Informal Payments In The Health Sector: A Case Study From Turkey

These small payments, from ordinary people, could have serious consequences for the health system and for patients.

by Mehtap Tatar, Hacer Özgen, Bayram Sahin, Paolo Belli, and Peter Berman

ABSTRACT: The practice of making informal payments in the health sector is common in a number of countries. It has become an important policy issue around the world. These payments can jeopardize governments' attempts to improve equity and access to care and policies targeted to the poor. It is widely believed that a considerable amount of out-of-pocket payment in the health sector in Turkey is informal. To examine this issue, we used a questionnaire adopted from a wider international study. We concluded that informal payments in Turkey are significant and have important implications for health care reform. [*Health Affairs* 26, no. 4 (2007): 1029–1039; 10.1377/hlthaff.26.4.1029]

Informal payments in the health sector have become an important health policy issue in a number of countries. In recent years, especially after the reform attempts in the former Soviet Union and increased focus on the health care systems of economies in transition, the extent and importance of informal payments have been discussed in various quarters. Research in several countries has drawn attention to the need to address this phenomenon in the context of improving health system performance.[1]

Turkey has a complex and fragmented health care system in terms of both financing and provision. This complexity results in a considerable amount of formal and informal out-of-pocket payment. However, discussions of informal payment are based on anecdotal evidence rather than data. This study, with its main focus on informal payment, is an important contribution to understanding private financing in Turkey.

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The Turkish Health Care System: A Brief Review

Turkey is a lower-middle-income country with a per capita gross domestic product (GDP) of US$3,383 in 2003. Life expectancy was estimated to be sixty-nine years for men and seventy-three years for women in 2004. Turkey's infant mortality rate (28 per 1,000 live births in 2004) is still high compared with other Organization for Economic Cooperation and Development (OECD) countries.[2]

■ **Health care delivery system.** Turkey's health care delivery system was very fragmented until 2005, when serious reform initiatives were undertaken to overcome this problem. Until 2005, the public sector had three main actors: the Ministry of Health (MoH), the Social Insurance Organization (SSK), and universities. As part of the reform agenda, all facilities belonging to the SSK were transferred to the MoH in 2005. However, in this paper we refer to the old system, because the SSK facilities were separate during the study period.

The MoH provided primary, secondary, and tertiary care through its primary health care facilities and hospitals scattered all around the country. It was also responsible for preventive services. The second actor in the arena, the SSK, was established as a social insurance organization for private-sector employees and blue-collar public-sector workers; it provided services directly through its own facilities until 2005. Universities and other public institutions (for example, the Ministry of Defense) also provided services to the populations they covered.

Although the private sector's share was low in terms of hospital beds (7.8 percent of total hospital beds were privately owned in 2004), it played a prominent role through private outpatient clinics. Doctors could work part time both in a public facility and in their private clinics.

■ **Health care spending and financing.** According to the latest National Health Accounts (NHA) study, Turkey spent 6.6 percent of its GDP for health in 2000.[3] At that time, Turkey's health care financing system was fragmented and complex. At the time of the NHA research, around 70 percent of the population was covered under five separate schemes, with varying benefit packages and regulations. The SSK, collecting premiums based on payroll wages, covered the largest segment of the population (around thirty million). The second scheme, Government Employees Retirement Fund (GERF; the pension fund for retired civil servants), was financed by the contributions of active civil servants. GERF purchased services from state facilities, universities, and the private sector. The third scheme covered active civil servants whose health spending was financed through allocations from the government budget. Civil servants covered in this scheme could use both public and private facilities. Bag-Kur, another public scheme, covered the self-employed and all others not covered by any other scheme outlined above. Bag-Kur purchased services from both public and private institutions. Finally, the Green Card scheme covered people under a certain income level assessed by minimum wage figures. This group's spending was financed from the government budget. During our research, this scheme covered only inpatient spending.

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In 2006, as part of the ongoing reforms, all of these schemes were merged under the newly introduced General Health Insurance Scheme (GHIS). The adaptation process still continues, and the new system was to have begun in January 2007.

Out-of-pocket spending is estimated at around 30 percent of total health spending in Turkey. According to the recent NHA study, Turkey's per capita out-of-pocket spending was US$54 in 2000.[4]

Study Data And Methods

For this study, we adopted the definition of *informal payment* developed for a wider study in four Central and East European (CEE) countries carried out by the Central and East European Health Network (CEEHN). *Informal payments* are defined as payments (in cash or in kind) made to service providers (person or institution) by those people who are entitled to the services, in addition to any legally defined payment.[5] According to this definition, the main determinants of informal payment in a health care system are the laws and regulations that are in force in a given country; the specific elements of payment deemed to be informal can vary from country to country.

