for a patient to obtain services of desired quality. Moreover, they are prepared to earn informal incomes by spending additional time and effort to identify best treatment options. Our respondents did not demonstrate any visible desire to charge more than it costs (as perceived by them), or to get the money at any price. Moreover, they categorically criticized all forms of extortion and racket.

However, the lack of legally-derived income makes doctors look for new ethical standards that would allow to accept informal payments. Many succeed in their search. Existing system of values is being transformed to justify informal payments. Psychologically, such system will be more comfortable for doctors, as it lifts the conflict between "old" ethical values and new realities. However, recognition of informal payments as a justified practice does not mean that all doctors resort to it. Health professional community still has consistent opponents of informal out-of-pocket payments. Nevertheless, as the interviews has shown, it is not likely that informal payment practices will ever be condemned by Russia's health professional community as a whole. And it is clear why: internal arguments used to justify such practices do not by and large contradict existing ethical principles, with one exception – formal prohibition. But you can hardly be a successful administrator if the only tool you use is people's fear of punishment.

4.1.3. Cases in which physicians consider informal payments unjustified

Although most doctors either tolerate or support informal payment practices, they also believe that there are situations in which informal payments or any attempts to derive them must be stopped. However, even in this case only a small part of respondents (5-10%) insist that *"doctors must never accept informal payments, no matter what the situation is"*. The greater part of doctors prefer "reasonable limits" to "complete ban".

We will try to describe those "reasonable limits". First of all, informal payments are considered as inadmissible, if they are a result of extortion or doctors' blackmail: *"Any form of extortion or racket must not be tolerated. You must take care of your patients, regardless of weather they pay or they don't"*. According to doctors, any patient must have a choice an opportunity to be served:

Most of our interviewees believe that informal payments shall never be made in the following situations:

- Attempts to extract money from a patient who requires emergency care – during the first 24 hours after admission - and is probably in shock;
- Being paid for a surgical operation that has resulted in severe complications or patient's death;
- Asking lonely retired people with severe conditions to pay;
- Extracting money from colleagues or doctors' relatives;
- Charging patients who have been recommended/referred by regional administration [government];
- Making a deal that may inflict damage to another person;

Although health institutions' administrators are convinced that informal payment practices are admissible "within reasonable limits", they specially indicated the need to stop doctors who start talking about money with patients who get admitted in critical condition: *"I am trying to prevent cases*

of extortion in the emergency ward. Next day after emergency admission, when nothing threatens the patient's life and he starts thinking, they probably may raise the monetary issue. The patient starts to realize that without paying he will have to spend 6 weeks in the hospital, but that that term may be reduced… Moreover, I obtain a written consent from each patient, where he says: "I have chosen doctor X, I have nothing against anesthetic Y, I have agreed to such and such conditions", - said a deputy chief doctor of an urban hospital in his interview.

Accepting money before the onset of a treatment course or surgery runs counter to existing ethical norms. However, doctors who do not charge patient in advance assume the risk of not being paid for their efforts: "No one in my profession takes money in advance, - says and OB/GYN doctor, - We must earn it first. Tissue recovery is a very patient-specific process. Sometimes you have to continue treatment. It is only when the job is fully accomplished that you can come to the patient and say: *"We discussed my remuneration before the operation. Now I have really earned it". Then they pay. However, each second patient refuses to pay after treatment has been provided. They just cheat. And it is those who have deceived you tell their friends that they have paid 3 or 5 or 10 thousand to you. But this is how a doctor should do it. Because first, it is a matter of his daily bread, and second, it is a good advertising. Not each of you patients is prepared to deceive you, but each one will be willing to tell his friends about a doctor who did an operation well. This gives that doctor a chance to earn more in the future"*.

A wish to avoid the risk of getting nothing makes some doctors charge their patients in advance. However, treatment outcomes may be unsatisfactory for the patient and his relatives. This leads to conflicts and complaints. Doctors hate that sort of publicity and, thus, reproach their colleagues who break the unspoken rules. Up-front payments are viewed by most doctors as unjustified, especially when a patient has to undergo an intervention with unpredictable outcomes. That is why payments "after" are preferred to those "before".

It should be admitted, however, that this rule is quite flexible and allows variations: *"You want me to tell you when do I think "shadow payments" can not be justified? It is when a patient comes to you before the operation and gives you money. Then he develops complications after the operation, and that makes you feel sick. The most terrible thing is when unpredicted severe complications develop (like thrombosis and infarction). Everything was supposed to go well. But the patient may be too old, and his organism was too weak, etc. And then you are trying to do everything to rectify your errors or lack of foresight. Generally, I think that you may take the money before or after treatment, but it should better be after"*.

Doctors react strongly to their colleagues' attempts to take money from older retired people. According to doctors, even small payments by old people may not be justified, because old men and babushkas have to pay a lot for drugs (especially if they have chronic cardiovascular conditions), and there are virtually no solvent people in this population group. However, old people often stand up for their rights, understanding that they can find protection against physician racketeers: *"A babushka with a walking-stick came to a hospital. She wanted them to hospitalize her immediately (she had to travel all the way from a distant village). The on-duty doctor says: "My shift is over. Ok, what do we do? I think 300 rubles will be enough… The babushka paid, then let the doctor fill out her history, and then went directly to the chief doctor of that hospital. The on-duty doctor wads fired. They fire people for accepting informal payments in every hospital from time to time. Charging informal fees is dangerous",* - says one of our respondents.

More than 50% of the interviewed doctors highly value what is called a "corporate solidarity" and are convinced that a doctor shall never take money from another doctor or his/her relatives for treatment. This rule certainly applies to colleagues who work at the same institution or high-ranked doctors from other facilities. It is shared by all (or almost all) doctors: "You shall never take money from your colleagues, friends and relatives, - says an OB/GYN doctor, - This is about corporate ethics. Most doctors think the same way. A colleague is untouchable. If another doctor is asking you for his or her relative, it is impossible to refuse. I'm not a modern person. All of my colleagues become kind of old-fashioned when it comes to things like that. I am strongly against extortion. Such practices do exist, but they are not done in public, you know. I understand that life has become very difficult. But some values are eternal, and you can not just step over them. Although I have become accustomed to a certain economic status, I can not and I never will take a penny from a colleague. If they do not pay me, ok, I'm not against".

The above statement shows how contradictory the norms regulating the respondent's behavior are, and how hard it is for her to find a compromise between her "current self" and her "old-fashioned self". However, an urge to clearly define "the close circle" and deal with people who belong to it based on customary norms, is stronger than her aspiration to reach a status of a well-off citizen. Even though her current life is difficult.

Taking money from chief doctors' or high-ranked regional or municipal officials' "protegees" is also tabooed. Even without warning, doctors behave very carefully with such patients and may even refuse to accept cash from people who share one room with them. Moreover, doctors would sometimes collect money in order to buy a necessary drug for a "special" patient in order to maintain their hospital's image and avoid potential problems with that person or his/her relatives in the future. This means that the fear of being caught red-handed is very strong and, thus, many doctors may defined as people who are forced by circumstances to accept informal payments, rather than unscrupulous characters who would do anything to get to the patient's money.

There are several other limitations, such as *"impossibility of accepting money for something that can inflict damage to another person"*, when a doctor gets paid for falsifying patient's diagnosis: *"I will never be part of a deal that may seriously damage somebody else. Say, I will never write a false medical certificate, because it can seriously damage that person. This is impossible. Period"*. (an internist of an urban teaching hospital).

Restrictive norms may be personal or group, but none of them can be viewed as an "iron imperative" and may be transformed on an as-needed basis. An explanation for this is that informal payment practices are usually hidden from the public and are rarely discussed in the open. As a result, diverse contradicting ethical norms/standards continue to mushroom.

4.1.4. Justification of informal payments by mid-level and junior medical staff

Nurses and nurse's aides face even worse financial distress than doctors. Does that make them try to get to patients' money at any price and adhere to less restrictive norms regarding informal payment practices?

As data generated from the interviews shows, nurses and doctors do not differ much in their attitudes to informal payments. There are nurses who *"regret that patients do not have that much money and are not prepared to pay"*. Like doctors, they sympathize with patients who can hardly afford drugs (let alone informal payments to medical staff). As a result, nurses and aides often have to get nothing more than a chocolate bar or soy candies, but that does not reduce their readiness to be as attentive as possible towards solvent patients: *"We would gladly accept the money, but patients rarely offer it. In the olden days patients were more grateful. But we understand them. They just can not pay. In the Soviet times everything was free and people had more money to spare*" – said a chief nurse of Cardiology.

There are less "consistent opponents" among nurses and aides. Most of the nurses are "forced supporters". This may be explained by the fact that nurses' official incomes are very low, and that people with secondary technical [college] education in Russia traditionally either strictly adhere to established ethical standards, or deny them. As a result, the nursing community has both "altruists" who are especially sympathetic with patients who are unable to pay for effective/expensive drugs and quality services, on the one hand, and those who are prepared to earn money "at any price" and close their eyes on other people's sufferings: *"I can not take money from my patients. Their relatives are poor people too. They have to sell the last goat and slaughter the last cow to buy drugs. I will never take even a candy bar from them. I will do everything to help a dying patient. It is easier at our [nurses'] level: it does not matter much whether the patient pays or not"*.

