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**Draft Discussion Note #13:  
“Official, Unofficial and Informal Fees for Health Care”**

James R. Killingsworth  
WHO, China

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## *Introduction*

The distinctions between official, unofficial and informal fees are worth re-considering. Unofficial fees necessarily refer to an authoritative mechanism of fee setting; some fees are set by authorities and some are not. The latter are unofficial ones. Presumably, official fees carry a stamp of approval for the goals of health policy and are established for purposes authorized for some combination of intrinsic reasons ("health," "disease burden," "health system goals," etc.) or extrinsic, meta-sectoral ones ("macro-level policy," "societal goals," etc.) Unofficial fees, again, do not carry such an imprimature. By coincidence, they might be suited to official aims but, as seems often the case, they are not. Unofficial fees have been defined as:

...payments to individuals or institutions in cash or in kind made outside official payment channels for services that are meant to be covered (*without direct charge*) by the public health care system<sup>1</sup>

By being a kind of up-start phenomenon, unofficial fees are said to serve multiple purposes, mainly ones that vary in their content from place to place. As "unofficial" fees, they seem linked with the functional and institutional frame in which they appear.<sup>2</sup> Further, by being unofficial, they have, in almost every case, some form of connection with the official purposes for which the official fees were set to begin with.

"Informal fees"<sup>3</sup> is a term less in currency now. Originally, though, the term denoted fees that originated as incrementally developed supplements or "patch-ups" to deficiencies in a health system's scheme of provision and finance. They were fees whose relation to official health system goals and health system finance were practically "insinuated." Of course, like unofficial fees, informal fees are not official. Nevertheless, informal fees developed more like a kind of "practice." They represented a more organically logical response to health system provision and funding problems than unofficial fees. By lore at least informal fees occupied a more ambiguous authoritative standing than unofficial fees, being partially legitimated by local exigency—originally, in many cases the public was asked by facility officials to "cooperate" or "assist" with shortages. Were they are official and "legal? No, most likely.

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<sup>1</sup> Lewis, M. (2000), Who is paying for health care in Eastern Europe and Central Asia? World Bank Publication.

<sup>2</sup> In many countries of the former Soviet Union and Central and Eastern Europe undergoing economic transition patients are routinely asked to pay unofficially for medicines and medical supplies required for their medical treatment. They are also frequently expected to supplement state health worker salaries with unofficial monetary or non-monetary payments See, World Bank (2000a) Armenia Institutional and governance review. Unpublished paper

<sup>3</sup> Ensore has given a definition of "informal fees" in his early work on these subjects. See Ensor, T and Savelyeva, L (1998), *Informal payments for health care in the Former Soviet Union: some evidence from Kazakhstan*. Health Policy and planning 13 (1): 41-49.

But are informal fees not just another sort of unofficial fee? Economically, they seem to function quite like unofficial fees, in that they seem to be a form of rent-seeking behavior. They can be graphed alongside other quantifications of “dead-weight loss” and “consumer surplus.” Still, there seem to be health systems with endemic provision and finance problems were better described as problems with “informal fees” rather than “unofficial” ones. Why? Still more to the point, why do we want to bother about these “outside fees”—whether they are labeled “unofficial” or “informal”? Are not “fees” just “fees” from the standpoint of the patient or health consumer—whether they are called fish or foul?

This discussion note re-explores the official, unofficial and informal distinction arguing, as most do, that unofficial and informal fees *should* be separated from “official” and “formal” fees. The note argues, however, that there are important reasons for looking at this batch of health fees along with the sum total of health care fees. In effect, “fees” are not just “fees” but in still other ways—important ones—“fees are, indeed, fees.” In considering these points, examples from reports about China, Bangladesh, and Central Asia/East Europe and the former Soviet Union will be summarized and analyzed.

### *Fees outside the health system—general issues*

The thesis of this paper is that fees outside the system change health system probabilities. In particular, they increase the likelihood of four mainly negative results for the overall goals and functions of these systems. They increase the probability that:

1. Health service access will be reduced for those least able to pay.
2. Uses of health service revenue will be siphoned off from stated system aims.
3. System “inefficiencies” will emerge and enlarge.
4. Medical practice will be distorted by perverse payment incentives.

In general, the problem of fees outside the system is one of guidance or rationalized behavior. These fees increase the probability that un-rationalized behavior, specifically behavior that conflicts with the positive, health supporting aim of health services, will be furthered while its opposite will be diminished.

The discussion note goes on, however, to ask whether “official fees” can and do accomplish the same result. In this part of the discussion, the same matter of impact upon health system goals and overall rationality appear.

### **System irrationality**

From the viewpoint of overall health system rationality, unofficial and informal fees, when they produce negative effects such as 1-4, are cut of one cloth and should be curbed *because of their irrationality for the system*. Although rationalized health system action is not an end in itself, its value for health is that it supports linkages between health service provision and better health. Whether the rationality is a planning or a competitive

market variety, the view of informal and unofficial fees is roughly the same--*control their negative, non-rational effects.*

### Limits of a "system irrationality" rationale

Frankly, the “system irrationality” viewpoint is simply too general to be of much use, despite its many interesting features. Certainly, rationality in the form of economic efficiency and effectiveness can be disturbed by outside fees. Further, the literature on rational behavior of rational systems<sup>4</sup> suggests that these fees are likely to make relations among the dominant and subordinated coalitions within the health system unstable or distorted and make system management difficult<sup>5</sup>. And in health systems having largely civil servant staff and where revenue collection threatens to overwhelm other motivators, goal displacement may occur—the core technologies of medicine and health can become “means” rather than “ends” to be protected and sustained.

Furthermore, a "system irrationality" treatment of unofficial and informal fees probably ignores too much. For example, “inside” fees are also economically and organizationally irrational. Market failures exist throughout health systems, especially where health systems are in transition or where incentives under-produce “positive externalities.” And planning for fees—whether through rate setting as seen in information-advanced economies or by price setting in economies with a central planning history—can distort patterns that promote economic efficiency and otherwise economically rational norms of system effectiveness. Further, whether unofficial and informal fees are present or not, organizational goals and objectives are often distorted and displaced by other patterns of action such as conflict between informal and formal rules and procedures that have almost nothing to do with fees—whether inside or outside a health facility or system.