We next classified informal payments into two categories: cash payments and gifts/in-kind payments. Cash payments were further divided into donations to public facilities, payments for physician services, payments for surgical services, payments for drugs, and payments for nurses and other personnel (Exhibit 1).

■ **Definitions: informal and formal.** All donations to public facilities were considered "informal." These donations actually resemble "brick payments" in Poland.[6] Although donations were supposed to be voluntary, those who refused to pay were denied services. All insurance copayments were considered "formal" in the study. Payments for physician services were considered formal if an insured person voluntarily visited a private doctor for better or faster service or to upgrade the services financed by his or her social security scheme. For the uninsured, these payments were also considered formal. Payments for physician services were defined as "informal" if an insured patient visited a doctor's private office to receive services that the patient was entitled to receive in a public facility. In other words, these payments were not for upgraded services but to obtain the basic services that should have been provided under the social insurance scheme.

All gifts and in-kind payments were considered "informal." In-kind payments included goods and services that were provided from outside the hospital while a patient was hospitalized. According to the rules and regulations for the covered population, hospitals should have provided all goods and services for patients during an inpatient episode. The goods and services under this classification included those that were the responsibility of the hospital; they did not include goods and services that reflected patients' preferences.

■ **Model questionnaire.** The model questionnaire for the CEEHN study was revised for use in studying the Turkish health care system. The recall period was two

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EXHIBIT 1
Definition And Examples Of Formal And Informal Payments In Turkey As Used In This Study

Type of payment	Definition	Formal	Informal
Donation	Amount paid to associations and foundations established in health facilities to generate extra resources; each patient visiting the facility had to make a donation before receiving any service; these entities were closed as of January 2005	Not applicable	All donations were accepted as informal; although donations are supposed to be voluntary, refusal to pay could result in denial of services
Physician services	Amount paid to physicians for medical attendance	Formal if an insured person voluntarily visited a private doctor for faster or better service; also formal if an uninsured patient visited a doctor's private office	Informal if the patient visited the doctor's private office to access the basic public-sector services to which the patient is entitled according to insurance status; payments were not for upgraded services but for basic services covered by the insurance scheme
Physician surgical services	Amount paid to surgeons for surgical procedures	If the patient did not have any health insurance and paid for surgical services, this was considered formal	If the patient was covered, the payment made to a surgeon to get surgical services that he or she is entitled to was considered informal; payment was not to upgrade services but to get the service (known as "knife payments" by the public); payments by the uninsured without a bill were also considered informal
Drugs	Amount paid for drugs (both OTC and prescribed)	Buying OTC medications for self-treatment and copayments for drugs were considered formal	If the patient was hospitalized and asked to buy prescribed drugs from an outside pharmacy, payment was considered informal; these drugs are those that should be provided by the hospital; they do not include patients' preferences for brand-name drugs instead of generics
Payments for other staff	Amount paid to providers other than physicians and surgeons	Not applicable	Regardless of insurance coverage and type of care received, all payments for nurses and other staff were considered informal since the provider bill already included payments for services by this group
Gifts and in-kind contributions	Noncash payments made to health care providers	Not applicable	All gifts and in-kind contributions were considered informal; in-kind contributions were defined as goods and services provided from outside the hospital while the patient was hospitalized

SOURCE: Definitions adopted by the study.
NOTE: OTC is over-the-counter.

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months for both inpatients and outpatients, to increase the opportunities to interview as many patients as possible. The research was carried out in a middle-size city in 2002. Three major selection criteria were considered in selecting the study site: being a middle-size city, reflecting general characteristics of the country's population, and exhibiting health insurance coverage of about 50 percent. According to the 2000 census, the population of the selected city was 383,508, with an average GDP of US$3,416 per capita. The city had MoH, SSK, and university facilities within its boundaries.

■ **Study sample.** A two-stage stratified cluster sample yielding a probability-proportionate-to-size sample was used based on the master sampling frame of the State Institute of Statistics (SIS) for 2000. The sampling procedures were completed by the SIS; with 900 randomly selected households, the study had a total sample of 3,727 people. The survey was carried out by trained interviewers conducting face-to-face interviews with the head of the household for household-related questions. All other questions regarding use and spending were addressed to each family member over age eighteen. For children (under age eighteen), questions were addressed to their mothers. There is usually a concern that in cases where informal payments are illegal, respondents might refrain from answering honestly. To keep this from happening, the formal/informal classification adopted for the study was not made clear to respondents. Also, utmost attention was devoted to the wording of the questionnaire to avoid any connotation about the illegality of these payments.