Like doctors, nurses believe that informal patients' payments are a response to miserable official health professionals' salaries. Like many doctors, they like their jobs, but dislike low salaries which make them think about the need to find a better-paid job.

Nurses see that informal payment practices have penetrated so many other sectors of economy, that they have to behave like other people [i.e. resort to such practices] in order to provide for themselves and their families. *"All of us – not only health professionals - have to live in the same conditions. We also have to make under-the-table payments somewhere. It is them [the government] who put us in such conditions. It is a chain reaction. I take my kid to school. His teacher says: He will get D for the term, but I can do math with him in the evening. It will cost you X rubles". What am I supposed to do? I must find the money. Where can I find the money? Wherever possible. That means my hospital"* (a hospital chief nurse).

Realizing that the statement above may be nothing but a "justifying reasoning to make life easier", we, however, can not fail to notice that it is difficult to expect lowest-income people to demonstrate consistent behavior aiming to turn down informal payments for ethical reasons. Treating solvent and insolvent patients equally is the best they can do.

Although most of the interviewed nurses insist that they treat all patients equally, chief nurses are positive that nurses and nurse's aides pay more attention to paying patients at the expense of low-income patients, and that informal payments are dangerous, because they accustom nurses to getting

additional – and sometimes unjustified – payments: *"I'm afraid that nurses will become accustomed to getting cash from patients. That will be a disaster. It's OK if a patient can pay. But what if it is a babushka who has nothing? No one will even come close to her. If a nurse develops a taste for getting cash from patients for everything she does, what will we do? Most of our patients are pauperized babushkas. The nurse will be serving only paying patients. I'm not against informal payments, but such payments must be done from time to time and shall not grow into a system. If a patient wants to do something to thank the nurse – let him or her do that, why not? Or when patient's relatives ask you to be more attentive to him: "you are on a 24-hour shift. Please look after our guy. Here is the money". But it must never grow into a system (like in Moscow where they rob patients). Maybe I have become too old. May be I'm old-fashioned. But it should never become a day-to-day practice: "If you pay, I'll replace your bedpan. But only if you pay". We must do everything to prevent it. Because medical profession is about mercy"*, - says a chief nurse.

Another chief nurse defined informal payments as a "threat", as they make it more difficult to manage people who are accustomed to take money from patients: *"Informal payments are threatening my authority. Because the more money you have, the more you change. The more patients pay, the less care will be delivered to those who can not pay. Like "I brought you a clean bedpan, and made an injection. Pay… " What will become of health profession? Whoever can take those payments, but not nurses"*.

Although unit heads and chief nurses are concerned about "excessive commercialization" of rank-and-file nurses, most of them believe that informal payments are justified just because *"if informal payments disappear, there will be no nurses left in public health institutions"*.

At the same time, most health officials and doctors are convinced that "nurses and nurse/s aides get only a small share", especially given that they have to live and take care of their families. As a rule, many of nurses are single mothers, which makes the problem even more complicated.

Thus, nurses are even more prepared and ready to accept informal payments, than doctors. However, they may be classified as "forced", rather than "consistent" supporters of informal payment practices. Recognizing that their economic status is extremely low, and trying to survive, nurses mobilize all available opportunities to earn additional money within their health acre institutions. They tend to be more attentive to those who can pay. Where unit heads and chief nurses are controlling the situation, nurses' performance with respect to non-paying patient is satisfactory, but not better than that. However, one should not forget that many nurses and nurse's aides deem it impossible to leave severe patients without care, even when such patients can not pay anything. This mitigates the problem, but does not eliminate it.

4.2. Group norms regulating informal payment practices

4.2.1. Discussion of informal payment practices by health care facilities' staff

According to respondents, informal payment practices have penetrated many health care facilities in Russia. The question is: have new group norms and rules evolved as a response to the growing prevalence of informal payments? And if they exist, do they get transferred from facility to facility? Can some collective/group sanctions be used against those who are found to be involved in informal payment practices?

First of all, we need to understand whether or not informal payment practices are discussed among health care staff; do such discussions start spontaneously or are organized by someone; who initiates them; and, finally, how do staff members react to people who are trying to openly discuss informal payment practices?

Our data show that there is no single norm or standard with respect to "openness vs. secrecy". Like in the case of informal revenue distribution, there are many subcultures developed under the influence of diverse factors.

Firstly, 2/3 of our respondents believe that IP practices, rules and norms are not subject to open discussion. Interestingly, IP practices are not broadly discussed neither in the places where their prevalence is high (i.e., large urban hospitals), nor where they are almost non-existent (e.g. district, AKA rural, hospitals).

Here are some of respondents' statements on the matter: *"You know, nobody shares with anyone: whatever you get is yours"*, - says a surgeon. *"Such practices are never discussed in public. You can only talk about them with your close friends. Even that is not easy. Generally, this topic is closed for discussion. It is a taboo"*. (an internist)

Some respondents are convinced that the topic may be tabooed by a unit head, who does not want it to be discussed in order to avoid publicity and preserve "the face of the unit": *"I have never*

heard discussions around such practices. Probably, each person who takes money from patients prefers to keep it low profile. And I have never heard about conflicts over distribution of ill-gotten incomes. Maybe some unit heads do know what is going on in their wards. Whatever the unit head wants he gets. If he/she does not want the topic to be discussed, there will be no discussion".

This "vow of silence" is explained by most of our respondents as follows: *"it is a secret thing that you are not supposed to discuss even with your friends"*. It should be noted, that this rule is used even in facilities where informal payment practices are widely used and may need some sort of management. The fact that many respondents insist on that IP practices should be discussed in their facilities may indicate that: the staff of a given facility have already developed clear-cut unspoken rules and norms with respect to informal payments or; such practices are perceived by doctors as inadmissible, which blocks communication on the matter. This conclusion may be confirmed by our respondents' statements: *"It is a shame, it is unpleasant. Why does it have to be discussed?… It burns your hands indeed"*.

However, we think that the lack of communication or open discussion is often caused by other – more complex - factors, than just "a wish to keep a shameful thing in secret". Among such factors are motives of "envy" and "unwillingness to share".

According to health administrators, a motive of envy is especially strong in public outpatient clinics and may lead to communication breakdowns with respect to any IP aspects, or result in open conflicts which most doctors and nurses try to avoid: *"Take our ultrasound diagnostic department for example. Informal payments are very prevalent there, because demand for US diagnostic services exceeds supply, and accessibility of such services is low. And US diagnosticians' salaries are very low. But people still want to work there, and other staff envy them. Internists do envy them. The same is true for surgeons. Many health professionals envy them, because not only they accept informal payments, but they also provide more official chargeable services. However, it is mainly nurses who have this envy. Because doctors in general have more opportunities to generate informal incomes. Nurses have only limited opportunities to this effect"*.

"The vow of silence" may also be a result of doctors' unwillingness to share their informal incomes with nurses. This is what one of our respondents said in his interview: *"If you are good at making that kind of money, you do not necessarily need publicity around it. Because when colleagues get to know that "someone thanked you", they start asking for their share, because you were not the only one who served that patient. If you keep it low profile, your have a better chance to retain more money"*.

Another important cause of the lack of communication around informal payment practices may be that there are no clear-cut group rules to adhere to, and that each doctor or nurse tends to act in his or her personal interests: *"Everyone is on his own. Why should they discuss it, and what should be discussed?*"

The lack of open discussion may be a result of some general unspoken ethical standards accepted by Russia's intelligentsia. For example, "decent educated people" are not supposed to discuss each other's incomes (especially "shadow" ones): *"No one talks about each other's incomes. And no one asks such questions. It is not polite. If you adhere to certain professional ethical standards, you are not supposed to compare doctors with each other"*.

However, the lack of verbal communication does not mean that the episodes of informal payments remain unnoticed by the staff. This is how a clinic administrator describes the situation: *"Doctors' and nurses' mentality has changed a lot since 1998 (when Russian national currency collapsed). Only few people would accept money from patients before that year, and such people were strongly criticized. It is different now: there are more people who take money from patients, then those who criticize that. Generally, informal payments have ceased to be a topic for open discussion"*.

Although most doctors, nurses and administrators consider informal payment practices as a matter tabooed for group communication/discussion, some of them indicate that such communication does exist. Situations in which people discuss IP-related matters may be classified as follows:

- High level of tension among medical staff in a given setting resulting in frequent conflicts, including those over informal revenue distribution;
- A given setting is lead by "soft-hearted" administrators who tolerate situations where nurses "peek into doctors' pockets";
- There is a marked conflict between generations in a given setting (i.e. conflict between older and younger doctors);
- There is a need to clarify and reconcile rules governing informal revenue generation or distribution;
- Confidential relationships within micro-groups allowing people to clarify existing rules with respect to informal payments.

According to our respondents, people start openly discussing IP-related issues either when a conflict breaks out, or inside groups where the level of mutual trust is high. An extensive open discussion which may even cross the boundaries of a given ward can be more often seen in conflict situations, while discussions to clarify/reconcile IP rules usually take place within smaller groups and do not involve everyone who works at a given ward. Very often such issues become a matter for open discussion when a conflict is about to break out between doctors and nurses over violation of unspoken IP distribution rules.

Informal payment rates and distribution arrangements get discussed more often than other issues, but – according to respondents – such conversations almost never involve anybody who does not belong to a given small group: *"Of course we discuss informal out-of-pocket payments. I don't know about other groups, but my group does discuss them. Moreover, we discuss who should be the "shareholders" in this or that "business" and how much should each of them receive"*, - said one of our respondents.

