Some Elements of Corruption in Transition Period in Moldova

Elena Stempovscaia

The economies of the developed countries and the NIS countries in their transition have met the same problems in the market economy that influence health system. Entering the transition period the majority of the NIS have registered the same performances in health system.

The principal items of the public health system were:

- Infectious diseases prophilaxy
- High level of financial protection
- Equality

The weak items were:

- non-infectious diseases control
- insufficient rehnical provision
- resources allocation and
- insufficient capacity of the system to cover all needs of consumers

After 10 years of transition period registered performances have changed greatly. They can be divided into three groups:

1. The first group includes the countries that have managed to maintain strong position inherited from the previous system and to improve some indentures of the system performance. These are countries with high level income per person and it was due to the fact that the reforms were all over the territory.

2. The second group includes the countries that have registered the decline of some indicators of system performance referring to financial protection and equality as well as infectious diseases increase. This group of countries is characterized by lower income per capita and a sharper economic decline. The health system reform was introduced later and is much more fragmented.

3. The third group includes the countries having registered worsening of health system performance – this is due to the fact of lower income per capita accompanied by severe economic decline. Azerbaian, Georgia and Moldavia belong to this group who suffered a public financial collapse with an extremely reduced level of social services sphere together with health system sector.

In the transition period, every Eastern European country has suffered to moderate to severe ones industrial enterprises and non-profitable sectors closure, interior market model collapse led to substance decline of the countries economics. The most severe decline has been registered in NIS with the fall from 50% to 70%. The economic crisis has provoked salary decrease, non-equality and poverty corruption elements appearance. Taking into consideration all the abovementioned, we have decided to attract attention to the issue of corruption element having appeared at the moment and to make a survey on the problem.

Informal Payment for Health Services

Informal payment is an old practice of additional payment for services supposedly covered by public funds. This phenomenon is increasingly common, and it shows how two major stakeholders deal with the health system crisis. In this context patients pay medical staff for services which are supposedly free-of-charge, not regulated at all, or prohibited. The practice is seriously under-searched and little is known.

Furthermore, it is difficult to define the concept and distinguish it from similar practices such as bribery, theft, patronage, influence peddling, or petty versus grand corruption. Is it the equivalent to bribery, a special incentive to do a professional service, which the medical staff is obliged to provide free of charge on behalf of the institution? Is it theft, because the medical staff is using public assets to perform services, but the profit is privately appropriated? Is it patronage, corruption, or only petty influence-peddling?

There is some overlap and conceptual uncertainly when one tries to define these practices, but our limited task is to describe a narrow segment of this complex, neutrally-labeled informal payment. Our goal is not scientific understanding, recommendations for coping, or moral judgement of the individuals involved, but rather partial identification and documentation of the phenomenon. If we are able to describe this informal structure of medical fees and costs in a time of troubles, it may help to estimate a realistic level of medical staff salaries and the capacity of patients to pay and serve as a benchmark for the coming privatization.

Very little is known about this issue and its history, and our survey covered a very brief period. How cultural legacy and the prior “shortage society” shaped this phenomenon is beyond our task and capacity to address here. It is obvious that a new economic and institutional crisis has accelerated this infrastructure, and makes the entire medical system counter-productive and meaningless. Is it a situational or durable practice? It remains to be seen.

Methodology and Approach

This part of our report is based on interviewieng 390 persons – 130 physicians, 130 nurses, and 130 patients – between June 20 and July 20 of 1999. Because the issue was delicate, our questionnaires were flexible and contained many open-ended questions. Our interviews were trained to establish a congenial atmosphere and relationship with respondents first. They were also asked to repeat questions, check and compare answers, and approach issues in a variety of ways. Most of the interviews took place in the republican and municipal hospitals in Chisinau; about a quarter were in two judet hospitals in Edinet and Soroa. The medical staff and groups of patients were interviewed in the same hospitals in order to compare their response. The team had additional

individual and group interviews in Chisinau, judet administrative centers, and villages.

The physicians' statements, especially about their patients' expenses, were standardized summaries rather than accurate accounts for the time period. The patients' statements were more precise and concrete but, as many physicians remarked, their statements concerning informal payments could be inflated. A key issue for our team was to deal with the willingness of medical staff to talk frankly about this delicate subject.

This problem was anticipated during the preparatory work. A young, local physician was hired as the local consultant, selected for his professional reputation within the medical community, his humane qualities, and his people skills. This was important in the initial phase, when the project design and the questionnaire were tested, and became crucial during the initial contacts where trust was established between our local consultant and the majority of interviewed physicians.