### *A closer look at unofficial and informal fees—3 cases*

If the “devil” remains in the details insofar as unofficial and informal fees are concerned, then what is that devil and where is it? Here some case material might help. Three instances have been chosen for Draft Discussion Note #13:

- Unofficial fees at Bangladesh facilities
- Informal fees in Central Asia/East Europe and former Soviet Union facilities
- “Red packet” money at facilities in China

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<sup>4</sup> Christiansen, S., P. Karnoe, J.S. Pedersen, and F. Dobbins (eds.) 1997. “Action in Institutions.” *American Behavioral Scientist*. 40: 389-538; Coase, Ronald H. 1937. “The Nature of the Firm.” *Economica* 4: 386-405; Coase, Ronald H. 1988 *The Firm, the Market, and the Law*. Chicago: University of Chicago Press; Dahlman, Carl J. 1979 “The Problem of Externality.” *Journal of Law and Economics*. 22: 141-162; Milgrom, Paul and John Roberts. 1992 *Economics, Organization and Management* Englewood Cliffs, NJ: Prentice-Hall; Williamson, Oliver E. 1985. *The Economic Institutions of Capitalism* New York: Free Press; Williamson, Oliver E. 1993. “The Evolving Science of Organizations” *Journal of Institutional and Theoretical Economics*. 149: 36-63.

<sup>5</sup> Thompson, James D. 1967. *Organizations in Action*. New York: McGraw Hill

Only the latter is not classified as clearly informal or unofficial –though it will be called “informal” in the end, since the China analysis is in process and since it is likely that “red packet” money is both informal and unofficial and points to the larger problem of the use of “official fees” in China.

## Bangladesh

In the period when Bangladesh considered further introduction of "official" fees to pay for health system costs, the subject of fees became a matter of general interest. The widespread collection of unofficial fees at health facilities was and still is a common form of rent-seeking behavior. Typically, unofficial fees are collected in the form of cash payments for the performance of required services, for direct purchase of drugs and medical-surgical requisites, and payments for service access. These unofficial health care fees at government health facilities were defined in the following way<sup>6</sup>:

Un-authorized fee payments that co-existed with “free care” and formally approved “official” health service charges collected at public facilities under the sanction of overall public policy

Studies using observational and interview methods explored the linkages between official and unofficial fees at multiple Bangladesh health facility levels: primary care (Thana Health Complexes), secondary (district hospitals), and specialist facilities (medical college hospitals). Payment levels for different income classes and different payer types were investigated at these facilities. The results highlighted potential equity, price, and institutional problems associated with unofficial fees.

Not only does the practice have clear income and equity effects, there also appear to have reduced patient satisfaction, perceptions of service quality while restricting the patient's ability to pay for health services. Still more broadly, the Bangladesh case showed that, in health care, unofficial fees at the facilities studies tended to:

- Displace official policies while replacing them with fee-functional policy at the institutional level
- Reduced merit goods production
- Distribute income at the facility level in an upward direction
- Distort human resource development
- Contribute to the growth of facility inefficiency
- Obstruct the progress of market reform in health.

The mechanism for producing these largely irrational and negative effects was "rent-seeking" behavior at the facility level. From the side of economic analysis, this rent seeking was allowed by the existence of rents that could be captured in the "inside" or

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<sup>6</sup>J Killingsworth, James, N. Hossain, Y Hedrick-Wong, S Thomas, A Rahman, and T Begum **Unofficial Fees in Bangladesh: price, equity and institutional issues** Health Policy and Planning 1999 14: 152-163.

official fee structure of the facilities involved. Direct economic effects depend not only upon the scope and intensity of unofficial fee collection but also upon the amount of “consumer surplus” available for fee collectors to capture. In Bangladesh and many other developing countries, public facilities provide highly subsidized “free” care intended for the poor so that the difference between what a consumer pays and is willing and able to pay, the consumer surplus, can be noticeable and significant. The rents captured by these near-monopolists come at considerable cost to society and at a significant opportunity cost to the patients who pay for them.

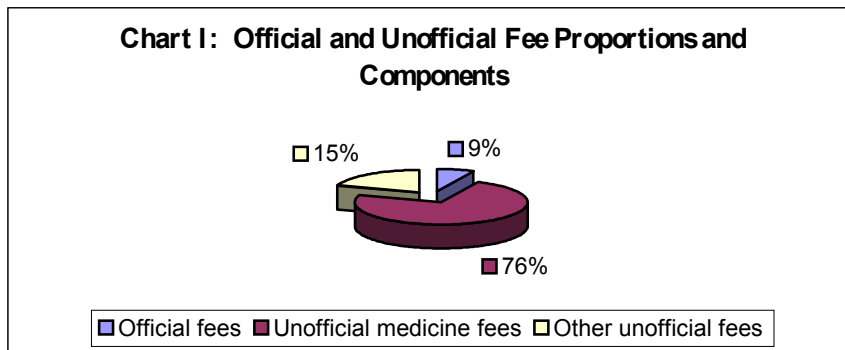
Further, in Bangladesh, as elsewhere, the utility maximizing choices of those who seek care are clouded by a lack of information needed to compare facilities, services, and costs, especially for those coming to a facility for the first time or who come for emergency care while expecting “free” service. If some individual or group can extract significant amounts from consumer surplus for personal gain through unofficial fees, the incentives to hold on to their “entitlements”<sup>7</sup> may override health service reforms and efforts to attain a more equitable distribution of health benefits. And where jobs are hard to find, pay is extremely low, and employee group activities are linked with party politics, even a modest consumer surplus can powerfully channel behavior at the facility level. Thus, the extraction of unofficial fees by employee groups at health facilities may have multiple negative effects upon health service provision.

One study reported that average per patient unofficial fee payments in Bangladesh consisted mainly of fee-for-commodity payments (medicines and in some cases supplies and surgical equipment items—85 percent), while unofficial fees-for-services (attendant care or medical interventions) and unofficial fees-for-access (better bed status, transportation) payments account for the remaining 15 percent<sup>8</sup>. Medicine payments are assumed to include the costs of pharmaceutical items themselves as well as cash paid to the individual who obtained the medicines for a patient.

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<sup>7</sup> “Entitlements” are linked with property rights viewpoints as well as the history of taxation in Bangladesh. See, Chatterjee, Partha. 2002 *A Princely Impostor?* Princeton, New Jersey: Princeton University Press, especially Ch 2, sections concerning “Bhawal under British Rule,” “The Court of Wards,” and “Zamindars and Tenants in East Bengal” on pp. 19-31.

<sup>8</sup> Further, where both a *collusion strategy* and an *information strategy* were at work at the facilities studied, it would seem reasonable to expect attitudes to be most negative toward 3<sup>rd</sup> and 4<sup>th</sup> class employees at those facilities where rent seeking takes the greatest bite from household income. But the results were inconclusive on these points in the Bangladesh case



Unofficial fees at Bangladesh facilities provide a generalized form of “rent seeking.” There, public employees who can position themselves as near-monopolists simply seek rents by charging fees greater than the opportunity costs of the next best alternative available to the patient—over and above the cost of producing the service, commodity, or accessibility for which the patient pays and under near-monopoly conditions *tolerated* at a public facility. The unofficial fee collection process—*rent capture*—frequently occurred in Bangladesh because government programs failed to deliver required levels of services, commodities, or accessibility, under conditions where “free care” was provided by the government itself. The importance of “free care” will be seen again in the case of the fee collections in Central Asia/East Europe and the former Soviet Union.