A wish to preserve their ward's image makes doctors do everything to minimize the "conflict zone". As a result, conflicts around informal payment practices almost never go public and stay confined within a given ward. A breach of verbal doctor-patient contract by the former is often discussed, as such cases can undermine the image of all doctors who work in the ward: *"Informal payments are usually discussed in a face-to-face manner and almost never become a matter for broad discussion. Sometimes they are discussed by a larger team… For example, when a doctor takes money from his patient and promises that he will implant a plate made of some specific metal. But later, when they remove that plate, they see that it is made of a worse kind of metal. Then team members get together to discuss that case"*.

Paradoxically, medical staff use the same criteria to assess the appropriateness of IP practices as are used by facility administrators – deviations from commonly-recognized rules, that is. As long as a doctor or nurse behave like "anybody else" and do not breach the established norms, their activity with respect to informal payments remains "unnoticed". But as soon as someone crosses the "reasonable" limit, he or she becomes a focus of discussion – either within a small team, or the entire personnel of his/her ward. However, doctors tend to sympathize with their "guilty" colleagues even in such cases, because they understand "how difficult it is for a Russian health professional to survive": *"We do discuss such things, but not very often – only when someone totally gets out of control and starts breaking all imaginable rules. But if they act within reasonable limits, we do not object. Everyone lives the way he can. Because official salaries are miserable. Some doctors are not good enough to charge additional fees, or can not do that because of their personal rules, but someone thinks that that is not an inadmissible thing"*, - says a chief of Gynecology.

Thus, it can be concluded that informal payments are not openly discussed in most Russia's health care institutions. This silence is caused by numerous and diverse reasons, but most of them deal with health professionals' unwillingness to accuse anyone of being involved in such practices, because none of them wants to become one of those accused one day ("Judge not, that ye be not judged"). When people get to discuss informal payments, they do it to review and reconsider existing practices or identify themselves with this or that micro-group.

4.2.2. Can health professionals influence informal payment practices and do they want it?

In order to answer that question, let's first of all analyze the following issues: how do professional groups treat their members who are involved in informal revenue-generating practices; are group sanctions imposed on those who cause or become involved in a scandal; what actions may cause a group reproach or support. We will then assess professional groups' ability to influence such practices.

The survey has shown that group norms regarding those involved in informal revenue-generating practices are usually hidden from the public, are very selective and often depend on how each particular person is treated by his/her colleagues. There are also commonly-recognized principals which are shared by majority of doctors and are a quintessence of doctors' personal experience of communication with patients and colleagues. Such principles, however, do not always become a matter for open discussion.

It is noticeable that unit heads, doctors and nurses demonstrate a high level of tolerance towards informal payments. Only $1/5^{th}$ of the interviewees consider such payments inadmissible. In reality, however, there must be even less opponents of informal payments, since some of our respondents could have concealed their true beliefs in order to look more "decent": *"People tolerate those who accept additional payments from patients, because it is patients who offer the money to thank their doctors"*.

According to our respondents, doctors may demonstrate various attitudes to a colleague who has been caught red-handed or became a center of open discussion or conflict, but most or them will either remain neutral, or express compassion and sympathy: *"They will express sympathy to a colleague who gets caught. All of us have to live under Damocles sword"*, - said a high-class surgeon.

One of the chief doctors expressed the same opinion. However, sympathy is usually expressed in a face-to-face manner. According to him, collective reproach or sanctions are possible, if the case becomes a subject for formal review, or gets to be discussed at a formally-organized meeting of staff conference: *"If someone gets caught red-handed, most of other doctors will say: "It is bad luck". What do you want from them? It is in their mentality. But they can express their sympathy only when they are sitting in a tea-room. No one will be brave enough to do it at a formal staff conference. I have seen several cases like that. However, the maximum they will do to the delinquent is ask him or her to stay within reasonable limits. They will not defend him, but they will not openly approve of his/her behavior"*.

However, you can hardly expect medical staff to openly condemn their colleagues without formal interference on the part of facility CEOs. More than 80% of our respondents believe that no doctor will openly reproach a red-handed colleague out of his/her own free will, unless that colleague's behavior threatens the institution's image.

Why is it that professional groups are so tolerant to those who accept money from patients? The answer is: doctors believe that they are forced to resort to such practices: *"If one of my colleagues gets caught red-handed, other doctors will sympathize with him. Because informal payments are a forced measure. Of course, an educated, intelligent decent person feels bad when he receives that envelope and thinks to himself: what if that patient starts doing tricks or cries out something like "crook" or "greedy bastard". This is very humiliating. People have to resort to such practices, because they have to keep afloat somehow. Because you have only one life. The government has to think of how to make our life better and avoid that sort of humiliation"*.

A very young doctor, who has just started learning collective rules and norms, also thinks that it is the government that is responsible for such order of things: *"If they catch me red-handed tomorrow, part of my colleagues will express sympathy, and the rest will stay out of it. But no one will reproach me. Definitely. Why? Because all of us live like beggars. It is our life that makes us do such things, and we are happy when patients give us even small sums. We have been put in this situation. In other words, they have forced us. I am a young woman. I want to wear decent clothes and eat decent food. I will not need it when I'm 70"*. Notice: a young doctor, who has not yet earned her colleagues' respect, is convinced that there will be no tough punishment for taking cash from patients.

Realization of the fact that tomorrow "it is you who may be caught" stops doctors and nurses from openly reproaching their colleagues who are known to take money from their patients. Moreover, any negative reaction to the colleague's behavior may mean taking the risk of being set up by that colleague in the future or being left without his support. That is why it will cost you less to say nothing: *"They can always find a way to set you up, if they think you deserve it. So, everyone respects each other*, - says an OB/GYN doctor, - *Or they can help you. Even knowing that I do make additional money, they never refuse to help me, because they are in the same situation, and they know that their colleagues know everything about them, too. If they are asking you to serve their patient, you don't care whether they receive money from that patient or not, although you may say to yourself: "You asked me to help, but you will be paid for that patient, and I will get nothing but "thanks", because tomorrow you will probably face the same situation and need their help. This is not because we are so noble and grateful, but because it is beneficial"*.

Respect to people who "know how to make money", and a wish to become wealthy also matter: *"I can imagine a situation where we – all of a sudden – learn that one of us takes money from patients. Some people would probably reproach him or her, but they will never say it loudly. Why? Because people who have money [and it does not matter how they earned it] are always respected by colleagues. All of us have more or less the same economic status, but if someone has found a way to live better, he gets people's respect. Everyone wants to lead a better life nowadays. But if that person gets caught, if everything goes public, he will probably be blamed (officially). There are people who are against informal payments, but there are not many of them"*.

No matter how liberal existing norms are, most of our respondents believe that everything should be done without crossing the "reasonable limits": *"Although we can never condemn one of our colleagues for making additional money, he or she must not cross the line. If someone does it, they tell him: "Do you have conscience at all?"*

What do group/collective ethical standards prohibit or approve? First of all, prohibitive norms do exist and are mainly used against doctors who break the rules accepted by their micro-communities or ignore their unit head's requests or orders [e.g. *"this is not about us"*].

Very often collective/group norms are not taken seriously by all staff members: *"We do discuss patients' payments, but we always make a joke out of it. I can not name any group norms, because we do not have any"*, - says an internist of an urban hospital where the prevalence of informal payments is especially high.

Although many respondents are convinced that collective norms regarding informal payments are non-existent, the survey has shown that such norms do exist and have similar characteristics is various settings/wards. These are perceived by our respondents as a matter-of-course reality or an inalienable part of their day-to-day activities and communication. As a result, people often do not realize that they are adhering to them.

Data generated in the course of interviews allow to draw a list of restricted behaviors/practices. It includes:

- Racket/extortion;
- Never discuss informal payments in public;
- Intentional breach of a verbal contract with your patient;
- The use of fixed rate-based payments (not always used);
- Accepting money for an operation that has resulted in complications or death;
- Active imposition of the deal on patients, with the exception of services to be provided by "unique" specialists and world or regional-class "superstars";
- Accepting informal payments from patients with severe conditions, low-income and lonely people (optional);
- Acting in the interests of pharmaceutical companies (prescribing specific branded drugs to patients) (not always used);

The list of permissive norms is also long enough and includes at least the following practices:

- Getting tangible thanks from the patient;
- Asking you patient to pay what he/she can for a service;
- Getting paid for a quality treatment that has not resulted in complications;
- Getting paid for being a world-class professional who has used or will use some unique technologies/equipment;
- Accepting money or gifts for being especially attentive to a paying patient;
- Accepting money/personal computers/household appliances/money for renovation for the ward/setting from a wealthy patient;
- Payments/gifts to nurses and nurse's aides for taking care of the paying patient.

Racket/extortion is generally prohibited, and many doctors have to adhere to this norm, although in departments where informal payments are especially prevalent (e.g. Surgery) it can be easily substituted with one of permissive norms (e.g. " Getting paid for being a world-class professional who uses some unique technologies/equipment "). Which of the two will be used depends on how seriously the second prohibitive rule ("Never discuss informal payments in public ") is taken by doctors in a given unit.

