A scoping review on informal payments in the health care sector; comparative analysis between Romania and Bulgaria.

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List of abbreviations

CEE = Central and Eastern Europe

CPI = Corruption Perception Index

DHIHs = District Health Insurance Houses

DPHAs = District Public Health Authorities

EU = European Union

GDP = Gross Domestic Product

GNI = Gross National Income

GPs General Practitioners

IPs = informal payments

LITS = Life in Transition Survey

MMS = minimum monthly salary

MoH = Ministry of Health

NFC = national framework contract

NHIF = National Health Insurance Fund

NHIH = National Health Insurance House

OBGYNs = Obstetrics-gynecologists

OECD = Organisation for Economic Co-operation and Development

PDL = Positive Drug List

RHIs = Regional Health Inspectorates

SHI = Social health insurance

TI = Transparency International

VHI = Voluntary Health Insurance

1 Introductory chapter

1.1 Background

I have chosen to write a scientific paper for my master thesis. In this introductory chapter I will introduce the subject of this thesis, namely informal payments in health care systems. I will compare the prevalence of informal payments in the health care sectors in Romania and Bulgaria. In this introductory chapter I will offer a more detailed perspective over aspects that are not extensively covered in the article manuscript.

Informal patient payments for health care represent a multifaceted phenomenon that does not have a generally accepted definition (Stepurko et al. 2010). Moreover, the latest systematic literature review conducted on this matter showcases the multitude of definitions found in the literature and highlight the difficulties in achieving a generally accepted definition. The conclusion of the review suggests there is a definition that comes close to providing "a more general framework for informal payments" (Chereches et al. 2013, 113). That definition was proposed by Gaal et al, and is as follows: "a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to" (Gaal et al. 2006, 276). This is the definition adopted by this paper.

Except for high-income countries in North America, North-West Europe and Australia, the existence of informal payments within health care systems has been confirmed in countries of all income levels, from low through high-income countries (Stepurko et al. 2010, Table 1, Khodamoradi, Ghaffari, et al. 2018, Table 1). This phenomenon has been widely studied across the world, especially in countries from Central and Eastern Europe, (CEE) like *Romania* (Stepurko et al. 2013, Stan 2012, Chereches et al. 2011), *Bulgaria* (Stepurko et al. 2013, Atanasova et al. 2013, Balabanova and McKee 2002, Atanasova et al. 2014), Albania (Burak and Vian 2007), Ukraine (Stepurko et al. 2013, Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015, Balabanova et al. 2004) and Hungary (Szende and Culyer 2006, Gaal, Evetovits, and McKee 2006, Gaal et al. 2006, Gaal and McKee 2005) just to name a

few; countries in Africa (Kankeu et al. 2016, Onwujekwe et al. 2010, Lievens and Serneels 2006, Mæstad and Mwisongo 2011, Kankeu and Ventelou 2016); and countries in Central, Eastern, Southern and Western Asia (Liu and Sun 2012, Gaál et al. 2010, Vafaei Najar et al. 2017, Aboutorabi et al. 2016).

1.2 Previous research

This section presents in more detail the literature that has been published on informal payments in health care settings in general and how the article contributes to this field of research. This section offers insight from the published literature on the following dimensions and characteristics of informal payments: *definitions* that conceptualize them, *determinants and contributing factors* of this phenomenon, *prevalence and other characteristics, attitudes* towards and *motivations for* informal payments, *methodologies and instruments* that measure this phenomenon, and *strategies* to reduce it. An abbreviated version of parts of this chapter will be found in the research article.

1.2.1 Definitions of informal payments

This paragraph presents some of the details from the systematic literature review that Chereches et al. have conducted on the definitions of informal payments. A total of 61 papers (research articles, books and official reports) were identified and analyzed; consequently 61 definitions of informal payments were extracted from them (Cherecheş et al. 2013, Table 1). The authors also found that there is a broad variety of terms used to denote informal payments. Most of the papers included in the review used the term "informal payments", while some papers used terms such as: bribes / bribe payment, envelope payments, gratitude payments, red packages / envelopes, under-the-table payments and unofficial payments / fees. In some papers these terms were used interchangeably with informal payments (Cherecheş et al. 2013, Table 2). The authors discuss this last point, highlighting that although they sometimes are used interchangeably, these terms are somewhat different. The terms envelope or under-the-table payments only denote the manner in which these payments are made and give no insight into their origin or destination. On the other hand, unofficial payments relate to transactions made for services and goods that should have either been free of charge or a part of the basic services

package. And informal payments, as the authors point out, distinguish themselves from the unofficial ones by being transactions "made above the official level". The authors conclude by stating that most of the definitions identified in the review "reflect the particular characteristics of the health care systems in which they are reported" (Chereches et al. 2013, 113).