As expected, many refused to be interviewed or answered questions very formally in line with the system's expectations, especially the high-ranking medical staff members. Younger physicians and nurses were ready to answer questions in a more honest way. Generation solidarity and shared values, interests, and concerns prevailed. Although some declined to cooperate, the vast majority was sincere and honest thanks to the skills and personal approach of our key consultant.

There may be a issue here of how representative the sample of the interviewed physicians is. Although this is a legitimate concern, we believe that our sample *is* representative, because we covered all major specialties and key capital and municipal hospitals, and the physicians are well established professionals with work experience of 10 or 15 years or more.

Summary of Key Findings

This a pioneering effort with limited resources and time, and the scope and depth of this survey are very modest. That is why our findings, data, comments, and conclusions should be seen as indications, trends, and hypotheses rather then truths. Our key findings are summarized and presented separately for physicians, nurses, and patients.

Physicians

According to the physicians' interviews, 65 to 70 percent are paid informally by their patients for their clinical work in hospitals. (Our patients' interviews show that 119, or 91.5 percent of them, paid their doctors informally during their hospitalization.)

In spite of expectations that almost all patients have paid their doctor informally, other questions in our survey show that more than 30 percent of them have not done so. Growing poverty has constrained a lot of patients; many interviews and reports have documented a growing pauperization of the population. Several doctors and patients told us that a “Samaritan attitude” or a “charity impulse” should be applied here. This moral constraint has prevented many of them from requesting an informal payment. In addition, many of patients are part of a reciprocal obligation circle, directly or indirectly. Medical staff is doing its services gratis, but there are expectations for reciprocal services. Finally, in extraordinary situations such as emergency cases, catastrophic and terminal diseases, request for the payment is improbable.

Cash is the key form of informal payment. Although there is a variation among specialties, our survey shows that 70 percent of doctors were paid in cash. The patients survey suggested that the cash and in-kind payments are equally common and given simultaneously.

In-kind informal payments include traditional gifts such as flowers, liqueur, and sweets, as well as item of barter. Agricultural products (meat, dairy, and vegetables), oil, sugar and “two big bags of flour” are the most frequent in-kind compensations. Doctors have received construction materials, gasoline and household appliances (TV set, video, washing machine). While the majority of physicians’ claim that services are rarely offered in payment, the list of services includes car repair, house maintenance, and sauna, air-tickets, or participation in international conferences at discount prices or free of charge. In-kind payment and services are a recent trend. Cash is dominant in the Chisinau municipal hospitals but in-kind payment and services prevail in republican hospitals and the two judets. In the two judets hospitals, the therapist and pediatricians receive in-kind payments (70-90 percent) but the surgeons and gynecologists receive cash (60-90 percent).

Informal payments differ according to specialty. Gynecology, obsterries, proctology, and urology are paid much higher than therapy and pediatrics, informal payment is higher in specialized fields such as angiography, rheumatology, plastic surgery, mamology, oncogonecology as well. Working experience, reputation, professional status, and established clinical relations with patients are factors that determine the amount of informal income. Small surgeries, cosmetic interventions, and nontraditional methods like acupuncture bring substantially more informal income than complex and long-term treatments. Scheduled surgery is lucrative, because there is time for physicians to bargain with clients and their families.

The ratio of informal payments to the average monthly salary of physicians for regular hospitals in the elate of Chisanau: It is 3.0 for pediatricians, 4.6 for internal medicine practitioners, 4.9 for surgeons, 6.7 for anesthesiologist, and 8.2 for gynecologist. Official salaries were always been low, but they have dropped even lower with the public sector crisis of the last few years. Physicians’ salaries ranged from $300 and $600 a year in early 1999; monthly salaries were 270 to 600 lei. Given the huge arreas, salaries are even lower. Based on physicians’ calculations, informal monthly income in Chisinau was

around 1900 lei for anesthesiologist, 1440 lei for surgeons, 840 lei for internist, and 600 lei for pediatricians. This was cash income. Monthly in-kind income was worth: 200 lei for surgeons, 260 lei for internist, 277 lei for gynecologist, and 380 for pediatricians. We should add cash equivalence for services received as informal payments, but they are irregular and it is difficult to transfer their worth into cash value.

All physicians claim that informal payments are given in gratitude of patients, but 58 of the 124 physicians who answered this question (46.7 percent) confirmed that they request informal payments from their patients. Interviews with patients, especially in regional hospitals, confirm the same patterns: there is a tacit, standardized scale of fees for informal payments. It seems that some specialties, such as anesthesiology, have established such a structure of fees for their services.