A prohibition to disclose informal payment practices is a more or less common norm which is observed by almost all health professionals, including unit heads. People who violate this norm almost always get condemned by their colleagues who work in the same unit, because "your unit's image" remains a powerful motivator for rank-and-file doctors and facility administrators. As a matter of fact, their personal popularity can attract less paying patients than that of their units/wards. Thus, they do care about what the public knows and thinks about their settings: *"I do not object when doctors and nurses in my ward take money from patients. IF they can do it – OK. But it must be beneficial to both sides, and it must not impair my department's good image"*, - says a Head of Surgery.

One of the strongest taboos is "never take money from severe cases or those who cannot pay". Violators of this norm may be condemned by all of their colleagues: *"Everyone who works in the ward will condemn a doctor who takes money from patients with severe conditions, or cancer patients, or those who can not pay at all. We also reproach doctors who say to low-income patients: "I will do this and that, but you will have to pay X or Y rubles to me". I think that it should be up to each patient (to pay or not to pay and how much)"*, - said an urologist.

It is important to note that, although professional teams may take measures against their members (when the latter violate the accepted norms or when there is a threat that cases of informal payments can go public), the piety to such measures is much lower than it could have been, given that all practices in question are illegal.

Some statements made by our respondents show that personal survival and personal success are so important to professional doctors, that they start caring less and less about what their colleagues think or do. The only thing they really care about is their practice (which –however – requires inputs

from other people). Thus, personal ambitions may be viewed as a shield that can make any collective attempts to influence an ambitious doctor's behavior ineffective. An ambitious informal leader is taken into account in any group: *"No one can make me do things that I do not want to do. I'm a leader in my ward, and no one of them will ever tell me that I get more money than they do. I do not envy people who earn more money than I do. If they do, it is good for them. There is only one woman who envies me. But she can not show that openly, because I'm stronger than her. I will always be able to show her who she really is. That is why she prefers to keep silence and to envy"*.

Another factor that can increase the level of personal resistance to collective sanctions/measures is internal control. A person who prefers to control himself may think of any external/imposed control as excessive and unpleasant: *"I must be true to myself first of all. What will my colleague feel or say is not that important. I've seen very many fellow doctors in my life and I can say that there are doctors who work just for the sake of it. There are many doctors like that. It is not true that all doctors take money from patients nowadays. Especially in the provinces. Nobody takes money from patients in our parts. Old-fashioned Russian community physicians are still there, that is, doctors who work hard and only the way their decency and conscience tell them"*, - said a doctor from a district (rural) hospital.

Thus, there are no uniform rules or uniform penalties associated with informal payments. Both rules and penalties are very selective and take into account each doctor's popularity, professional level and preparedness/willingness to help other staff members. If a given doctor is not very much respected by his colleagues, his penalty for being caught red-handed when accepting money from his patient may be more severe that that imposed on a doctor who is liked by his colleagues: *"There are rules, but everything depends on the circumstances. Two different people may face a different punishment for the same thing. The punishment may depend on who you are and what you did"*.

Even in a situation when young inexperienced doctors are found guilty of extorting money from patients, older colleagues do not tend to exert to much pressure on them and resort to tough measures only it the conflict between a younger colleague and his/her patient goes public: *"I know many doctors. All of them are surprised by what young doctors do. Younger doctors' views are so different from ours,* - says an experienced OB/GYN specialist, - *They want to live better. They are looking around. However, I can not say that I support the things they do. We belong to an older team, we do not interfere and there is nothing we can do to influence the youngsters. But if anything specific gets to the surface – a conflict or something – we will have to say our word to them. The unit head will do it first of all"*.

Surprisingly, according to some respondents, it is those who do not accept informal payments who are more likely to be reproached, that those who are known to accept such payments: *"Certainly, everybody blames a doctor who does not take anything from patients, because he/she spoils the picture. But I do not know anyone who would not accept money from patients. Maybe I just don't know much"*.

A person who has been caught red-handed may also become a topic for group discussion. His/her colleagues' reaction is predictable: "do not let them catch you" or "poor thing/bad luck": *"Reactions may differ. But most doctors will say: "You are a fool, because you let them catch you". But the rest of colleagues will just feel sorry for him/her"*.

The survey has shown that more and more doctors get accustomed to informal payments. They tend to abandon group/collective prohibitive measures and are becoming more and more liberal to those who are known to be involved in informal payment practices. Here is what a hospital-based internist said in her interview: *"When I started my career, those who were taking money from their patients could not tolerate those who were not doing it, and vice versa. Now there are no clear boundaries between the two types. All of us accept "patients' gratitude". And no one reproaches that. Because we have to survive"*.

Thus, each hospital unit has a diverse collection of restrictive and permissive norms/rules with respect to informal patients' payments. However, these norms are not shared by all staff members and are applied selectively. Restrictions concerning extortion/racket and disclosure are supported by most doctors and nurses. Most popular permissive rules include those allowing to accept the money if it is offered by the patient and the one that does not prohibit to set a flexible price for doctors' or nurses' services. The extent to which a doctor or nurse may violate unspoken rules and norms depend on his/her authority and professional level. Informal payments are getting more and more accepted by health professionals. This does not mean, however, that there are no doctors who continue to be consistent opponents of such practices.

4.2.3. Can existing group norms be used to regulate informal payments?

Health professionals' attitudes towards informal out-of-pocket payments are very diverse and very similar at the same time. All health professionals believe that the cause of informal payments is

the government's failure to take a proper care of them and reimburse their work in accordance with their social importance, education and skills. However, none of them believe that the government will ever start dealing with the problem in the visible future. Many health professionals feel very uncomfortable and tense when they are asked to talk about informal patients' payments. That is probably why so many of them support the "patients' gratitude model" and oppose extortion/racket.

However, we do not want to idealize the situation. Doctors' mentality hosts both traditional ethical values and new free-market-type imperatives. This complex combination allows both non-market and market-oriented behaviors. There are doctors and nurses who have already started using informal payments as their main source of income. They are ready to exchange their services (of high and substandard quality) for patients' money and gifts.

Analysis of existing personal and collective norms regarding informal payments shows, that physician groups interfere with IP practices only if they go beyond "reasonable" limits and cause conflicts. In all other cases *"everybody lives the way they want"*. The only limit is *"do not do anything that may impair good image of your ward"*, because it is that image, along with doctors' professional knowledge and skills, determines how many solvent and high-ranked patients will the ward receive. This results in another prohibition: *"do not allow it to go public"*. Apart from anything else, any conflict implies interference by superior organizations and administrators and, thus, should be avoided.

The diversity of ethical regulators and norms results in that each individual starts making situational decisions (i.e. "what is better for me now"). According to available data, the most prevalent personal ethical standards are those that allow to accept payments if they are initiated by patients (payments made out of gratitude), or set flexible "shadow" prices for services (i.e. depending on each patient's ability to pay). It may be safely assumed that such norms have become generally recognized by Russia's health professional community. This does not mean, however, that there are no doctors who refuse to comply with these commonly-recognized collective norms.

The survey does not allow to conclude that medical groups do nothing at all to regulate behaviors of their members. When collectively-adopted restrictive and permissive norms are shared by each member of the group, such norms do influence personal behavioral stereotypes and, thus, regulate informal payment practices. The ban on extortion/racket which is supported by overwhelming majority of doctors and nurses is a good example. People who violate it are in most cases asked to leave their institutions. However, if there is no match between personal and group norms and rules, an individual – especially if he or she is a high-class specialist – continues to implement personal behavioral schemes without listening to what his or her colleagues say. Thus, collective norms and rules can only be effective if they are shared by each member of a given group.

To summarize, modern medical ethics in Russia is a sophisticated fusion of the old and new paradigms, and it is extremely difficult for health professionals to navigate through them. There are no tough imperative norms imposed by superior organizations/authorities that could be viewed as fair by doctors. As a result, neither collective, nor individual participants in the process can effectively influence each other. Under these circumstances, informal payment practices develop chaotically and is restrained only by fear of punishment and fatigue of the players – doctors, nurses and administrators. The norms themselves are transforming from regulators into temptations and produce less and less restrictions. This allows to assume that if left alone, the IP practice will continue to evolve. The only thing that prevents its even faster development is personal and – to some extent – collective norms, which, however, are very unstable and prone to situational influences. Unfortunately, the way the norms are changing becomes less and less acceptable to Russian society.

4.3. Health authorities' and health financiers' attitudes towards informal payments

4.3.1. Social policy-makers' awareness of informal payment practices

The survey allows to conclude that Russian health authorities are aware of informal payments practices and the forms they take. Virtually all health care administrators/managers whom we surveyed, are convinced that informal payment practices exist in all state-owned health care institutions located in their regions.

There are several channels through which health officials receive information about IP practices. They include:

- Patients' complaints;
- Complaints from :superior officials in charge of social policy implementation in the region; other regional and municipal officials and; colleagues who have been served at health institutions;

- Complaints from health insurance companies;
- Information from doctors who are – for this or that reason – interested in contacting with health authorities;
- Information from relatives and friends;
- Information from colleagues.

Most patients' complaints describe situations where patients are asked to purchase drugs and disposable materials/devices and obtain low-quality services. As a rule, complaints against health professionals who obtain money from patients are filed by patients' relatives and only when patients dies in hospital. According to health officials, such complaints account for only 5 to 10 percent of all complaints filed with health authorities.