1.2.2 Determinants and contributing factors

A recent systematic review that performed a qualitative synthesis on 62 studies on informal patient payments identified a wide range of determinants and contributing factors to this phenomenon and highlighted the complex nature of such payments. The authors classified the determinants under two groups: internal context and external context of a health care system; factors that are not characteristics of a health care system being labeled under the latter category. Factors related to the external context of health care system included three main themes: *demographic characteristics of health service consumers* (individual and household features), "*patient's personality features"* like perceptions and attitudes, beliefs, and feelings related to informal payments as well as patient physician relationships; and lastly "*social and cultural backgrounds of the community"* like low community participation, low public / patient awareness about health care services and patient rights, normative cultural values (gratitude and tradition, compulsory social behavior), culture of corruption in the country as well as lack of trust in the political system, government and insurance system. (Pourtaleb et al. 2020, Table 3). The authors state that the factors under these three themes within the external context of the health care system "are among the most important motivations for unofficial payments" (Pourtaleb et al. 2020, 6).

Factors that contribute to informal patient payments within the internal context of health care systems are identified and grouped under five main themes: "*stewardship weakness"* such as lack of legal support towards informal payments and lack of transparency and accountability among other factors; "*sustainable financing and social protection weakness"* like inefficiency in financial management of health care systems, reliance on out-of-pocket payments, low income for physicians and medical personnel, as well as issues related to insurance schemes (poor and vague definitions of the basic benefit package) just to name a

few in this category; "*human resources' organizational behavior challenges",* which include factors like lack of staff motivation, poor human resource management and moral / ethical related issues; "*challenges of drugs, medical products and services delivery provision process"* such as inefficient patient complain process, lack of access to health care services and lack of medication and other medical supplies and lastly "*change management weakness"* related to lack of political will and follow-up of reform as well as reform failure (Pourtaleb et al. 2020, Table 4).

The authors mention that aspects related to stewardship like "weak health system leadership and governance lead to arising different levels of corruption in health system, which represents another major contributing factor in justifying unofficial patients' payments" (Pourtaleb et al. 2020, 7). With regards to factors under the health financing system, the authors highlight the link between "insurance coverage and reduction of [informal payments] IPs", while a delay in the reimbursement of insurances can increase informal payments, especially among physicians (Pourtaleb et al. 2020, 7). Finally, within the same financing theme, the authors highlight that the low payments towards health care providers and the low wages of employees have lead informal payments to be regarded by medical organizations in general and physicians in particular, as a tool for raising additional revenues (Pourtaleb et al. 2020, 7).

1.2.3 Prevalence and other characteristics

Most of these findings will also be included in the article in an abbreviated version. In 2010 Stepurko et al. published a systematic and critical review of research methods and instruments related to informal patient payments which offers an overview of the empirical literature published between 1995 and 2010, with data collected between 1990 and 2005 (Stepurko et al. 2010). Similarly, Khodamoradi et al. followed up this subject by publishing a systematic review on the methodology and burden of informal payments eight years later, covering the empirical literature published between 1996 and 2015, with data collected between 1990 and 2015 (Khodamoradi, Ghaffari, et al. 2018). The review published in 2010 identified and analyzed 31 publications (24 articles and 7 reports/books) (Stepurko et al. 2010, 4), while the review published in 2018 identified 38 articles (Khodamoradi,

Ghaffari, et al. 2018, Figure 1); with a number of 12 studies overlapping between the two reviews. Stepurko et al. report a wide range in the incidence of informal payments, between under 10% through to over 70% of the respondents of the included studies making informal payments (Stepurko et al. 2010, Table 5). The authors mention that these large differences could be explained by the way these percentages were estimated (Stepurko et al. 2010, 9). In the same manner, Khodamoradi et al. report a wide range in the prevalence of informal payments, from 2% to 80%, that could be attributed to the different methods of data collection used in the selected articles (Khodamoradi, Ghaffari, et al. 2018, e33).