Study Findings

■ **Extent of informal payment.** The share of informal payments in the Turkish health care system has been widely discussed, but substantive evidence has been lacking. Our study is extremely important, as the only example that focuses mainly on informal payments.

Discussions around informal health care payments have provoked studies in a number of countries. One example is the CEEHN study carried out in four countries: Czech Republic, Hungary, Poland, and Romania.[7] In the Czech Republic, out-of-pocket payments in general and informal payments in particular were negligible. Hungary and Poland had significant amounts of out-of-pocket payment, especially for outpatient care and pharmaceuticals. However, informal payments were not widespread and were usually for inpatient care and surgery. Among the four countries studied, Romania had significant levels of informal payment (40 percent of total out-of-pocket payments were informal). Another study that focused on informal payments for ambulatory care in Poland found that informal payments to institutional providers amounted to 10 percent of all out-of-pocket payments.[8] And a similar study conducted in Bulgaria found that 21.2 percent of males and 27.3 percent of females had made informal payments during the course of their treatment.[9] Jane Falkingham also found significant amounts of informal payment in Tajikistan.[10]

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In our study of Turkey, 25 percent of total out-of-pocket payments in 2002 were informal (Exhibit 2). Amounts paid per paying person were very close for formal and informal payments. We found that these payments were quite extensive, which needs to be taken into account in financing decisions.

■ **Types of informal payments.** The survey results revealed that 70.1 percent of out-of-pocket payments were formal payments for care; 4.4 percent were formal payments for self-care. Of the informal payments, 71.6 percent were informal cash payments, 27.5 percent were in-kind contributions, and 0.9 percent were gifts (data not shown).

Total informal out-of-pocket payments were higher for outpatient care than for inpatient care. However, informal payments constituted a higher share (53.0 percent) of out-of-pocket payments for inpatient episodes than formal payments did. These findings highlight two important issues. The first is the role of part-time or dual-practice providers in outpatient care. Part-timers are mainly physicians who, although employed in government services, maintain private practices and engage in self-referral (referring patients to the hospital where the doctor works) and other unethical practices. It should once again be emphasized that the informal payments made to these practitioners were not to upgrade the basic services to which patients were entitled and were not to get additional services that were outside the responsibilities of the social security schemes.

The second issue, underfunding of services or underinsurance, requires patients to purchase drugs, food, medical devices, and so forth, during hospitalization. The existence of underfunding was confirmed by a household survey carried out as part of the NHA study, which found that 30 percent of inpatients surveyed bought their prescribed drugs outside the hospital during a hospitalization.[11]

Purpose of payments and type of provider. The shares of total out-of-pocket payments made in the context of public and private providers were 31.7 percent and 68.3 percent, respectively. When out-of-pocket payments were broken down by purpose and the public-private status of providers, it was found that 62 percent of payments made to public-sector providers were formal and 38 percent were informal. For private-sector providers, these amounts were 78 percent formal and 22 per-

EXHIBIT 2
Extent And Type of Out-of-Pocket Payments, Formal And Informal, 2002 (Millions Of Turkish Lira With U.S. Dollar Equivalents)

	Total payments in sample	Payments per person in study sample	Payments per person making payments in study sample
Formal	130,237 ($86,072)	35 ($23)	203 ($134)
Informal	44,550 ($29,442)	12 ($8)	193 ($127)
Total	174,787 ($115,514)	47 ($31)	262 ($173)

SOURCE: Authors' analysis of data from the Informal Payments Project.
NOTE: One dollar = 1.513.112 Turkish lira (TL) for 2002 (http://www.tcmb.gov.tr).

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cent informal. In the public sector, the majority of both formal and informal payments were made for drugs. For informal payments, physicians' surgical services (23.5 percent) and donations to public facilities (11.1 percent) were the next two highest categories. The effect of underinsurance and "knife payments" (the practice of surgeons' asking for extra money for undertaking surgery) can clearly be seen from this finding. As far as the private sector is concerned, informal payments were predominantly for physicians' medical services (99 percent), reflecting the influence of part-timers. The negative influence of part-timers on the health sector has long been discussed in various quarters.[12]

Purpose of payments and insurance status. Breaking down the purpose of payments according to insurance status provided some evidence about informal payments to part-time practitioners (Exhibit 3). The majority of informal payments by the insured population were for physicians' medical services. Less than 1 percent of informal payments for physicians' medical and surgical services were in-kind contributions or gifts; the rest were cash payments (data not shown). It was also found that 85.1 percent of the cash payments were made before treatment and 14.9 percent after treatment (data not shown). This finding indicates that payments were not signs of gratitude but were made to obtain services.