Social policy-makers in the regions are very well informed not only about the scope of informal payment practices in their region, but also about where such practices are most prevalent (i.e. specific institutions or units thereof). Regional administrators have a more or less clear picture of what is going on not only in the regional capital, but in every town of the region.

Regional law-makers do not recognize that informal payments have become a universal practice, as they rarely receive complaints about such practices. People more often complain about officially-set prices of specific health services that they can not afford.

Regional and municipal health authorities believe that it is health care facilities' chief doctors (administrators) who should play a leading role in curbing informal payment practices, as they have more tools to influence their own staff, than are available to regional or municipal authorities. However, regional and municipal health officials complain about the lack of interest on the part of facility managers: *"Chief doctors know everything: who, how much and for what. But they do not interfere with such practices, because they have to think about the future"*.

Most of our respondents admit that informal payments are extremely prevalent and recognize the need to respond to patients' complaints, but refer to *"impossibility to influence someone without having a solid material evidence"*.

4.3.2. Justification of informal payments by health authorities and financiers

Most of surveyed health officials are convinced that informal payments are a result of a chronic lack of public health funding and extremely low doctors' and nurses' salaries. Some of our respondents expressed their support to IP practices: *"Informal payments will always be there, unless the government does something to raise doctors' social status. A doctor should not receive less than a worker. The status that doctors deserve should be maintained by the government. Otherwise doctors will have to maintain it on their own. Doctors are embarrassed to take money from their patients, but what else can they do, if the government is not able to pay them decent salaries?"* Health officials and chief doctors name *"substantial increase in doctors' and nurses' salaries"* as a mandatory prerequisite for successful IP practice control.

According to health officials, another cause of informal payments is a lack or complete absence of performance-based provider payment arrangements. Doctors are not adequately motivated to work better and have to seek "shadow" incentives – patients' payments for services, that is. *"If the only reimbursement that a doctor in getting is his flat salary, he is not motivated to do his/her work better*, - says a representative of a health financing body, - *Doctors at state-owned institutions continue to receive flat salaries, and there are no performance-based incentive systems in place. Patients provide such incentives. Unfortunately, informal payments have become the only incentive for doctors"*.

Some health officials say that it is patients' wish and ability to pay for services of a better quality that has informal payment practices so prevalent.

Some of our respondents define IP practices as "inadmissible and dangerous". However, they do not have tools to control such practices (or do not want to look for such tools). Health officials' reluctance to interfere may be caused by "corporate solidarity" and unwillingness to take unpopular tough measures: *"It is unethical to interfere with IP practices, because as average Russian doctor gets only 30 U.S. dollars a month"*.

4.3.3. Can informal payments be controlled?

The survey has demonstrated: representatives of all managing groups (health authorities, chief doctors, unit heads and chief nurses) are convinced that IP practices must be controlled, but the current situation does not present any opportunities to exert such control to the full extent.

Although health officials do realize the importance of controlling IP practices and have appropriate tools to do that, they doubt that such control can ever be effectively implemented.

Health officials indicate the lack of laws and regulations governing the entire sphere of chargeable service provision. This makes any attempts to control IP practices "semi-legitimate". Health officials complained about the lack of legal mechanisms to influence IP practices: *"Informal payments have become a real disaster for health authorities. It is terrible to feel that there is nothing you can actually do about them. I just don't have the necessary tools. If only we had laws or policies clearly defining what services may be paid for by patients… That could have reduced the problem of informal payments. It is easier to manage things when there are clear-cut laws and regulations in place",* - said a representative of a health department.

Most of the regional and municipal health officials insist that they will not be unable to do anything about informal payments without support form the national Ministry of Health and the Duma (Russia's Parliament): *"Something has to be done. But it is impossible to do it at a regional level. Appropriate federal laws and regulations must be passed. We do not have enough tools to influence the situation. So, it is better to pretend that the problem does not exist"*.

Paradoxically, each health official believes that it is his/her subordinates who must be empowered to control informal payments. Thus, health authorities at each level tend to delegate that [unpleasant] function to lower levels: *"Only chief doctors can effectively control informal payment practices. If we interfere, that will mean that we will start performing chief doctors' functions. I think that this problem in each given facility may be resolved, but only if certain [law-enforcement] structures get involved. They can use labeled money for example. One or two presidents must be created to demonstrate that control does exist. Fear of punishment can seriously help to reduce the scope of such practices. However, you can be sure that those who are interested in preserving informal payments will take counter-measures. That is why facility chief doctors have to think about possible consequences before they start bothering those who accept money from patients. Every chief doctor says: I know exactly who in my institution is involved in IP practices". And they also know how much money their doctors charge"*.

Although health officials believe that it is facility chief doctors who should be in charge of controlling IP practices, they are not sure that chief doctors are actually interested in doing so: *"I think that chief doctors do have appropriate tools to control such practices. But each chief doctor thinks: "What will I get if I start doing that? What are the pros and cons?" And I am sure that chief doctors benefit more from closing their eyes on IP practices. Since they know exactly who is involved and how much they take, they can always use that knowledge when they want these people to do something for their facility. By letting everyone know that he "knows everything", the chief doctor gets another tool to influence his staff in order to attain his facility's goals and objectives"*.

Health insurers in the regions reserve the right to interfere with informal payment practices, but are only prepared to do that when their clients are asked to pay for drugs. Responsibility for taking measures against all other informal payments should be delegated to chief doctors: *"We can not control all IP practices, because we only get to know something when a client calls and tells us. If someone pays his money and does not complain, how are we supposed to know? I'm not a police inspector, and I'm not supposed to interrogate doctors to collect information about whether or not one of their colleagues is involved in such practices",* - said a leader of a private health insurance company.

That opinion is shared by a leader of a regional mandatory health insurance fund who also said that that IP control was not on the list of his organization's objectives: *"We have a lot problems to deal with even without informal payments. However, patients do call us from time to time. Most of them complain about doctors who ask them to purchase drugs. We do not have a very well-developed PR department. It is private health insurers who are supposed to work directly with people. So most patients complain to them"*.

Leaders of the mandatory health insurance funds believe that it is facility chief doctors who must control the situation, but they are not sure that the latter are capable of doing that effectively: *"Chief doctors do have means to influence the situation, but I cannot say whether they do it or not. It all depends on each given chief doctor. As a rule, chief doctors are influential and respected people. They give orders, and their staff have to obey. But some chief doctors are not respected by their subordinates and get ignored by them. This is a matter of personal authority. If a leader is respected – they will listen to him. If not, orders or policies will not help. But do chief doctors really want to eliminate IP practices in their settings? Very often a chief doctor is a former rank-and-file staff member of the same facility. Thus, the only effective form of control is that done by a private health insurance company. Because you can not assign a public prosecutor or investigator to each doctor or nurse. Also, much depends on each doctor's conscience. But many of them have forgotten that word"*.

Chief doctors and their deputies prefer to delegate IP control functions to unit heads, believing that any overreaction may leave the facility without high-class specialists: *"It is my belief that a hospital administrator must act like a chess player and see two or three moves ahead,* - says a deputy

chief doctor, - *Ok, we will catch them red-handed and fire them. Then our friends will call us saying that they need high-quality treatment. What will we do then? So, I do not think that we should make sudden moves. We need to think of something that will make doctors' lives better"*.

Like health officials, chief doctors complain about the lack of effective tools to control IP practices, on the one hand, and the possible consequences of such control for their facilities' professional human resource potential, on the other: *"Yes, I do not have sufficient tools to influence IP practices in my facility. Does the President of the Russian Federation have them? I have 1,500 people in my hospital. It is impossible to control all of them. Anyway, if I take tough measures, my best doctors will resign and find employment elsewhere. And I will left alone. However, I do realize that something has to be done about informal payments, because the hospital has to keep developing"*.

Most of the surveyed chief doctors believe that certain measures must be taken, but only when a formal complaint from a patient or unit head is filed. However, they say that the number of such complaints is negligible: *"I know nothing about informal payments in my facility. But if they report to me, especially if they submit a formal complaint, I will not hesitate to take appropriate measures. Doctors know that I have to report to the Tax Inspection and that there is a person there who supervises us. I will have to inform him about what happened. But if all that is done carefully and is kept low profile, why not? I always tell them: "I understand everything, but if you do anything wrong to a patient, the responsibility is yours". That is why we do care about how patients' histories are filled out"*.

Hospital chief doctors are convinced that they have managed to minimize extortion/racket at their facilities, but they also admit that they are unable to exterminate such practices completely: "I have to deal with informal payments often enough. But it is impossible to eradicate them completely. The only thing you can do is try to prevent extortion/racket. Things like racket shall not be tolerated. It is inadmissible when a doctor says to his/her patient: *"Give me money. Period"*. *A doctor must be careful about when to ask for money, and what to ask for. Because sometimes they start extorting money from a patient who is admitted to the hospital with some severe condition: "I will not operate before I get money from you". We are trying to expose such doctors and give them what they deserve. In order to show what may happen to a doctor who does things like that. Informal payments will always be there, but they must not cross reasonable limits"*.