With shortcomings in Bangladesh’s “free care” programs, unofficial fee collectors apparently:

- Recognized that essential or nearly essential deficiencies exist in the program of free care being offered.
- Determined that consumers at health facilities would be willing and able to pay as individuals for a set of substituted and *ad hoc* services, commodities, and access arrangements.
- Rightly believed that the government will either suspend enforcement against those who provide *ad hoc* versions of missing or ignore such initiatives.
- Anticipated that implicit government policy will tolerate the exercise of a near-monopoly by unofficial fee collectors, provided that their secondary market does not become too obvious or draconian.
- Assumed that information disparities exist between fee collectors (near-monopolists) and patients (consumers) which can be exploited to the advantage of the fee collectors—provided that patient defenses can be thwarted or overcome.

Still, *rent capture* occurred mainly when a sizeable consumer surplus was available. In the case of required but missing services, commodities, and access arrangements at Bangladesh facilities a sizeable consumer surplus does indeed exist. Patients at District Hospitals and Maternity Clinics lack the information needed to judge which services, commodities, and forms of access are essential for their health. Physicians and other

professionals (agents for the patient), substituted their trained professional judgment for that of the patient (the principal or consumer). Told by the physician or other professional agent that something required for their health is not available or seeing that they need a service or minimal access to care, patients will seek required yet missing elements from any available source.

The patient in the Bangladesh case is vulnerable to *rent capture* by anyone who can be positioned as a near-monopolist commodity/service provider or service access gatekeeper and then exert control over price and quantity. The unofficial fee collector simply *captures* part of the difference between what the consumer is able and willing to pay and what they have been required to pay at the facility, i.e. nothing in the case of “free care.”

Unofficial fee collectors assess the ability to pay and willingness to pay of each individual patient so that they can seek rents from a first-degree price discrimination position. The first-degree positioning of patients contrasts with traditional or third-degree price discrimination, where customers are grouped into price classes and frequently pay less than what the monopolist can maximally extract in a first-degree case by settling into arbitrage-free classes. Second-degree price discrimination also exists at Bangladesh health facilities. There, fee collectors know the demand characteristics of patients in general but cannot tell which patient has which characteristic and, as a result, which price to charge.

Under the ambiguities of second-degree price discrimination, the patient has some defenses against a maximum unofficial rent capture approach. First-degree price discrimination in health care is the most difficult position for consumers, since the near-monopolist is able to identify the exact level of individual patient demand and then use superior mobility, authoritative positioning, and tolerated information control techniques to thwart collective defense by patients.

It appears that, in the Bangladesh case, collectors attempted to exploit patient ignorance and the requirements of health care treatments to capture first-degree price discrimination rents. Patients, not well fitted into classes, resorted to pleading poverty or used local influence to limit the damage that would be inflicted by first-degree price discrimination. So, where possible, patients try to “exempt out” of unofficial fee collection in all its forms. But, failing that, they apparently settle for second-degree price discrimination.

It is not clear at what points patients make market comparisons or search through family members for alternative sources of supply. Here information and collusion become conjointly important in unofficial fee taking. Where unofficial fee collection operates largely because patients have little or no information—apparently the case for first time patients at many Bangladesh facilities—then near-monopolist employees will maximize their gains by keeping patients uninformed about alternative sources of supply or about the ability of others to provide commodities, services, or access.

Where patients are least informed, that is, unofficial fee collectors are likely to pursue an *information control strategy*. If collusion is needed to consolidate information control,

then fee collectors were likely to launch an active effort to vertically integrate sources of supply (e.g., pharmacies near the facility) or service access (e.g., residents or administrators at various levels). This latter approach represented a *collusive control strategy* approach to rent capture.

Rent capturing near-monopolists in Bangladesh try to maximize their position while patients and their families attempted to protect themselves from information vulnerability. The extreme positions in this drama are indicated in Table 1.

<b>Table 1: Unofficial Fee Collectors vs. Patient Vulnerabilities</b>	
<b>Preferred “Rent Capture” Position</b>	<b>Preferred Patient Position</b>
Emergency	Non-emergency
First-time Attendance	Previous Attendance
Ability/Willingness to Pay is known by rent seekers	Ability/Willingness to Pay is unclear or not known by rent seekers
Patients priced as individuals	Patients priced as classes or groups
<i>Information and Collusion Strategy</i> in use by rent seekers	Only <i>Information Strategy</i> in use by rent seekers
Activity tolerated by facility	Activity discouraged or banned by facility
Arbitrage present	Arbitrage absent

What Table 1 cannot show, however, is the extent to which social welfare loss accrues due to the amount of resources expended by rent seekers and patients to minimize one another’s power. It is reasonable to believe that such costs may be quite limited where unofficial fee takers provided valuable services or provided essential commodities and much needed access from the patient’s (consumer) viewpoint. But in many Bangladesh facilities, the attitude of patients toward 3<sup>rd</sup> and 4<sup>th</sup> class employees and the quality of their service was uniformly low, thereby suggesting that social welfare costs for rent capture in Bangladesh might be significantly high.

And there are ambiguities in the Bangladesh case. For example, the large proportion of fee-for-commodity payments in the total leave it unclear whether dissatisfaction is focused upon specific personnel groups or on the shortages of drugs and supplies with which they are associated. Another ambiguity is introduced by the chain-market nature of hospitals. The hospital’s lack of unity as a provider is reinforced when many agents collect unofficial fees, at times directly competing with one another, with the effect that goals other than rent capture enter the picture.

Fear of detection may lead a fee collector to modify the intensity of effort involved. For instance, the near-monopolist may not wish to charge the rich and influential for services when they might make life difficult subsequently. With price variability dependent upon so many forces and *ad hoc* considerations, price disclosure occurs only at the point of purchase so that the consumer has very little information about the real price of health care. The patient perceives price as a virtual lottery of prices. Reacting against the immediate tensions of the situation, patients use the weapons at hand, raise the social cost of health care, reduce the efficiency of the health care market, elevate their level of dissatisfaction, and raise the probability that utilization rates at public facilities will reach still lower levels.

The Bangladesh case of "unofficial fees" suggests that still other factors are at work, including the burdensome effect of enlarged opportunity costs, the perceived seriousness of the patient's illnesses, treatment-specific quality assessments made by the patients, and a wide range of other possible explanations. It is clear that additional research concerning unofficial fees, social costs, and quality must be carried out where "rent capture" patterns prevail.

### Central Asia, East Europe and former Soviet Union<sup>9</sup>

The term "informal fees" was originally applied to outside fees collected in this area of the world. As was noted above, these fees appeared on a widespread basis when the economic reforms and labor displacements of the former Soviet Union and Central/East Europe began to take hold. Their "informality" seemed to be a kind of "organic" or incremental development at the facility level.