Stepurko et al.'s review reports findings on other characteristics of informal payments like the initiator (provider / user), type (in cash / in-kind), setting (outpatient / inpatient), timing (before, during or after treatment) and size of these payments. The findings showcase that both patients and providers initiate the payment, either by offering it as an expression of gratitude (users) or by requesting it (providers). Payments in cash and in kind (gifts) are equally reported, and a few earlier studies also mention payments under the form of various services. In terms of settings, a higher rate of informal payments was reported towards medical specialists like surgeons (inpatient), dentists and obstetricians-gynecologists (OBGYNs) while payments towards general practitioners (GPs) (outpatient) were also common. In terms of timing, the results show that payments in cash mainly occurred before or during the treatment, while gifts were usually offered after the treatment or service was provided. The size or volume of these payments was reported in only 5 publications, with 3 stating that the amount paid was less than 30% of the monthly income and the other 2 stating a rate of more than 80% of the monthly income (Stepurko et al. 2010, Table 4). The authors mention, however, that these findings are not that comparable since the tools used to measure the volume differed greatly between the studies (Stepurko et al. 2010, 6).

Some of these findings are consistent with the results Khodamoradi et al. have found, with most studies reporting findings both for in cash and in kind (gifts) type of informal payment. The review also confirms that most of these payments occur in inpatient settings than outpatient; and that physicians were the main health care personnel category to receive informal payments. Distinctly from the Stepurko et al., the balance between who

initiated the payments shifted towards the user, most payments being reported to have been made voluntarily (Khodamoradi, Ghaffari, et al. 2018, e30).

In terms of the magnitude of these payments, although Khodamoradi et al. show that this feature was measured in numerous countries, the authors also conclude that a comparison is difficult to achieve due to the heterogeneity in measuring methods and different years when the research was conducted. Although comparisons were not made, the review reports findings on countries individually, some of which are mentioned at the end of this paragraph. In order to measure the magnitude of informal payments, quite a few studies chose to calculate informal payments as shares of household income or health expenditure. Results from Bulgaria in 1997 show that the median cash payment ($4) was 4.4% of the average monthly salary and 21% of the minimum monthly salary. Results on gifts were also reported, with the median gift payment ($1.3) being 1.5% and 7% of the average and minimum monthly salary. For Hungary, in 1999, a range of 3% to 20% of the household income was reported to be spent on informal payments. And in Greece, the estimate for 2012 was that 28% (€1.5 billion) of the household health care expenditure went towards informal payments (Khodamoradi, Ghaffari, et al. 2018, e30).

1.2.4 Attitudes and motivation

Other important characteristics of informal payments reported by Stepurko et al. are attitudes towards and patient motivation for informal payments. About a quarter of the publications included in the analysis reported expression of gratitude as a motivation behind informal payments, while more than a quarter of the studies identified improved services provision, in terms of better quality and faster access, as a motivating factor (Stepurko et al. 2010, 6). With regards to the provider side, it has been noted that physicians claim low and inconsistent salaries, lack of government involvement and "the need to keep services going" as reasons for relying on informal payments (Lewis 2007, 989). Similarly, a qualitative study that included 64 health care workers in Tanzania showed that all participants agreed that the inadequacy of their salaries as compared to their needs was one of the main reasons for informal payments (Stringhini et al. 2009, 5,6). The study revealed, however, that this practice lowers the health care staffs' motivation and

was associated with “fear of being detected, loss of self-esteem, a sense of guilt and humiliation” (Stringhini et al. 2009, 8).

In terms of attitudes, Stepurko et al.’s review from 2010 reported that only a handful of studies investigated this area and the results are contrasting. In 3 studies, such payments were perceived as “tradition and gratuity”, while in 3 other studies such payments were considered a form of corruption and unlawful behavior (Stepurko et al. 2010, 9). Another study on a representative population of Hungarians reveals that patient attitudes span over three types: acceptance, doubtfulness and opposition. (Baji et al. 2013).