Physicians offer consultations in the home, as a family doctor. The majority of physicians confirmed having 15 to 20 such patients on a regular basis. The fee for one visit and/or consultation in between 25 and 50 lei (up to 100 lei if a physician is an university professor or chief of the department). Several physicians told us privately that many of their colleagues have made arrangements to reduce their hospital workload and have accepted up to 50 percent reduction in salary to gain more opportunity to work privately. It is difficult to estimate this type of income, but it may be two to three times higher then the informal income earned in hospitals.

There is a conceptual problem here. These services are informal in sense that they are not regulated, but they are not illegal. They are private relations between doctors and patients, performed outside the hospital. However, doctors may perform these services during their regular working time, or they may make use of the hospital facilities and equipment. They may also use their influence to divert patients from using their services in hospitals in order to serve them privately.

Many doctors make special arrangements with local private pharmacies whereby they receive 5 percent of their price if they prescribe the pharmacies' products. Our estimate is that this increases the monthly income by an additional 200 lei. Some physicians have told us informally that they buy medicines at wholesale prices and sell them to their patients at recall prices. Even the medicines obtained through international aid have been sold at market prices. Although many people provided this information, we are uncertain as to whether this was hospital practice or doctor practice.

Nurses

Although informal payments for nurses are widespread and follow the pattern set for physicians, the amounts of these payments are negligible. Many nurses reported having no informal income at all. Nurses from Chisinau hospitals have monthly informal incomes around 80 lei in cash and about 42 lei in-kind. The average ratio of informal income in relation to their regular monthly salaries is

0.6 to 1.9 percent. Given that official salaries are extraordinarily low and very much in arrears, the majority of patients did not see these informal payments as a serious burden. Part of the in-kind payments should be understood as the traditional “gratitude legacy”. This means that nurses usually receive small presents of flowers, cheap perfumes, deodorants, sweets, fruits, and juices.

Nurses working in specialized units such as proctology, urology, and neurosurgery have higher informal incomes. Nurses working with surgical units get their informal incomes from the surgeons, not from patients. The best-paid nurses work in the gynecology and obstetrics units. The fees for a birth delivery were fixed at 100 lei per delivery in July of 1999. In addition, a growing portion of the informal income is coming from performing a variety of services in patients’ homes (pretensions, injections, home ere, massage). In spite of all these efforts to increase their formal and informal incomes, the majority of nurses interviewed were extremely unsatisfied with their income. The young nurses in particular planned to leave their profession and find other more lucrative jobs. Since the job market in Moldava is tight, the only option is seasonal migration to the European countries.

Patients

Due to a drastic budget decline, the central health administration allowed hospitals and other medical units to establish official fees for services in January 1999. These fees cover all services provided during the hospitalization, including food. This was a decisive more toward privatization and commercialization of health services. However, these costs, accompanied by informal payments to medical staff, have become a real financial challenge for patients. Patients reported that these costs for hospitalization were 990 lei at therapeutic units, 1037 lei at pediatric units, 1231 lei in gynecology/obstetrics units, and as much as 2200 lei at surgical units. Given that the patients’ average monthly salary was 274 lei in period May-July of 1999, it is not surprising that three-quarters of them see those costs as unbearable. Patients report substantially higher official fees for hospitalization than physicians. It may be that physicians refer to the planned fees without calculating the number of services or days spent in hospitals. Our patients report their real costs based on services received.

The introduction of official fees has not eliminated informal payments to medical staff. In the spring of 1999 informal payments made up 6 percent of total costs in therapeutic units and 31 percent of total costs in surgical units of hospitals with official fees for admission. There are differences in how much patients really pay informally. In practice patients pay 68 lei in therapeutic units, 153 lei in pediatric units, 381 lei in gynecology/obstretrics (raging from 50 to 2750 lei), and 600 lei in surgical units.

When asked why they were making informal payments to medical staff during the hospitalization, patients gave a single reason: to get a better service. Here are some of their explanations: “If you don’t remunerate medical staff nobody pays attention to you”; ”If you come with a present for a doctor, he will treat you

well. Otherwise will not any attention”:; “Physicians do not pay much attention to the patients without receiving money in advance”; ”Physicians say: the way we receive our salaries from the government is the way we treat patients. The more payment received the better the treatment”; “After compensation, my doctor’s attitude radically changed.” The two interviews commended: “She is angry with physicians who do not do anything unless paid” and “After she remunerated the medical staff, they considerably increased the quality of services.” The pressure to pay informally is more complex then the doctor request or the expectations that services will be improved. There is fear of a possible fatal outcome, total distrust in professional ethics of medical staff, an inability to resist cultural expectations, or a rational response to a chaotic reality. All those possibilities needed more study.