Whether the payments in this section are "illegal" or not is an open question but their legality is at least ambiguous. Significant proportions of patients in Bulgaria, Poland, and Turkmenistan (43%, 46%, and 50% respectively) paid for services that were officially free.<sup>10</sup> In Tajikistan, 70% of survey respondents stated that they expected to have to pay for health care.<sup>11</sup>

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<sup>9</sup> This section draws heavily upon the fact base found in the recent literature review conducted by Robin Thompson (Centre for Health Economics, University of York) and Ana Xavier (LICOS Centre for Transition Economics, Belgium) for Central Asia, East Europe and the former Soviet Union. See his forthcoming study of unofficial fees at Kazakhstan hospitals. Almost all bibliographical work is theirs in this section. Any factual errors, omissions or misinterpretations of Thompson's and Xavier's work are this author's.

<sup>10</sup> Delcheva, E. Balabanova, D. McKee, M. (1997). *Under-the-counter payments for health care: evidence from Bulgaria*. Health Policy 42: 89-100; Chawla, M., Berman, P., Kawiorska, D. (1998) *Financing health services in Poland: new evidence on private expenditures*. Health Economics 7: 337-346; Ladbury, S. (1997). *Social Assessment Study: Turkmenistan*. Unpublished World Bank report

<sup>11</sup> Mirzoev, T. (1999). *Corruption in Tajikistan as seen by the private sector*. Unpublished paper. Budapest, Hungary.

Those who have studied these matters closely, e.g., Thompson, Witter and Ensor, report<sup>12</sup> that circumstances of payment are important, most particularly the steep decline in public payment for "free services." As Thompson and Xavier summarize the matter<sup>13</sup>:

Unofficial payments are rooted in systems of bargaining and connections inherited from the socialist system (Smith, 1973). According to Kornai (2000) and Gaal (1999a,b) the planned and rigid nature of health care provision led patients to search for mechanisms to obtain better and faster services than what they would obtain as the basic state services, more attention and a preferred doctor. Payments would buy patients a little freedom. At the same time, medical activity, although a demanding and intellectual activity, received very little financial reward, which could be increased with the unofficial payments. The widespread existence of unofficial payments for health care is closely related to the impact of economic restructuring which has included the closure of uncompetitive state and private enterprises and increasing unemployment. The resulting decline in tax revenue and subsequent reductions in government health sector funding have meant that patients contribute to the shortfall in funding.

In skeleton form, the evidence from this area of the world suggests the following main points.

1. *Government fund reductions* and the attendant reduction in staff and services led to chronic shortages and inadequate equipment so that patients or their relatives are typically requested to pay for the medicines and other supplies required for their medical treatment through unofficial fees. Also, drug purchase commonly requires unofficial expenditure as well<sup>14</sup> In Kazakhstan, for example, Ensor and Savelyeva estimated that patients might be paying around US\$50 for in-patient medicines.<sup>15</sup>
2. *Conditions in the health system* provide a supportive environment for informal fee collection. Health worker salaries are low relative to other state and private sector professions) and service delays are common in a setting where the private sector is often virtually non-existent. Without some form of private sector, professional income supplementation is unlikely. In Lithuania and Ukraine, for example, workers have waited up to three months to be paid, with reports of longer delays in Russia.<sup>16</sup> Other

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<sup>12</sup> Thompson, R., Witter, S. (2000), *Informal payments in transition economies: implications for health sector reform*. International Journal of Health Planning and Management, 15, 169-187; Ensor, T and Savelyeva, L (1998), *Informal payments for health care in the Former Soviet Union: some evidence from Kazakhstan*. Health Policy and planning 13 (1): 41-49

<sup>13</sup> Thompson, Robin and Ana Xavier, forthcoming publication.

<sup>14</sup> Lewis, M. (2000), *Who is paying for health care in Eastern Europe and Central Asia?* World Bank Publication.

<sup>15</sup> Ensor, T and Savelyeva, L (1998), *Informal payments for health care in the Former Soviet Union: some evidence from Kazakhstan*. Health Policy and planning 13 (1): 41-49

<sup>16</sup> Healy and McKee (1997) *Health sector reform in Central and Eastern Europe*. Health Policy and Planning 12 (4) 286-295.

conditions act as a catalyst for unofficial fees in these areas. Again, as Thompson and Xavier point out<sup>17</sup>:

The presence of widespread corruption and minimal sanctions, for those who are caught taking such payments, fuels unofficial payments. Non-reporting by patients, weak corruption monitoring and weak enforcement of sanctions by the government and physicians' lack of accountability to a higher authority help maintain the system. Patients' lack of information may also help maintain the system of unofficial payments.

3. *Physician payments.* The majority of unofficial payments are given to physicians. In Poland 81% of payments were paid to physicians with the rest being paid to other health workers<sup>18</sup>. Payments may also constitute gifts or tips to health workers, which in some cases may have just a voluntary character. Nonetheless, in the Czech Republic over 27% of patients gave gifts to obtain better treatment whilst 7% gave gifts out of fear of receiving no treatment<sup>19</sup>. Unofficial payments double the average gross salary of physicians in Poland, whereas specialist doctors in Albania can earn five times their salary through unofficial payments<sup>20</sup>. In Hungary, unofficial payments constitute 62% of the net income of physicians<sup>21</sup>. Finally, in Estonia, 60% of physicians reported receiving at least one non-cash gift each week and some received a monetary tip (Barr, 1996). Of those who had received a monetary tip, the average amount was around 18.5% of their monthly salary.

Thompson, drawing upon his earlier work with Witter, concludes that, in general, these informal and unofficial payments can be viewed as an attempt to improve service quality received in chronically underfunded state facilities<sup>22</sup>. The reasons are multiple, but tend to emphasize the motivation of "physician effort":

The improvements *involved* are wide-ranging and...include, for example, more effective medicines than those offered without charge by the state, minimally invasive surgical technologies rather than conventional surgery, or simply more "effort" undertaken by the physician...Anecdotal reports suggest that motivating physician "effort" is one of the key reasons for payment<sup>23</sup>. Field<sup>24</sup> suggests that unofficial

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<sup>17</sup> Thompson, Robin and Ana Xavier, forthcoming publication.

<sup>18</sup> Chawla, M., Berman, P., Kawiorska, D. (1998) *Financing health services in Poland: new evidence on private expenditures*. Health Economics 7: 337-346.

<sup>19</sup> Masopust, V. (1989). *Bribes in health care and patients opinions*. Medline abstract, source Cesk Zdrav 37 (6-7): 299-307.

<sup>20</sup> Healy and McKee, *Op. Cit.*

<sup>21</sup> Kornai, J. (2000) *Hidden in an envelope: gratitude payments to medical doctors in Hungary*.