1.2.5 Previous research methods

Both Stepurko et al. and Khodamoradi et al. focus on giving an overview of the research methods and instruments used in the study of informal payments. Stepurko et al. report that studies analyzed informal payments from the perspective of the general public (household members and patients) as well as providers and officials, some studies including both sample type perspectives in their research. In terms of sampling areas, these ranged from districts and cities to single and multiple countries, both representative and non-representative sample areas. Most studies opted for a probabilistic sampling design like random, stratified and stratified random sampling, while some studies also used convenience and snowball sampling. Most studies (12) reported a sample size under 1.000 respondents, 9 studies had a sample size ranging from 1.000 to 2.000, 5 studies reporting sample sizes of 2.000 to 3.000, 3 studies has a sample size greater than 10.000 respondents and 2 studies gave no indication of their sample sizes. Of the 31 included studies, 18 used only one type of data collection method; few studies using two, three or more types and for 6 of them the authors mention that the method was unclear. In terms of types of data collection methods, the most prevalent method was face-to-face structured interview and interview on the user side and providers respectively. In the case of consumers, other methods employed were focus-group discussions, semi-structured in-depth interviews, telephone interviews and self-administered questionnaires. Focus groups and self-administered questionnaires were also applied to providers (Stepurko et al. 2010, Table 2). Although only 9 studies reported their response rate, this was mostly high (70% to higher

than 90%), with only one study that used telephone interviews reporting a response rate lower than 20% (Stepurko et al. 2010, 6).

In terms of research instruments, the authors identified a series of questions that both users and providers were asked about in the studies included in the analysis. These questions were along the themes of recalling incidence and estimating the size of informal payments; type, moment and perceived effect of such payments; reasons for giving (general public) and receiving (provider) them as well as attitudes towards informal payments. Respondents from the users' side were also asked about who the beneficiaries of such payments are; while providers were asked about mechanisms of collecting them as well as methods to reduce them. Recall period for the general public varied from less than a month to 12 months or more, while only 2 two alternatives of recall period (last week and two years ago) applied to providers and officials (Stepurko et al. 2010, Table 3).

Khodamoradi et al.'s findings are consistent with the findings previously described. The review included 38 articles in the analysis and shows that research on informal payments was conducted from the consumers' perspective (households, individuals and patients) as well as from the providers' and officials' perspective. Moreover, studies that had the general public as a sample unit tended to be quantitative and have sample sizes larger than 1.000 respondents; while studies on providers were mainly qualitative with under 150 participants. The sample size of the quantitative studies ranged from less than 1.000 to more than 10.000 participants. In terms of sample selection, the most used designs were probabilistic sampling (simple and stratified) (Khodamoradi, Ghaffari, et al. 2018, Table 2). These findings are in line with the ones from Stepurko et al (Stepurko et al. 2010). Other less frequently used sampling designs were stratified (non-randomized or not mentioned), convenience, snowball and purposive. The most frequently used data collection method on the user side was face-to-face interviews, while focus group discussion was the most prevalent instrument on the provider side. The variety of recall periods is also confirmed in this review, with the most often used being 12 months (Khodamoradi, Ghaffari, et al. 2018, Table 2). The authors argue that the heterogeneity in the recall period could have had an effect on the recorded prevalence (Khodamoradi, Ghaffari, et al. 2018, e33). The review

concludes that “serious methodological difficulties exist with informal payment measurement” (Khodamoradi, Ghaffari, et al. 2018, e34).

1.2.6 Strategies

A recently published systematic review gathered the available evidence on proposed strategies to reduce informal payments. The systematic literature search was conducted in October 2015 and resulted in 10 articles that were included in the synthesis; covering the period of 2000 through 2014 (Zandian et al. 2019, 915). The main strategies that were proposed in the articles are related to making readily available information around what the insured individuals are entitled to, what copayments they have to make and what rights they have as patients. Another aspect was related to changing the belief that they have to make informal payments in order to get better quality care. It was pointed out by most studies that regulatory reforms are needed in order to address the issue of informal payments (Zandian et al. 2019, 920).