For the Green Card holders, as expected, the majority of the formal payments were made for drugs, because the scheme did not cover drug spending during the study period. However, the results also show that 64 percent of informal payments were for physicians' surgical services and 15.6 percent, for physicians' medical services. This shows that even people with certificates of poverty had to pay the "knife payment" and were often inappropriately referred to doctors' private offices rather than the public facilities where these doctors also practiced part time.

■ **Settings.** The study also revealed important results regarding the settings in which informal payments were made. The majority of the informal payments were made in specialist physicians' offices (19.1 percent), followed by public hospitals

EXHIBIT 3
Purpose Of Formal And Informal Out-Of-Pocket Payments According To Insurance Status, Turkey, 2002

	Insured		Green Card holders		Uninsured	
Purpose	**Formal**	**Informal**	**Formal**	**Informal**	**Formal**	**Informal**
Donation	–[a]	6.4%	–[a]	1.4%	–[a]	2.6%
Physicians' medical services	25.6%	79.5	10.6%	15.6	22.1%	9.8
Physicians' surgical services	–[a]	6.8	–[a]	64.0	9.9	0.1
Drugs	53.6	2.1	89.4	9.5	55.0	82.5
Laboratory/imaging tests	11.2	–[a]	–[a]	–[a]	13.0	–[a]
Nurses'/other staffs' care	–[a]	–[a]	–[a]	5.7	–[a]	0.1
Other services	9.6	5.2	–[a]	3.8	–[a]	4.9

SOURCE: Authors' analysis of data from the Informal Payments Project.
[a] Not applicable.

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(17.4 percent; data not shown). The majority of the informal payments in public facilities occurred in MoH facilities (81.1 percent), followed by SSK hospitals (12.8 percent). In addition, insured patients paid informal payments predominantly (69 percent) in private specialists' offices, whereas Green Card holders made such payments predominantly (56 percent) to public hospitals (data not shown).

The above findings verify two major policy areas in Turkey: the underinsurance phenomenon that is an issue under almost all insurance schemes, and the influence of part-time providers. Concerning underinsurance, although on paper there is widespread coverage of services for people covered by available schemes, in practice there seem to be serious shortfalls in getting basic services.

■ **Reasons for giving informal payments.** Patients' reasons for giving informal payments can provide invaluable information to health policymakers.

Cash payments. Being grateful or following customs played very little role in informal cash payments (Exhibit 4). Peter Gaal and Martin McKee state that making a "donation" as a sign of being grateful to a physician reflects primarily social and cultural mores.[13] However, our results indicate that patients did not cite cultural factors as their rationales for informal cash payments. Also, as stated earlier, the majority of these payments were made before treatment, which indicates that they were not signs of gratitude for a service well performed.

Incentives for getting more attention at the time of treatment or in the future were stated as the underlying reasons for informal cash payments (Exhibit 4). This shows that although forcing people to pay was not a major issue in the study sample, it almost became a norm that to get better treatment, people felt obliged to pay providers extra. Gaal and McKee also state that when one is assessing the impact of informal payments on system performance, researchers and policymakers should address the question of whether there was a difference in the ser-

EXHIBIT 4
Patients' Stated Motivation For Making Informal Out-Of-Pocket Payments, Turkey, 2002

Motivation	Cash	Gift
No benefits: patient was grateful	2.0%	30.0%
No benefits: it is customary	1.3	20.0
No benefits: patient was arbitrarily forced	5.4	–[a]
To expedite treatment	14.2	5.0
To obtain more careful attention from doctor	59.2	10.0
To obtain more careful attention from nurse		10.0
To obtain better-quality medicines	0.6	–[a]
To establish a better relationship with physician for future treatment	14.1	25.0
To get extra ancillary services (single room, TV in room, etc.)	0.6	–[a]
Other	2.6	–[a]

SOURCE: Authors' analysis of data from the Informal Payments Project.
[a] No one responded with the given reason.

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vice for payers and nonpayers.[14] If informal payers receive better services than nonpayers, then there are serious consequences in terms of equity and access to care. Our findings suggest that physicians' private offices were major settings for informal payments. This implies unequal access among patients. Dina Balabanova and McKee also found similar discrimination favoring the better-off and paying patients in Bulgaria.[15]

Gifts. The situation was the opposite for gift payments. Being grateful was the most important reason for gifts and in-kind payments, followed by the expectation of establishing a good relationship with the physician for the future. Another question about respondents' attitudes toward out-of-pocket payments in general revealed that 89.4 percent had negative feelings about these payments.