Unpublished paper for the Festschrift in honour of George Soros

<sup>22</sup> Thompson, R., Witter, S. (2000), *Informal payments in transition economies: implications for health sector reform*. International Journal of Health Planning and Management, 15, 169-187

<sup>23</sup> Thompson, R., Witter, S. (2000), *Informal payments in transition economies: implications for health sector reform*. International Journal of Health Planning and Management, 15, 169-187.

<sup>24</sup> Field, M. (1989). *The position of the Soviet physician*. Milbank Quarterly. Vol 66: (2), 182-201.

payments “constitute a countervailing power at the disposal of the patient to exert some kind of control over the physician”. Lewis *et al.*<sup>25</sup> find that patients paid to save time and Gaal<sup>26</sup> suggests that payments are made so as to change the attitude of providers towards the patient and adapt treatment to the patient’s convenience. Kornai (2000) argues that these payments are “bribe” given by patients to doctors to ensure extra-attention, moving them up the queue thus obtaining a shorter period of waiting, a better bed or a chosen doctor. Much of the unofficial payments literature has focused on differing types of unofficial payment and the contribution these payments make to total health care spending<sup>27</sup>. According to Lewis<sup>28</sup>, “a greater understanding is important if abuse of the system is to be addressed and resolved”.

New work by Thompson is forthcoming to analyze the causal relations present in the Central Asia and former Soviet Union region.<sup>29</sup>

## China

Work on informal and unofficial fees in China has been conducted periodically, but remains largely in Chinese language. An exception is the study now being conducted through the Chinese Academy of the Social Sciences (CASS) with Western Pacific Regional Office and WHO, China support. This study has yet to take a position on the terms "informal" and "unofficial." It focuses, instead on the term widely used for outside payments in China: "Red Packet" payments.

Traditionally, Chinese patients provided a "red packet" for doctors whose services were appreciated. This was a traditional Chinese expression of gratitude to the healer. Professor Zhao Hong, Principal Investigator in the study, will link health system finance with the social history of reciprocity in exchanging gifts from which the "red packet" payment grew. She will explore, as well, its connection with the need to maintain long-term relationships, prove social status and obtain credit and social protection within larger social system norms. It is the aim of the CASS study to determine the extent to which "red package" payments are now part of access to medical services and whether such "informal" payments are now an integral part of the system at China's governmental and non-governmental non-profit hospitals.

"Red package" costs add to the cost of fees at Chinese hospitals and other facilities and, under current conditions, add to the perception that fees for basic and limited care at public hospitals are higher than those at private facilities--for roughly the same procedure.<sup>30</sup>

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<sup>25</sup> Lewis, *Op. Cit.*

<sup>26</sup> Gaal, P. (1999a). *Informal payments in the Hungarian health services*. Unpublished paper. Health Services Management Training centre, Semmelweis University of medicine, Budapest, Hungary.

<sup>27</sup> Thompson and Witter, *Op. Cit.*; Lewis, *Op. Cit.*

<sup>28</sup> Lewis, *Op. Cit.*

<sup>29</sup> Thompson and Xavier, forthcoming.

<sup>30</sup> See, Lim Meng Kin, Yang Hui, Zhang Tuohong, Zhou Zin, Feng Wen, Chen Yude, Chen Shaoxian, Liu Yi, Zhen Jianzhong. 2002 “The Role and Scope of Private Medical Practice in China” WHO/UNDP-MOH Cooperative project under UNDP funding. Beijing—Draft Final Report.

Further, "red packet" payments appear to be more prominent at specialist facilities and to specialists than among non-specialists. The CASS study will explore the specific social history of the red package to identify its links with the emergence of Western medicine in the Guomindang period and then China's "dual system" from 1949 to 1978. Similarly, the study will explore the red package payment under market reforms since 1978.

The CASS study intends to explore the extent of inequity associated with these payments as well as a series of related questions:

- Are red package payments more significant in poorer, low-income areas than richer, high-income areas--i.e., under circumstances where the roots of "tradition" have become less firm
- The extent to which red packet payments support clinics and hospitals where supplies and other materials are in short supply
- The exact impact of "tradition" on the red packet practice in China and how it leads to variation from informal and unofficial fees in other countries
- How the red packet has evolved as health system finance has evolved in China
- The specific barrier these payments serve for preventive service access--e.g. for vaccinations and other essential primary care services
- Uneven consequences for family planning and reproductive health issues faced largely by women.

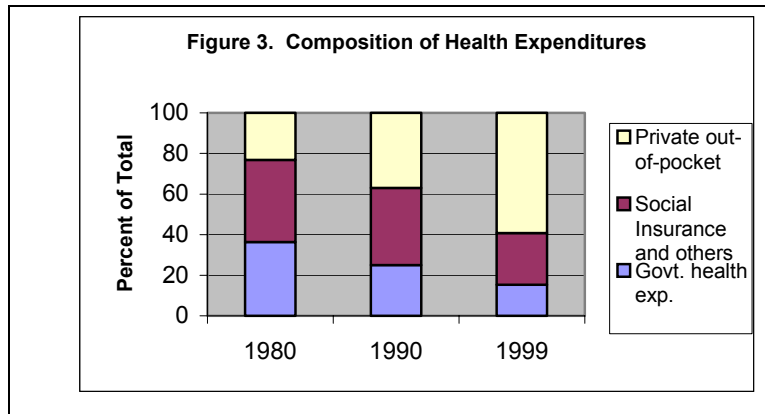
What is important for the China case, however, is the relation between outside fees and official ones. In fact, this point is critical since it shows the importance of official fee regimes for "unofficial ones" in almost the reverse way from most health systems. Since the period of intensive health system reform using market principles during the late 1970s and early 1980s the following has occurred<sup>31</sup>:

The main expenditure facts of the Chinese system are:

- Total health expenditures were equivalent to 5.1 percent of GDP in 1999.
- Total health expenditure per capita was 331.9 Yuan in 1999, or about US\$40.10 in 1999. This spending is up from \$ 9.40 in 1981 and \$13.60 in 1990.
- Government sources accounted for 15 percent of total health expenditures in 1999, down from 25 percent in 1990 and 36 percent in 1980. The government's share at present is very low compared to other countries.
- Private household sources accounted for 59 percent in 1999, up from 37 percent in 1990 and 23 percent in 1980.
- Social insurance and others accounted for 26 percent in 1999, down from 38 percent in 1990 and 41 percent in 1980.

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<sup>31</sup> Source, National Health Accounts. Chinese Health Economics Institute. 2000.



Source: China National Health Accounts, CHEI 1999

Public health expenditure, as a share of government spending, has declined from 76 percent in 1990 to 70 percent in 1999, while the public health proportion of total expenditure on health in China has declined from 19 percent in 1990 to 11 percent in 1999.

Whatever the China case shows about the red package as an informal fee will be eclipsed by the extent of private expenditure in the China system today.