1.3 Romania and Bulgaria

The subject of this research focused on informal payments in Romania and Bulgaria. The motivation behind choosing these two cases / countries on which to conduct a qualitative comparative analysis is based on the similarities between Romania and Bulgaria in terms of the history, reforms and the organization of the health care systems; as well as similar political contexts. The prevalence of informal payments, however, seems to be higher in Romania than in Bulgaria (Stepurko, Pavlova, Gryga, and Groot 2015). This section provides an overview of the health care systems’ historical background, how the health care systems are organized, what health care services are provided, and a brief listing of relevant legislation related to user charges.

1.3.1 Health care systems – historical background

Romania’s first law on the organization of the health care system took effect in 1874, at a time when the country was made up of two principalities, Moldova and Wallachia while Transylvania was part of the Austro-Hungarian empire. While the law determined health services to be provided by the state, having the Health Directorate as a central authority,

small-sized insurance systems for sickness and work accidents also emerged. With the end of World War I, in 1918, Transylvania became part of Romania and the legislation was applied across the country and by this time the sickness insurance systems covered other populations groups as well (Vlădescu et al. 2016, 17). Between the two World Wars, Romania followed a Bismarckian sickness-fund model and had a social insurance system in place financed through an income-related premium paid out by employees and employers; however, only 5% of the population was insured (Vlădescu et al. 2008, 22).

Similarly, in 1906 Bulgaria also introduced illness insurance for state workers and their family members and passed the Act on Worker Insurance for Illness and Injury in 1918. In 1924, Bulgaria also implemented a social health insurance scheme following the principles of a Bismarckian insurance model. It was mandatory for all workers and civil servants working for the government or in public and private organizations to have social insurance in case of accidents, sickness, maternity, disability and old age. A Social Insurance Fund was created to finance the construction of new hospitals and other health care facilities (Dimova et al. 2018, Box 2.1).

However, after the Second World War, in 1949, as part of the Soviet Bloc, Romania gradually moved towards implementing a Semashko-type health care system that remained in place until the fall of communism in1989. During these four decades, the health care system was characterized by a high degree of centralization and regulation, government financing, a rigid management and state provision of health services (any previous private system being prohibited) that sought to provide free medical services at the point of delivery and achieve universal coverage. A new health law was passed in 1978 and in 1983 out-of-pocket payments were established for some ambulatory services. However, the lack of competition, underfunding, rigid norms, inefficiency, poor quality of health services and unsuitable health care equipment and facilities drove the pressure for change which started to occur after 1990. The consequence of the strict Semashko model were seen in the issues the health care system faced after its fall, such as low percentage of gross domestic product (GDP) being directed towards health, resources that were centralized and inequitably distributed (with political leaders being privileged and “under the table payments” taking place), poor quality of the primary care services and a growing inequity between regions

and social groups in terms of provision of health care; just to name a few (Vlădescu et al. 2008, 22). According to Vlădescu et al., informal payments have a long history in Romania and are deeply rooted in the culture, and during the communist period this practice grew in intensity (Vlădescu et al. 2008, 58).

A new Health Insurance Act was passed in 1945, in Bulgaria, which extended the health insurance coverage. The Constitution adopted in 1947 radically affected the health care system. Similar to Romania, the communist administration started replacing the existing health care system with the Semashko model. Between 1948 and 1949, all private hospitals, pharmacies and clinics were passed under the central state's control. After 1950, the financing of the health care system shifted towards generating revenues from taxation. Just like in Romania, the Bulgarian system was centralized with an almost full public ownership. The People's Health Act was passed in 1973 which detailed how the Bulgarian health care system was organized. The system sought to provide free medical care at the point of delivery and strive for increased access. The curative system with a focus on infectious diseases control could not meet the needs of increasing patients with chronic diseases, partly due to rigid and central control. The system was also facing underfunding, but this fact was never officially admitted (Georgieva et al. 2007, 15 - 16). Informal payments for medical services and medicine were also a common practice in Bulgaria over these four decades (Georgieva et al. 2007, 1).