Summary And Concluding Remarks

Reform attempts in Turkey's health care system, begun in the early 1990s, were in line with similar developments in other countries. However, these initial attempts failed over time because of repeated political and economic crises. Starting in late 2002, reform initiatives came to the fore again, and radical changes have already been made to support the proposed system.[16]

■ **Key features of the reform agenda.** *To introduce a GHIS ensuring financial protection to the whole population.* Unlike previous attempts, this scheme merges all existing insurance schemes under one new general scheme with unified benefits. The government will pay premiums for those who are unable to pay. The legal process is completed, and the system was to have gone into effect beginning in January 2007.

To introduce a family practitioner scheme as the backbone of the primary care reforms. Accordingly, each person in the country is to be registered on the list of a family practitioner paid per capita. This is the first level of the referral chain. A pilot study in a selected province has already begun.

To introduce a purchaser-provider split in the long run and to create autonomous hospitals. According to the envisaged system, an internal market is to be created where the MoH will mainly deal with policy making and regulation, and the GHIS will be the main purchaser of services from facilities and practitioners competing with one another.

■ **Key conclusions and their relevance to the reforms.** First, we found that 25 percent of total out-of-pocket payments were informal payments. This is higher than in the Czech Republic and Poland, similar to Bulgaria, but lower than in Romania. This implies that Turkey's total health expenditure might be higher than stated in official data.

Second, we found that most informal payments were in the form of cash and that respondents stated their distaste for making these payments in general. This indicates that informal payments are not made to show gratitude or for cultural reasons but to ensure the receipt of services that are among patients' basic rights.

Third, payments to physicians for medical (in offices) and surgical services

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were the most important types of informal payment, indicating the role of part-timers in the health care sector. It is widely acknowledged that in Turkey, if patients want to get the service to which their insurance entitles them, patients must visit a doctor's private office first. The practice of "knife payments" is also widespread. The current reform proposals on the financing side do little to control these phenomena, which suggests that informal payments will continue even after the reforms are fully implemented.

Fourth, our findings highlight underinsurance as an important issue for health policymakers. Underinsurance occurs when patients make extra informal payments for services to which their insurance status entitles them. Underinsurance status is not related to getting upgraded services or to copayments. The phenomenon was verified by the fact that the insured population also made informal payments, especially in physicians' offices and for physician services in public hospitals. This is an important finding, because Turkey is planning to extend insurance coverage to the whole population. The benefit package of the proposed GHIS will be similar to those of the existing schemes. However, as this survey showed, being covered does not help one avoid both formal and informal out-of-pocket payments if the provision-side reforms are not parallel.

Fifth, even the Green Card holders, who theoretically constitute the poorest segment of the population, had to make informal payments. Ironically, most of these payments occurred in MoH facilities. "Knife payments" also constituted a large share for Green Card holders.

Sixth, the results also raise important equity issues. For instance, in the public sector, the poor paid more informal payments per capita than the rich. The elderly also made more informal payments per capita than the young. It was also very interesting to see that the unemployed made more informal payments per capita in the public sector than the employed. These findings were further confirmed by an analysis of reasons for not seeking, delaying, or interrupting treatment. Many people—even those with insurance—did not seek treatment because of lack of money. Lack of money was the main reason for interrupting treatment, cited by 93.3 percent of Green Card holders and by 73.3 percent of the insured population.

It might be argued that providers seek informal payments to supplement their low public-sector salaries. Recently, an attempt was made to improve these salaries, and doctors in the public sector started to be paid extra depending on their "performance" (numbers of patients seen, operations, lab tests, and so forth). Because this "pay-for-performance" initiative is quite new, it is impossible to comment on its potential influence on the unnecessary use of services and on informal payments.

Last, but by no means least, it can be argued that the government can enforce rules and regulations to control informal payments. Informal payments such as "knife payments" are illegal; if caught receiving them, providers are punished seriously. However, only a few patients have been willing to denounce these doctors.

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Although this study revealed important evidence regarding the extent of informal payment and its distribution in Turkey, it represents only a small geographic area; therefore, it might be desirable to replicate it in other regions. The findings of this and other studies should be taken into account as Turkey embarks on its major health reform initiative. Turkey is attempting to control corruption in all dimensions of the economy, including health. However, the focus in the health sector is usually on large-scale corruption. Informal payments, involving small payments by ordinary people and in some cases by the financially deprived, are usually ignored. When extended to the whole country, the impact of these payments could exceed that of large-scale corruption, and their consequences could be more serious and direct, both on the health system and on patients.

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