### *Analysis*

The case of China is a telling one, even though the evidence concerning red packet payments is largely yet to come. This is because so much is already known about official fees and the Chinese health system. And the important fact is this. In the main, many of the problems associated with outside fees are, in China's case, problems linked with "official fees" not outside fees.

Interestingly, those concerned for population and needs-based provision of health care services in China--particularly primary care services--suggest that the current decentralized system of public provision and private payment in China poses almost exactly the same problems as those posed by outside fees in other health systems:

1. Health service access will be reduced for those least able to pay.
2. Uses of health service revenue will be siphoned off from stated system aims.
3. System "inefficiencies" will emerge and enlarge.
4. Medical practice will be distorted by perverse payment incentives.

For example, the recent National Rural Health Conference in China<sup>32</sup>—under State Council Sponsorship—noted that, despite significant achievements, rural health work "still remains weak" and suffers from numerous problems:

<sup>32</sup> Document of the Central Committee of CPC. 2002-11-01. "Decisions of the Central Committee of the CPC and the State Council on Further Strengthening Rural Health Work" Beijing p. 1.

- Delayed system reform
- Insufficient capital investment
- Shortage of medical personnel
- Backward infrastructure
- Problematic rural cooperative medical-care services
- Serious epidemic and endemic diseases in some areas
- Evidence of poverty or returning to poverty of farmers

To pay attention to these problems the National Conference was undertaken and the guidance of the “Decisions of the Central Committee of the CPC and the State Council on Further Strengthening Rural Health Work” was produced. These problems are also noted by State Development Planning Commission reports concerning both urban and rural areas and focusing, among other points, upon rapid rises in the cost of medical care<sup>33</sup>:

But now, the medical expenditure in urban and rural areas increased more rapidly than income growth rate in urban and rural areas and economic affordability in the same period. Statistic data in 1990-1997 show that GDP per capita, income per capita of the urban households, thenet income per capita in rural households, national fiscal revenue increased 9.9%, 6.70%, 4.98%, and 6.23% annually respectively. In the same period, the health expenditure per visit and per case of inpatient went up 16.7% and 14.77% respectively in the general hospitals.

As noted in a recent review of health care financing in China<sup>34</sup>:

A conclusion from the Chinese experiences [in recent health care provision] could be that public ownership in no way precludes commercialization of health care provision.

The point to be made is that “official fees” or revenue instruments can, just as easily as “unofficial” and “informal” fees, be associated with distortions of system goals, facility actions and patient access.

### *Analytic points*

Though many points could be made, only 4 will be suggested here.

*Analytic point #1* It is rather obvious but vitally important to see that major problems of access and quality appear to be associated with *fees*--whether the fees in question are official and "inside" the health system or outside the health system. The point is like the

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<sup>33</sup> Social Development Department of State Development Planning Commission. December 18, 2001. “Strategy for the Sustainable Health Development in China” China/WHO Project. Beijing.

<sup>34</sup> , Bogg, Lennart. *Health Care Financing in China: Equity in Transition* Stockholm, Sweden: Karolinska University Press. p. 55.

one found repeatedly in National Health Accounts exercises--sources of funds are not necessarily linked with uses by an economic or rationalized pathway.

Of course, this general point about fees is an hypothesis to be tested. But the China case may be an especially telling one since it raises a number of issues:

- Is there a threshold point after which fees of any kind distort or undermine overall health system goals?
- After a certain threshold point, do official fees function as unofficial ones? And what does this mean for health and health security policy in general?
- Does it make a difference, since official fees presumably can be directed by public policy, that distortions are due to official rather than unofficial or informal ones?
- Are there conditions under which market principles necessarily produce system distortions via unofficial and informal fees? What are those conditions? Are they general and suitable to economic policy remedy or are they conditions that must be addressed in the specific social history of a country?
- Are there "types" of health system problems linked with fee-based distortion? What are these "types"? Can they be stated formally or presented as historical "ideal types" so that policy can develop general remedies for them?

If nothing else, the literature concerning public-private partnerships, private payments, unofficial and informal fees, and facility-specific fees need to be reviewed in terms of impact on intermediate and final health system goals.

And, in fact, this first analytic point also suggests that further investigation is required concerning the interplay of payments and system goals. The direction of flow of influences within the health system may be fee-to-goal but the direction may also be goal-to-fee; it is important to know which is dominant, of course.

*Analytic point #2.* Institutional and social history does matter for the operation of official and outside fees in a health system, probably significantly. In China, for example, the traditional and deeply rooted courtesy feature of the red package makes likely an especially strong impact of red package payments upon poor patients and those having relatively stronger traditional beliefs. In Bangladesh, the history of tax and property relationships with fee collection under the Zamindar system may have legitimated opportunistic fee-taking within the overall public policy of the country.<sup>35</sup> To the extent that is true, any form of official fee taking is likely to be subject to "rent seeking" behavior.

But social history and economics interact. In Bangladesh, for example, "rent capture" in health (as opposed to "rent seeking") also depends on

- The existence of consumer surplus to capture within the official fee system

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<sup>35</sup> See Chatterjee, Partha. 2002 *A Princely Impostor?* Princeton, New Jersey: Princeton University Press.

- Weak enforcement of official fees collection and other professional behavior norms within the health system
- Coincidence of sharp declines or low levels of funding for previously "free care" services

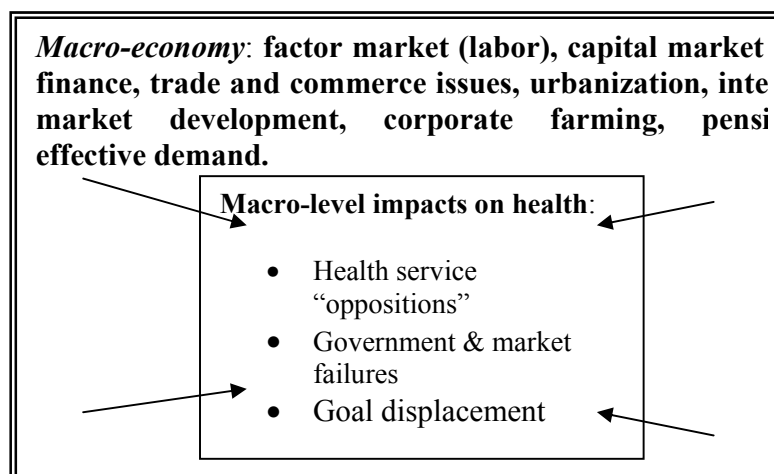
To this picture, it might be added, in the case of former Soviet Union and Central Asia/East Europe, that a social history of community sacrifice in the event of collective need may facilitate the "organic" development of informal fees. This warrant for action focuses upon materials and supplies and then gravitates to physician service payments. . It is vitally important that the conditions under which inside and outside fees distort goal be specified.