Some of our respondents (mainly directors/owners of private clinics) believe that informal payments must and can be eradicated, and that it is chief doctors who must do the job. According to them, high prevalence of informal payments at public medical institutions is a result of poor managerial/leadership skills: *"A chief doctor of a state-owned hospital shall and can do that. But he should invent a system of appropriate measures. He should form a team of goal-oriented people. It is easy to say: "We can not do that". This is just a lack of professional competence. I am positive about that. The salary issue must be resolved. No argue about that. A chief doctor has economists and financial experts. What's the problem? Think of something! What public health care facilities really need is good managers. But good managers feel very uncomfortable at a state-owned hospital. Because they can not force themselves to go to the district/regional/whatever health department and bow before officials and beg. Because you can only have good relations with officials, if you sit there quietly and say "yes, sir" al the time. But there are no good managers among people who can tolerate that"*. Most unit heads and chief nurses also believe that informal payment practices can not or should not be controlled. Moreover, many of them see informal payment practices as a means to retain professional medical staff and make medical teams/groups more manageable. Some unit heads believe that proposals to control IP practices are science fiction: *"The problem of informal payments is a problem of doctors and their conscience. We have laws. A doctor takes money from his patient. I do not know about that. Good. This is not my problem. This is law enforcement agencies' problem. But if I receive a formal complaint from a patient, I will have to take certain measures. But it is impossible to introduce a total control. To control everyone is a science fiction. How am I supposed to do that? Look, we have been talking for about an hour, and I do not have any idea of what has been going on out there. And I really do not need to know about informal payments. Anyway, it is simply impossible to control it"*.

Some respondents gave a paradoxical opinion, according to which only inexperienced administrators do anything at all to control informal payments, because they want to prove to their bosses that they can manage their units: *"Theoretically, informal payments can be controlled. I know several wards where such measures are being taken. But that is possible only at the lowest levels of your organizational structure. Because the chief doctor and unit heads realize that they benefit from having extra-class doctors at their hospital. The more people like that they have, the more paying clients they will be able to attract. Then everybody will feel good. So, the lower the level/importance of a unit, the more its head tries to pretend to have things in order. He just wants to prove to himself and his bosses that people respect him and are afraid to disobey"*.

As a rule, unit heads step in when: 1) there is an open conflict as a result of extortion/racket or; 2) *"doctor's arms grow from the wrong place"* – that is, when a doctor takes the money and then does something that results in complications or death;

Despite everything they say, unit heads and chief nurses – like chief doctors – are afraid of loosing high-qualified doctors. Chief doctors, especially those who continue to practice, may not be interested in curbing informal payments for personal reasons. In a situation like that, "bad peace is better than a good war": *"Unit heads, if they remain practicing surgeons, also take money from their patients, - one of our respondents said, - Why should they stop informal payments? They allow other doctors to do that, and other doctors let them do the same thing. Their fear is defeated by money"*.

Does that mean that nothing at all is done to curb IP practices? "Yes" would not be the most appropriate answer. Realizing that it is extremely difficult to control such practices, many respondents, however, say that they are trying to introduce at least some forms of control, just because an uncontrolled development of IP practices is dangerous and fraught with serious consequences. However, we can not say that all surveyed administrators consider themselves as "forced proponents of control measures". Leaders of private health institutions, as well as administrators who tend to use authoritarian management style, do implement consistent measures to control informal payments at their settings (unlike the rest of administrators who support the "deviation control" model).

4.3.4. Models of informal payment control

There are several models used by Russia's health care providers to control informal payment practices. They include:

- Random control in response to formal complaints;
- Random control in response to informal complaints (investigation of extortion/racket episodes);
- Large-scale tough control with the use of such measures as withholding bonuses or educational/professional training opportunities;
- Indirect control by way of minimizing doctors'/nurses' need for informal payments (through granting higher salaries, bonus payments and development of legitimate chargeable service delivery);
- Horizontal corporate control

Random control in response to formal complaints/ "signals" is the most frequently used type of control in Russia's health care facilities (public hospitals in particular). This is a least costly form of control that implies a retrospective formal investigation carried out in response to a patient of other person's written complaint about the fact of informal payment.

Although most of our respondents say that open scandals over informal payments do occur, and that some doctors get fired as a result, that does not happen too often. According to health officials and chief doctors, such incidents occur only 1 or 2 times a year, but – according to respondents - this form of control is very effective. As a rule, all such cases go public and serve as a good lesson to those who are about to start their shadow revenue-generating careers.

However, such form of control can not be overly effective, because it teaches doctors to act smarter and never "wash the ward's dirty linen in public" instead of eliminating IP practices. Along with that, this type of control serves as a warning to doctors and cultivates fear of loosing the job and be blamed by colleagues. But, according to respondents, it is not always that those who "get caught red-handed officially" are the worst bribe-takers in the institution. Nor do official statements always reflect the actual situation with informal payments in a given facility. We can not rule out a possibility that this mechanism may be used as a tool that administrators or doctors use to get rid of those whom they do not like very much.

Random control in response to unofficial "signals". Extortion of money from patients is averted by most doctors. Our respondents were unanimous in their readiness to fight such practices. Even an "unofficial signal" about an alleged fact of extortion makes hospital administrators react. As a rule, a doctor who is suspected of practicing extortion gets a verbal warning. Probation period given to that doctor to "renew himself" depends on his standing, professional level and even financial status of his family. As a rule, there is no second warning: if the doctor gets caught red-handed again, he gets fired.

Naturally, if there is a conspiracy of staff or informal revenue distribution arrangements, cases of extortion are not investigated as consistently as they should. But if a given doctor acts on his own, the chances of him being penalized or fired increase multifold.

Large-scale tough control with the use of financial penalties is broadly used at private clinics, while in the public sector it remains rare and is more likely to be used as a chief doctor's personal strategy.

In the course of the survey this type of control was reported only by one chief physician of a public outpatient clinic and several administrators of private health care settings. Varieties of this control model were also reported at an urban hospital and several structural units of a large clinic. Some administrators reported to have been using tough measures to minimize informal payment practices at their facilities. However, not all of them were sure that they were doing well: *"I am a proponent of tough measures, - said one of the chief doctors, - there must be public executions. When a little bird tells me, I warn the alleged offender. When I receive solid evidence, I fire him"*.

Interestingly, none of the surveyed chief doctors who claimed to be supporters of tough measures had used such measures directly. Most of administrators preferred to use an "indirect influence" to minimize IP practices in their clinics. Chief doctor of a large public outpatient clinic, a man experienced at playing bureaucratic games, said that he had been using an "increased attention technique" against doctors who could not be directly accused of extorting money from their patients: "I can not say directly to a doctor: *"You extort money from patients", and I'm not a police investigator to keep saying: "Comrade, what you are doing is wrong" all the time. But I alter conditions for that person and start exerting a tougher control over his actions. I let him know that he is being watched. And he knows exactly what that means. I use the same technique for an entire department or unit. I just start watching that unit closely: why is it that official revenues generated by that unit are going down; why do physicians there always fail to see all patients who have an appointment; why their performance is changing? And this proves to be effective. Secondly, we have a very good incentive – an opportunity to participate in professional training programs. Only best physicians may be sent to study. Thus, if you combine tough control with measures to create a bad publicity for a person who is involved in extortion practices, you will get the desired result"*.

Indirect control. According to private clinic administrators, they create conditions in which each doctor's fear of loosing his/her job or bonus overweighs temptation to get an informal payment from a patient: "Informal payments are non-existent in my clinic, - says a chief doctors of a private clinic, - Honestly. I'll explain why. Technically, I do nothing special. It is just that all of my employees highly appreciate their jobs. They receive decent salaries and are afraid of loosing them. Any of my doctors will refuse to accept 100 or 200 or 500 rubles from a patient. What if that patient works for me?"

Leaders of private health institutions do not necessarily fire "violators of in-house rules". Rather, they tend to impose financial penalties (e.g. withdrawal of a bonus payment, reduction in salary, etc.): *"If one of my employees gets caught in the act of accepting a "shadow" payment, I will not fire him. Why should I fire a good professional. "Everything depends on your cadres". But he will receive the lowest possible salary and be unable to feed his family. One month on such salary will be enough for him ho learn his lesson. If a cook who works at our cafeteria steals something, he will receive only 50% of his regular salary. However, such cases are extremely rare at my facility. My people are a well-knit team of professionals. And they love their jobs"*.

Development of legally-provided chargeable services is another effective tool to control informal payment, provided, however, that all relevant financial flows and contracts are controlled personally by health institution's CEO. One of our respondents, chief doctor of a public clinic, has set such a goal and – according to him – has achieved good results. He is convinced that, although informal payments may occur even when a clinic is legally providing chargeable services, the prevalence of such payments can not be that high. However, doctors should be appropriately motivated to provide chargeable services (e.g. get a higher share of what patients pay through the clinic's cash register), and all financial flows resulting from such services should be properly controlled.

Corporate control is implemented through health professionals' demands that their colleagues must use "fair" models of informal revenue distribution. The contents of such control were discussed in Section 3.2. above.

To summarize, most health care administrators and financiers are not prepared to effectively control informal payment practices in Russia. There is no consensus among administrators on how to regulate such practices. Rules and norms around informal payments are just being formed, but they are extremely variable. Moreover, many health care managers do not believe that IP practices can be controlled at all. Both IP practices and measures to control them are chaotic, and there are virtually no people who are prepared or able to assume responsibility for doing the job. Those who are determined to fight illegal payments do that on their own and resemble lonely warriors who have to confront superior enemy forces. Most chief doctors are unable and sometimes do not want to interfere with informal practices at their institutions.