A substantial number of patients were pleased with their doctors and willing to pay. Some were aware of their doctors’ very low incomes and suggested that doctors’ salaries should be much higher; they saw their informal fees as a kind of compensation and adjustment. Many doctors accept that a lot of their patients are poor and they reject informal fees. This is confirmed in many patients’ comments: ”Physicians don’t ask, they know their patients are poor.” This answer was heard many times, especially in rural areas. We were present when a group of doctors collected a small cash donating for a poor patient who was waiting to be discharged from the hospital, and we interviewed several doctors who had invested their income in improving their offices or buying needed equipment.

Medicines are the highest single expense for hospitalized patients – 26 to 49 percent of their total costs. All the patients in our sample paid for their medicines although 24.6 percent reported that part of the medicines was given gratis. They all agree that the gratis medicines were very basic and inexpensive. On average, the paid 275 lei for medicines in pediatric units, 342 lei in gynecology/obstretrics units, 493 lei in therapeutic units, and 965 lei in surgical units.

The costs of medicines are much lower in the two rational hospitals we studied. There are two explanations. First, due to a low market demand for medicines outside of the capital, there is not enough incentive for private pharmacies to invest and expand their operations. Second, a prolonged crisis, professional isolation, and a lack of opportunities for training and exchange have made local doctors unaware of many new, efficient, and more expensive medicines.

The hospital pharmacies are literally empty, and a lot of them are closed. Trade with medicines is totally privatized and increasingly deregulated. Private pharmacies have stopped supplying public health services due their inability to pay. Ninety-five percent of medicine in Moldova is imported, and there are competing networks of pharmacies usually clustered around one big pharmaceutical producer. A decreasing capacity of the Government to regulate and impose control makes patients powerless. The medicine market is divided among small groups of sellers, who try to monopolize their positions. Our hypothesis was that patients have started supplying themselves with medicines from the black market and/or by trading among each other. According to our

survey all medicines bought by interviewed patients were sold in private, licensed pharmacies.

According to doctors, the 1999 introduction of official fees for admission to hospitals has decreased the informal and direct payments to physicians and nurses substantially. First, there has been a drastic decrease in the number of patients in all hospitals we studied, with the number of occupied beds reduced by one-third to half according to physicians estimates. Our team observed that several hospitals departments in Orhei and Hinaesti were almost without patients in May and June of 1999 and pediatric departments in Chisinau had only six or seven patients during visit in summer of 1999. Second, the advanced pauperization of the population has exhausted available resources for the most people. Many patients had to stop hospital treatment due to the lack of money. More than three quarters of the complained that the official fees for admission curbed the informal payments to doctors in the course of 1999. In addition, public disclosure of official fees makes the informal payment a moral issue for many doctors. The new norm requirement called the “financial plan” obliges each doctor to perform a certain number of activities and prevents many doctors from fulfilling their “official norms”. While they search for new patients they are unable to negotiate for informal payments.

Patients’ capacity to pay for health expenses varies. Although three-quarters of the patients claim that the formal and informal fees are extraordinarily high, our data demonstrate that their medical costs regularly exceed their official salaries and another incomes. The patients were asked to tell us where this money was coming from: combined family income is the main source of their informal payments (35.4 percent); parents, children, and relatives are almost equally important (30.7). Patients are usually explicit in stating that the money was provided by their parents or children and borrowed from relatives (and less from friends). Income from the shadow economy combined with family income and support, from relatives is the third most important source (21.5 percent). Finally, between 5 and 10 percent of patients, mostly from rural areas, reported they were forced to sell their cows and pigs in order to pay health bills.

A woman from the village of Budai told us that in March of 1999, her family spent around 8000 lei on the treatment of her husband (close to $800 at that time) for medicines, infusion systems, liquids, syringes, bandages, and six pairs of surgical gloves. (All these items were requested by the hospital.) The sum includes informal payment for the surgical operation done in Telenesti and Chisinau hospitals. They did not any fees in the Intensive Care department, but they did pay for the medicines. In the post-surgical phase they were paying 200 to 300 lei per day for services and medicines. The woman had to travel twice to Balti and once Singerei in order to buy blood plasma and erythrocyte mass because the hospital did not have blood for transfusion, even for emergency cases. This cost her 70 lei per liter.

A lot of patients were reluctant to disclose the sources of their incomes, and some answers were not precise or direct. A local inhabitant of the village Budai, Orhei Judet, told us that she was not able to calculate her medical expenses because she had not seen cash in her hands for the last six months.