Broadly speaking, it appears that "fee effects" might be linked with system patterns. Among the principle ones are likely to be the following:

1. Directional linkages between the "big box" of macro-economic policy and the smaller box of health sector policy (of course, admitting interactions)
2. Un-even areas of application of market principles and development in the several market-like components of the health sector
3. Social history patterns that shape the function of fee-to-goal and goal-to-fee relationships

*Point 1.* Big-box, small-box flows of influence are especially important and obvious in China, where the socialist market economy is evolving and where these influences set in motion a cluster of "driver" principles for the health sector. In particular, the relationships involved are summarized in Diagram 1 where 3 resulting health system issues are especially prominent.

**Diagram 1: Big-box/Small-box flows of influence in China**

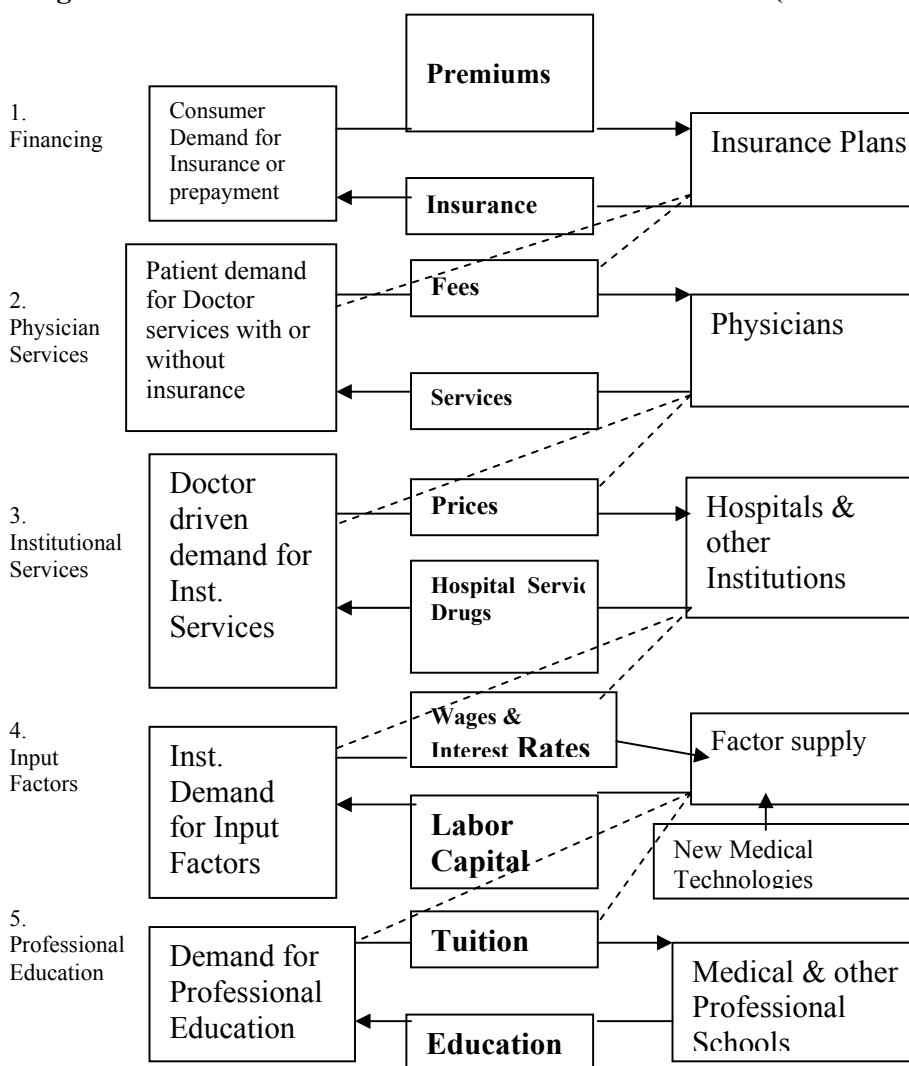


But the literature on Central Asia/East Europe and the former Soviet Union seems to bear out the importance of big-box/small-box relations. Perhaps if donor policy is linked with

macro-economic policy in Bangladesh, the same direction of influence and, hence fee effects, could be seen.

*Point 2.* As far as un-evenness of market principle development, this larger pattern can be understood in terms of what William Hsiao calls the “abnormal economics” of medicine and health. William Hsiao's depiction of the multiple markets in health--Diagram 2. Again, using the case of China, the extent and depth and operative nature of "market principles" in the several key components of health system So, for China, these traditional market components exist but exhibit varying degrees of development, government control and regulation, and institutional maturity.

**Diagram 2** “Abnormal” economics of medicine and health (c.f. William Hsiao)<sup>36</sup>



<sup>36</sup> Hsiao. "Abnormal Economics in the Health Sector." Berman, Peter, ed. *Health Sector Reform in Developing Countries*. Cambridge, MA: Harvard University Press, 1995.

*Point 3* Social history and economic patterns are only theoretically separable. In actual fact, global patterns of development are filtered through the overlay of history. This is clear by a moment's reflection on the specific influence of Bismark, Beveridge, and Lyndon Johnson and the Hill-Burton Act upon the health systems of Germany, the UK and the US--just to name three systems. Social history--as a bedrock of community positions affecting the function and interpretation of health system initiatives--cannot be overlooked.

For inside and outside fees, these broad influences must be understood along with insights from macro and micro-economics, institutional economics and insurance or other payment systems. In China, for example, the history of the red package is part of tradition and traditional medicine as well as festivals, relations between young and old, family and community socialization and many other key subjects linked with the operation of informal fees in health. This sort of social sub-stratum will, in its own way, shape the operation of fees in the health system. How much? To what extent? In what manner? Through what policy mechanisms, taxation patterns, facility revenue policies, with what kind of health human resource policy, and under what regime of enforcement, investigation and incentives are all matters to be determined by specific investigations.

But the general point remains. Social history should not be ignored in trying to understand and remedy the distortions of fees on intermediate and final health system goals.

*Analytic Point 4.* Official, unofficial and informal fees each have separate effects on health system goals, access to health services and more investigation of these separate effects is required.

From a system or even facility wide perspective, macro-level forces affect the operation of official, unofficial and informal fees in different ways—thereby affecting goal-to-fee patterns and fee-to-goal patterns as well.

1. In China, where macro-policy has resulted in declining government subsidy of health services relative to private, official fees, the red packet payment (informal payment) may be a nuisance for those with reasonable income and a barrier for traditional poor families. But it is the official fees that represent a likely service barrier for low-income families—in 2000 roughly 60% of patients from rural areas now leave hospitals before they have fully recovered because they cannot afford the costs.<sup>37</sup> Distortions and displacements of a fee-to-goal sort appear to be from *official fees* to health system goals, not from informal fees to health system goals. The impact of Big-to-Small Box influences appears to be the shift in extent and nature of public sector spending upon facility incentives to use official fees for revenue generation and hence as a barrier to service access.<sup>38</sup> The quest for revenue through official fees has led to goal displacement and

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<sup>37</sup> China Daily (11 June, 2002).