A series of reforms in the health care sector followed in 1989. Between 1990 and 2002 a series of legislative acts were passed, and Romania's health care system slowly shifted from a system that was centralized, owned and controlled by the state and tax-based towards a pluralistic social health insurance system and less centralized; with a contractual relationship being created between health care providers as sellers and health insurance houses as purchasers. The reform process was, however, slow and heavily influenced by the political parties in power. For example, between 1997 and 2000, the Liberals and Christian Democrats steered towards a social health insurance system, while between 2001 and 2004, the Social Democrats steered towards changes that aimed to recover and reinforce state control over the resources. A new and comprehensive Health Reform Law was passed in May 2006 and replaced the existing legislative acts. The new law included most of the

measures that had to be taken to achieve the Government policy objectives on health and improve the system's performance. Out of the total of 17 elements of the law, some of the most notable being related to "social health insurance, private health insurance, hospitals, community care, primary health care, pharmaceuticals, emergency services, public health, national and European health card, national health programmes, professional liability, establishment of a national school of public health and management" (Vlădescu et al. 2008, 23 - 24). This law is still in place today, with a high number of amendments (Vlădescu et al. 2016, 17).

Similarly, after 1989, the Bulgarian health care system went through a series of reforms. With a new Constitution of the Republic of Bulgaria in 1991 followed the beginning of an economic reform. While the shift from a centrally planned economy towards a market economy took place, the need to shift the health care system back into a social insurance system was discussed. Thus, between 1989 and 1996, the private sector was reestablished, state monopoly over the health care system was overthrown and a move towards a decentralized administration was made. The most substantial changes to the health care system, however, were made between 1997 and 2001. The legal basis of the social health insurance system was adopted under the form of a reform package that consisted of the following acts: Health Insurance Act (1998), Health Care Establishment Act (1999), Act on Professional Organizations (1998) and an Act on Medicines and Pharmacies in Human Medicine (1995). The Public Health Act from 1973 was replaced by Health Act passed in 2005, marking the completion of the reform. The reform was, however, heavily criticized because of its inconsistency and partial and conflicting measures; as well as for its lack of transparency by isolating the health professional community and general public from the political process (Dimova et al. 2018, 25 - 26).

1.3.2 Health care systems organization

Romania's health care system mirrors how the country is divided administratively, namely at the national and district level. The national level has the responsibility to set general objectives, while district level authorities are responsible for service provision and follow the rules established at the central level. Thus, at the central level, the Ministry of Health

(MoH) has a stewardship role and holds the administrative authority. The MoH oversees the regulatory framework, while at the district level responsibilities evolve around provision of health care services. The MoH is represented at the local level by the District Public Health Authorities (DPHAs) in the 41 districts (counties) of the country and one in Bucharest. The National Health Insurance House (NHIH) is responsible for the administration and regulation of the social health insurance scheme (e.g. resource allocation), which in principle is compulsory, and has district representatives, the District Health Insurance Houses (DHIHs). The MoH and the NHIH agree on a Framework Contract every two years, and it includes the rules by which the DHIHs arrange to enter a contract agreement for services with public and private providers (GPs, specialist practices, hospitals, laboratories etc.). The rules revolve around the provider payment mechanisms and what the insured are entitled to in a form of a benefit package (Vlădescu et al. 2016). Employers used to transfer the share of the social health insurance contributions of their employees to the NHIH, but due to employers consistently failing to pay out the contributions, in 2017 a new legislation was introduced. Employees became responsible of paying their full premiums and the salary levels were increased due to this shift. Vulnerable groups (unemployed, retired individuals with low pensions and individuals on social benefits) are exempted from paying the contribution. Their share is paid from the state budget towards the NHIH; thus, the government ensures their health care coverage. Moreover, pregnant women, children and students under 26, individuals with disabilities or suffering from a chronically ill disease, are also exempted from paying the contribution. Their health care services usage is, however, covered from contributions of the working population (OECD 2019b, 9). The voluntary health insurance (VHI) market is highly underdeveloped in Romania. Partly because individuals that are entitled to the statutory health insurance scheme provided by the state cannot opt out of it and substitute it with a VHI. VHIs are mainly covering services of a supplementary nature like better hospital accommodation, choice of provider and private care; and do not function as a complementary health scheme to the statutory one (Vlădescu et al. 2016, 66).