Federal authorities believe that it is regional and municipal administrators who must assume the ultimate responsibility for solving the problem, and have so far done nothing to assist them.

As a result, it is unit heads who have to carry the burden. However, almost all of them are former rank-and-file doctors and are least prepared to find solutions that cold be acceptable to society. Free-market relations in the Russian health care system are evolving too slow, and that means only one thing: informal payment practices will continue to spread, as the populations' incomes continue to grow. Thus, the situation where a doctor puts the money of his patients directly in his pocket seems to satisfy almost everyone.

4.4. Health professionals' attitudes towards legalization of payments for health care

One of the practical objectives of the study was to assess a possible impact of informal practices legalization. Will informal practices give way to formal financial arrangements if patients will have to pay for health services officially, and how will that affect accessibility of health care? Our first step was to collect health professionals' thoughts about the idea of legalizing out-of-pocket payments for services provided by public medical institutions.

Most of our respondents either support the idea, or may support it on certain conditions. It is mainly social policy-makers who are strongly against any attempts to reconsider the existing free health care benefits program ("government guarantees"). For example, according to a regional executive official, *"people still resent the fact that nothing is available at public hospitals for free… The problem is that we have failed to cultivate the middle class. There is no middle class in Russia. We do not have personal bank accounts. Only few people can pay for services. Let's legalize their payments. We already have a list of chargeable services. Generally, many patients complain that they have been asked to bring their own bed linen or purchase drugs. … They ask why and on what legal grounds? That is why, given the way most people live, they will never agree to pay officially"*.

Health professionals who receive informal payments only rarely support the idea to legalize payments. *"Where informal payments are not made or accepted, doctors will vote for legalization"*. For such doctors, legalization will mean a chance to increase their salaries in a legitimate way and without the need to feel embarrassment and fear associated with illegal payment practices. To illustrate that, we will give two respondents' statements as an example: *"If patients start paying officially for certain services, and doctors will start receiving a decent share of that money, that will be much better than what we have today (e.g. candies that we hate so much). A pack of good candies costs 80 rubles. Let them go and pay that sum through the cash-register"*. Legitimate payments *"are much more convenient, because you know exactly how much you will get and for what. It is about stability. Because now we never know whether the patient will pay or not. If a law is passed to legalize out-of-pocket payments, that will be great"*.

Health professionals who receive under-the-table payments frequently will want to preserve them, since they allow to generate more additional income for a given doctor, than official chargeable service provision. That is why such doctors may support the idea of legalization only if that does not impair their incomes. *"I am not against patients paying officially (through the cash-register). But the share that I will be getting must be adequate to my knowledge and effort"*.

Doctors are prepared to trade part of their incomes for a lower risk of being caught red-handed or humiliated by privately paying patients. They will vote for legalization, if they continue to receive 70 to 80 percent of the total amount paid by patients for services that are now being reimbursed in an under-the-table manner: *"Certainly, out-of-pocket payments must be legalized. At least I will be able to sleep better. I/m ready to pay 13% income tax on that money". "What if such legalization results in a more substantial reduction of your income? (moderator)". "Then let everything remain as it is now"*. Another respondent said: *"If the government decides to give us only a small share of what patients will be legally paying for services, doctors will start raising "shadow" prices. And everything will remain the same. But patients will have to pay much more than they do now"*. An absolute majority of doctors believe that only decent salaries will be able to resolve the problem of informal out-of-pocket payments.

Almost all proponents of out-of-pocket payment legalization believe that there should be different prices for different population groups.

Virtually no one supports an idea to make patients pay for all types and modalities of health services. *"I am personally interested in further development of chargeable health services, because the more people pay, the higher salary I get. But I really feel sorry for people". "Most people do not have savings. Nobody has money today, neither the government nor the population. So, if you legalize payments for a wider range of services, people will start dying"*.

According to health professionals, official fee-for-service arrangements should be introduced only for those who can afford to pay. Underprivileged population groups should continue to be served free of charge. Here are several typical examples: *"Not every patient is able to pay his/her doctor. Look at people we serve. Most of them are rural residents. Very poor and unattended. They often can not buy some simple drug that we do not have in the ward, let alone payments for services and to doctors and nurses. However, there are patients who can pay. If they start paying officially, that will increase our salaries substantially"*, - says a chief nurse who works at a regional hospital. *"If you make all people pay for all surgical interventions, that will be too hard. Only few people are able to pay,* - says a pulmonologist of an urban hospital, - *Now it is like those who can pay – do it, and those who can not – do not. If someone can not pay, he or she may buy us a bottle of cognac or say: "If anything happens to your TV set or car, I will always be there to help you"*.

However, some doctors have a different point of view on the problem of IP legalization: *"All health services should be provided for officially-set fees. If a patient comes to a health care facility, he is supposed to be earning money or be able to get it somewhere. All health services must become chargeable. But the fees should not be high. So that an ordinary person can come to a hospital and afford his or her treatment. Of course it must not be like 25,000 rubles. I think 500 rubles will be an appropriate fee. But everyone has to pay. Even an old retired person will be able to get a sum like that". "Russian people are not so poor to be unable to pay even for the fact of hospital admission and our paperwork. Say, he or she pays 100 rubles to a hospital for admission. That's it for starters. It's a symbolic co-payment. As you know, we have drug shortages at public hospitals. I should be allowed to say to my patient: "To get cured you will need this and that. We only have this and that drug available, but they are not very good for you. But the hospital has a private pharmacy on the ground floor. You can buy more effective drugs there, but only If you wish". So we will gradually come to a health care system co-funded by the population"*.

Some respondents believe that patients should pay for "the right to choose" or for services that are not caused by medical necessity. Payments are justified when *"a patient has choice and knows exactly what he pays for"* (a hospital-based internist*). "Patients should pay for cosmetic things and diagnostic services when there are no medical indications for such services. For example, a patient is absolutely healthy, but wants to get screened for preventative purposes". "It will only be fair if those who have money would pay for a better quality, or an opportunity to choose a doctor, or fast hospital admission,* - says a head of Surgery of an urban hospital, - *Some people do have enough money to pay for that, but there are not too many of them"*.

Some respondents say that it would be technically difficult to introduce payments for certain population categories, while continuing to provide them free-of-charge for other groups. *"How the money is supposed to be divided between doctors who serve low-income patients, on the one hand, and those who treat paying patients? How can patients be physically divided within the hospital? And we also can not divide doctors into those who treat only "free-of-charge patients" and those who serve only paying ones. I would like to see the current situation preserved. Why? Because the government is not ready, and most of the people are not prepared for such changes. However, the seedlings of the paid-for health care should be planted today. But we should not move too fast. We must test various options first. Russians have seen too many experiments"*.

CONCLUSION

Data generated by the survey allow to make a clear conclusion: if nothing is done to change existing rules governing health care delivery and provider payment, informal payment practices will develop.. Even the highest possible increase in public health funding will not be sufficient to avert informal payment practices.

If recurrent public health budgets start to gradually increase, but formal institutions regulating conditions of health care delivery remain unchanged, the range of services and items for which informal payments are currently made will narrow for certain population groups (e.g., the poor will not necessarily heave to pay for drugs, disposable materials or surgical interventions performed under obsolete protocols). However, the size of under-the-table payments a will continue to increase with the growth in personal incomes of population. In that case, stratification of the population in terms of access to quality health care will be increasing dramatically.

Legalization of patients' under-the-table payments for health services will inevitably lead to a situation where official prices of health services will be higher than the current "shadow" prices. As a result, many services will become unaffordable for low- and medium-income population groups.

The extent to which under-the-table payments will be replaced by those made via cash registers will depend on i) what proportion of health care will be provided under officially-allowed fee-for-service arrangements and ii) what share of revenues generated through chargeable service provision will go to those who will be providing such services. Legally-derived doctors' and nurses' incomes will somewhat increase, and the need to resort to informal revenue-generating practices may decrease for those health professionals who now encounter informal payments only rarely. However, the situation will remain the same for doctors whose current revenues are mainly derived from patients' under-the-table payments. No form of legalization alone – without appropriate changes made to applicable tax legislation – will allow to substantially increase such doctors' official salaries to the level comparable with those of their current informal incomes. Most of such doctors will find ways to overcome new barriers between them and their patients' money. Moreover, legalization of informal payments and a tougher control will not eliminate under-the-table payments made by patients for psychological reasons - to get more attention and to minimize perceived risks. Given that many Russian doctors have a vast experience in deriving informal revenues, new ways of doing it will certainly be invented.

If the government defines: i) a minimum set of free-of-charge health services [free health care benefit package]; ii) population groups entitled to free services provided in excess of the minimum package and; iii) population categories who will have to fully or partially compensate the cost of services provided in excess of the free benefit package, informal payments will become less prevalent, but will not disappear at all. Provision of chargeable and free-of-charge services by the same health care institution will make doctors/nurses intentionally reduce the quality of free services in order to make their recipients pay.

If health care providers get divided into those who may, and those who may not provide chargeable services (that is, if public health institutions will not be officially allowed to charge fees for services), the health care delivery system will become polarized. As a result, health care facilities will be divided into "clinics for the rich" and "clinics for the poor". And the gap between the quality of services provided by the two groups will continue to grow. Prices offered by "clinics for the rich" will include all cost categories and taxes and, thus, be high enough. The prevalence of under-the-table payments in such clinics will go down, but that will make services provided there less affordable for low- and medium-income strata.