<sup>38</sup> See remarks by the MOH Director of Health Statistics and Information in 2001. Lawrence, Susan V. "The Sickness Trap" *Far Eastern Economic Review* (June 13, 2002). There, Dr. Keqin Rao and Prof.

distortion—a fee-to-goal impact resulting, at least in part,<sup>39</sup> from Big-to-Small box policy reform.

In Central Asia/East Europe and the former Soviet Union, the patterns seem to be from fee-to-goal and, in many instances, from informal fee to goal and only by its deficient character from official fee-to-goal. There, the impact of Big-to-Small Box influences is the impact of declining support for public expenditure for public service provision and toward other areas of public sector work or toward support for the commercial sector.

In Bangladesh, the scarcity of resources of all sorts within the Big Box appears to have led by default to unofficial fee displacement of health system goals—an unofficial fee-to-health goal displacement at the facility level. This parallels the informal fee-to-goal displacement in Central Asia/East Europe but relies heavily upon patterns of fee-taking linked with overall property rights and taxation policy from the Bangladesh “Big-Box” inward.

2. From the view of the patient, the “fees are fees” view often prevails. In some cases in Bangladesh and Central Asia/East Europe, patients and health consumers have not known whether a fee was official or informal and unofficial. A fee, it seems, was just a fee. But what is important is where the fee—official, unofficial, informal falls along the following continuum<sup>40</sup>:

Nuisance	Obstacle	Barrier	Self-exclusion
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Here, the matter of uneven system component development may be critical. If patients do not have a legal system that clearly defines and enforces property rights<sup>41</sup> and tax collection in a manner distinct from the “entitlements” or “emoluments” of office—as Max Weber noted long ago.<sup>42</sup> Even if the medical education and the professional input markets are well developed and governed by strong codes of ethics, the need for regulation and enforcement (and an associated information base that is hard to afford in developing countries) regime must be developed within the Big Box to properly control what goes on with “fees” in the Small Box. If not, then the fee-to-goal effect of fees (official, unofficial, informal) is likely to be highly significant, if not oppressive for the health of vulnerable groups.

3. Within the Small Box, the separate effects of a fee-to-goal and goal-to-fee sort must be specified by research. As the cases show, *conditions are critical for “fee” effects* upon health system actions and goals. To further model the relations between

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William Hsiao suggested that the profit motive, as well as disease transitions, have led to revenue-seeking because facilities must support themselves.

<sup>39</sup> See also, Bogg, Lennart. *Health Care Financing in China: Equity in Transition* Stockholm, Sweden: Karolinska University Press, especially pp. 38-42 and pp. 50-57 (especially, p. 55).

<sup>40</sup> My thanks to Mr. Alan Schnur of WHO, China for suggestions in this area.

<sup>41</sup> See Ho, Peter. 2001. “Who Owns China’s Land? Policies, Property Rights and Deliberate Institutional Ambiguity,” *The China Quarterly* (2001), pp 394-421.

<sup>42</sup> See Weber’s formalized definition of “bureaucracy” in Gerth, Hans and C.W. Mills. 1946. *From Max Weber* New York: Galaxy Books.

“conditions” and “fees” within the Small Box is a critical step—without which the larger set of conditions (Big Box-to-Small Box and market component development and structure) will not make much sense. Finally, within the Small Box, the operation of social history factors must be clarified to determine its role in the formation, operation and control of official, unofficial and informal fee effects on health services and their finance.

## *Conclusion*

This report has argued that health system goals--intermediate and overall--are affected by fees and that informal and unofficial fees should be seen as part of "fee impacts" in a health system. Further, it is contended that conditions have much to do with the long-term impact of and significance of fees for health systems--particularly for unofficial and informal fees. Informal fees seem to be fitted to conditions and health system circumstances that differ from those where unofficial fees are collected as part of a process of "rent capture" for consumer surplus. And yet, informal and unofficial fees may share common circumstances, especially:

- The existence of consumer surplus to capture within the official fee system
- Weak enforcement of official fees collection and other professional behavior norms within the health system
- Coincidence of sharp declines or low levels of funding for previously "free care" services

This report also argues that many broad questions remain about the impact of fees--inside or outside (unofficial and informal) on health systems. These include at least the following issues:

- Is there a threshold point after which fees of any kind distort or undermine overall health system goals?
- After a certain threshold point, do official fees function as unofficial ones? And what does this mean for health and health security policy in general?
- Does it make a difference, since official fees presumably can be directed by public policy, that distortions are due to official rather than unofficial or informal ones?
- Are there conditions under which market principles necessarily produce system distortions via unofficial and informal fees? What are those conditions? Are they general and suitable to economic policy remedy or are they conditions that must be addressed in the specific social history of a country?
- Are there "types" of health system problems linked with fee-based distortion? What are these "types"? Can they be stated formally or presented as historical "ideal types" so that policy can develop general remedies for them?

Still further, official, unofficial and informal fees in health need to recognize the influence of three system patterns likely to have a major effect on how fees affect a health system. These are:

1. Directional linkages between the "big box" of macro-economic policy and the smaller box of health sector policy (of course, admitting interactions)
2. Un-even areas of application of market principles and development in the several market-like components of the health sector
3. Social history patterns that shape the function of fee-to-goal and goal-to-fee relationships

Finally, official, unofficial and informal fees each have separate effects on health system goals, access to health services and more investigation of these separate effects is required. In three areas, this is especially important:

1. Where macro-policy has resulted in declining government subsidy of health services relative to public goods provision and commercial priorities at the level of the "Big Box," distortions and displacements of a fee-to-goal sort appear to be more likely from *official fees* to health system goals, not from informal fees to health system goals. This pattern may change, though, when social history or market development and regulatory/informational support are lacking—so that fee-to-goal distortions are primarily affected by unofficial and informal fees.
2. From the view of the patient, what is important is where the fee—official, unofficial, informal falls along the following continuum:

Nuisance	Obstacle	Barrier	Self-exclusion
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Even if the medical education and the professional input markets are well developed and governed by strong codes of ethics, the need for regulation and enforcement (and an associated information base that is hard to afford in developing countries) regime must be developed within the Big Box to properly control what goes on with "fees" in the Small Box. If not, then the fee-to-goal effect of fees (official, unofficial, informal) is likely to be highly significant, if not oppressive for the health of vulnerable groups.

2. Within the Small Box, the separate effects of a fee-to-goal and goal-to-fee sort must be specified by research.
3. Within the Small Box, the separate effects of a fee-to-goal and goal-to-fee sort must be specified by research.

If such matters are taken into account, a more complex but nevertheless adequate understanding of fees in health may result with attendant benefit for policy-makers and those concerned for the public finance of public goods in health.