Analysis of alternative informal payments legalization options shows that all of them are fraught with negative social/economic/political consequences. However, the failure to change the situation will also result in increased social tension. As a Vice-Governor of one of the two regions said: *"no acceptable solution can be seen so far"*.

The following ***recommendations for state policy-makers*** can be made based on the outcomes of the survey:

1. Legalization of illegal payments for health services will not be a satisfactory solution to the current problem of mismatch between declared amount of state guarantees and that of available public funds. There is no win-win solution to the problem. An option should be chosen that will have the minimum negative impact.

Possible solutions may include the following:

- Assure sufficient funding of only one of the two parts of the government guarantees program [i.e. free health care benefits program], specifically, the mandatory health insurance (MHI) program (package);
- Revise the list of health services to be provided under the MHI program, but try to avoid a large-scale legalization of informal payments.

2. The government should more clearly define its obligations regarding free-of-charge health services to be included in the MHI package. The contents of that benefit package should be made more clear and specific (e.g., what services, drugs, etc. must be provided free of charge to patients with specific conditions) and represent a set of attainable medical/economic standards based on realistically available resources.

Thus, the government needs to clearly define health services which can actually be provided free of charge to the population under the mandatory health insurance program. Again, the benefit package may not contain more services than the government will actually be able to pay for.

Provided that these conditions are observed and more effective mechanisms are installed to control free-of-charge and chargeable service provision, an adequate level of access to health services and drugs included in the MHI package may be achieved.

3. It is not reasonable for the government to revise existing guarantees of free access to services that will be not included in the revised MHI benefit package.

It will take a long time before a gap between excessive guarantees and available public funding disappears. Thus, excessive services should be provided on the base of open waiting lists or on a fee-for-service basis.

4. It will be impossible to eradicate informal patients' payments completely. However, prevention of such payments for services to be provided under the revised [realistic] MHI program is a must.

5. Attempts to use administrative or criminal prosecution against those who make or accept under-the-table payments for services excluded from revised MHI program will be ineffective. We recommend that indirect measures should be used instead, such as: provide support to legitimate chargeable health care services and regulate prices of monopolized health services (i.e. services provided with the use of unique/high-tech equipment and technologies available to only few health institutions) so that officially-set prices could limit the growth of the "shadow" prices for the same services.

In order to do so, existing price/rate-setting regulations must be changed.

The study of the various aspects of health care delivery in Russia will continue. The Independent Institute for Social Policy is currently implementing a project to analyze the prevalence of various schemes used by Russian residents to pay - officially and unofficially - for health services, and to learn more about what Russians think about the possibility of changing such schemes in the future.

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Goals and Key Guidelines of the Independent Institute for Social Policy (IISP)

The IISP was incorporated in December 2000.

The **main goal** of IISP is to support and develop the social-effect ideas and initiatives offering new approaches to social policy.

The **key guidelines** of IISP:

- Social policy research.
- Support for independent sociological and economic studies in social policy (provision of grants).
- Independent review and evaluation of social implications of management decisions for government agencies and businesses and not-for-profit organizations.
- Provision of consulting services on social policy issues.
- Developing a large-scale database for review of social processes.
- Organizing open discussions (seminars, roundtables, conferences, etc…) on key social policy issues.
- Developing and implementing educational programs for new knowledge build-up and inclusion into social policy.
- Editing and publishing magazines, guides, scientific, educational and information materials and other relevant literature.
- Participation in relevant international projects and joining the international community.

IISP founders are such locally and internationally recognized organizations as: the Russian Public Opinion Research Center (VZIOM), the oldest social studies establishment which carried out major social policy research projects both in Russia and abroad, and the Academy of National Economy under the Government RF, the educational and research center boasting economic reform research projects for Russia. Besides, the ANE is a major manager training center offering also basic and post-graduate education to economists and sociologists. VZIOM and ANE are high-authority organizations which managed non-governmental organizations in economics and social studies. The founder's high status and resources available will facilitate the roll-out of and publicizing the outcomes of IISP activities among the scientific and expert community at large.

IISP Director: Tatiana M. Maleva, Ph.D./Economics
Chairwoman of Trustees Board: Acad. Tatiana I. Zaslavskaya, Dr. /Economics.
Chairwoman of Scientific Council: Lyudmila A. Khakhulina, Ph.D./Economics

Grant Program

Grant Program Director: E.Yu. Shatalova. Coordinator: E.V. Shepeleva.

Three grant competitions were held during 1997-2001, with 60 grants awarded and over 200 beneficiaries in total. Ever more grant projects are implemented in Russia's regions (from 23% in 1st round of competition to 60% in the 3rd one). Traditionally, each round ends up with a large summary conference discussing grant project outcomes. The 4th round of grant competition was announced in December 2001 and crowned with the winner seminar in April 2002. Overall, 19 grants were awarded and respective projects are currently underway.

While summarizing the five-years' grant program, it should be stated that many research projects contributed enormously to better understanding of Russia's socio-economic reality and impacted on political decision-making. As to the quality of the 4th round bids, they were no worse.

Research Program

Program Directors: S.V. Shishkin, Dr. /Economics , *and L.N. Ovtcharova, Ph.D./Economics*
Senior Researcher: S.V.Sourkov, Ph.D/E.
Researcher: G.E. Besstremyannaya
Coordinators: A.I. Pishnyak, L.O. Popova and M.V. Savelyeva

An important stage in the IISP institutional development was its research program launched in October 2001. Currently, this program is implementing a package of major research projects in various relevant areas of Russia's social sector.

IISP research projects in 2001-2003:

1. Review of access to university education for socially disadvantaged groups. Grant from the Ford Foundation. Team Leader: S.V. Shishkin, Dr./Economics.
2. Social Impact of Russia's Accession to WTO. GFF. Team Leader: L.N. Ovtcharova, Ph.D./Economics.
3. Review of Relationship Between Formal and Informal Rules of Social Service Provision (health care provider payment model). GFF. Team Leader: S.V.Shishkin, D r./Economics.
4. Review of the Impact of Various Government Guarantee (health benefits) Strategies in Health. Grant from the Moscow Public Science Foundation (MPSF). Team Leader: S.V. Shishkin, D r./Economics.
5. Generations and Gender. Dependencies and Quality of Life. Pan-European Research Coordinated by theDemographic Department, UN European Economic Commission. Team Leader: T.M. Maleva, Ph.D./E.
6. Economic and Statistical Analysis of Labour Markets for Alternative Civil Service. Grant of MPSF. Team Leader: T.M. Maleva, Ph.D./E.
7. Alternative Civil Service in Russia. Labour Relations and Socio-Economic Issues. Grant of Sozidaniye (Creation) Supra-Regional Charity Foundation. Team Leader: T.M. Maleva, Ph.D./E.
8. Ensuring More Access for Low-Income Groups to Social Services and Benefits Guaranteed by Government. Grant from Boell Foundation, Germany. Team Leader: L.N. Ovtcharova. Ph.D./E.
9. Review of the Impact of Russia's Energy Sector Restructuring on Households. R&D Customer: High School of Economics and RAO IES. Team Leader: L.N.Ovtcharova, Ph.D./E.

The following projects are being developed additionally:

1. Comprehensive Review of the Socio-Economic Impact of Social Service Reform on Russian Households. Consultations are underway with the Ministry of Economic Development and Trade RF; Department of Social Development of the Government Office RF; and DFID, UK. Team Leader: T.M. Maleva, Ph.D./E.
2. Social Protection for Socially Disadvantaged Groups. Tacis Project. International consortium (in progress). Team Leader: L.N. Ovtcharova, Ph.D./E.

Database Development Program

Team Leader: L.A. Khakhulina, Ph.D./Economics. Coordinator: L.B.Kossova, Ph.D./Technology. Programmer: A.A. Pigareva.

The goal of the program is to develop and test the content as well as technical, financial and operating environment for the national public database on social policy.

Key objectives:

- Develop the database using the research outcomes provided by various organizations, research teams and individual researchers who are willing to participate in the project.
- Test the main technical, financial and regulatory principles of data storage and distribution, including relationships with data providers and users.
- Provide training to users how to use the data.
- Establish relations with the international database community.

The key outcome of the program will be the complete communities of sociologists, economists, political researchers, demographers and others (organizations or individuals) interested in developing the national database on social policy. Currently, the database includes over 40 representative libraries of the leading Russia's social research agencies, institutes, etc. The database will be expanded significantly in the near future due to more data providers drawn in. The IISP maintains close contact with the international librarian community and participates in relevant international conferences and symposiums.

Publication Program

Program Director: O.V. Synyavskaya, Ph.D./Economics.

The IISP web-site has developed intensively in 2001-2002 (www.socialpolicy.ru) and contains the data on IISP, its background, mission, executive bodies; individual programs, including the details of grant competitions; list and outline of research projects; database software and system; as well as references to IISP employees.

The 2001 summary report is available in Russian and English and highlights the outcomes of all IISP programs. The deliverables of the IISP project deliverables (Team Leader: S.V. Shishkin, D.E.) were published in section: IISP Working Papers, Free Health Care: Reality and Prospects, Moscow,

2002. Preparation for publication is underway of the collection of papers by the 3rd round-grant beneficiaries, to be entitled: Social Policy: Reality of 21st Century.

For more information on ISSP, refer to web-site: www.socpol.ru