The organization of Bulgaria's health care system shares some similarities with Romania's health care system, but there are also some variations. The main actors at the national level

in a hierarchical level are the National Assembly, the Council of Ministries and the Ministry of Health (MoH). At the same level with the MoH are also the other Ministries, the National Health Insurance Fund (NHIF) and the professional organization of physicians and dentists. The MoH is responsible on one hand for how the system is organized and functions (from health legislations, to integration and supervision of its subordinated bodies); and on the other hand it finances particular kinds of health services like public health services, emergency care, transfusions, transplantations, tuberculosis treatment and inpatient mental health services (Dimova et al. 2018, 20), unlike in Romania. At the national level, the MoH together with Council of Ministries sets the priorities in health policy through the Government Program and the National Health Strategy. At the district level, the Regional Health Inspectorates (RHIs) are responsible for organizing and implementing the state health policies. Unlike in Romania, Bulgaria's NHIF is a public institution independent from the government (executive power) governed by a body made up of government representatives, patient representatives, syndicates and employers. Its main function is to ensure an equal access to the health care system for the insured by financing the medications, and the medical and dental services that are included in a basic benefit package. The prices and types of services included in this package are negotiated on an annual basis between Bulgaria's professional association of physicians and dentists and the NHIF. Similar to Romania, their agreement is drawn up under a form of a contract, the national framework contract (NFC) that specifies the rights and obligations of the parties involved (NHIF, insured individuals and health care providers); as well as how the care is organized and monitoring mechanisms. The NHIF is represented at the district level by 28 Regional Health Inspectorates (RHIs); and they are responsible for contracting public or private health care providers operating within their region following the NFC. The NHIF is the single payer for the compulsory social health insurance (SHI) (Dimova et al. 2018, 21 - 22). Unlike in Romania, VHI plays a more active role and has a broader coverage: complementary services and user fees not covered by the NHIF (e.g. specific laboratory tests), supplementary services such as better services and services included in the NHIF's insurance package like hospital treatment. (Dimova et al. 2018, 83). While the MoH covered the services mentioned above; medication, diagnostic, treatment and rehabilitation services are covered by the insurance system composed of the SHI and VHI. (Dimova et al. 2018, 21).

1.3.3 Health care services

This section describes what each health insurance benefit packages encompasses in order to highlight any differences and presents a comparison of the user charges between the two countries. Additionally, this section also touches upon other types of out-of-pocket payments that health care users are making and the share of these payments out of the total health care expenditure.

1.3.3.1 Benefit Package and User Charges

Romania

All insured individuals in Romania are entitled to a basic benefits package and is presented in the Framework Contract. The package in uniform for all individuals that are insured and includes health care services (preventive health care services, ambulatory and hospital care, dental services, medical emergency and rehabilitation services, pre-, intra- and post-birth medical services as well as home care nursing), pharmaceuticals / drugs, health care materials and medical devices like orthopedic devices. For those who are not insured, a minimum package is established following three criteria: “life-threatening emergencies, epidemic-prone/infectious diseases and birth”. For some of these goods and services a user charge is applied (cost-sharing) and these payments are one of the forms of out-of-pocket payments (Vlădescu et al. 2016, 57 - 58).

User charges were first introduced in Romania in 2002 and their purpose was to decrease the inadequate demand for health services, to raise revenue and achieve cost-containment. This regulation states that representatives from the MoH and the NHIH form a commission that decides upon a list of services for which user fees apply. After the College of Physicians agrees upon it, the list is introduced in the Framework Contract and ready to be implemented. The 2002 regulation, however, was only implemented in 2013, and only for inpatient care. Private providers that have a contractual relationship with the DHIH can impose extra billing for the services they provide, this process is, however, not regulated (Vlădescu et al. 2016, 63).

Bulgaria

Individuals in Bulgaria insured through the social health insurance are entitled to a basic benefit package that covers a wide range of health care services and goods. The package is regulated through three ordinances passed by the MoH; and it covers primary outpatient medical care, specialized outpatient medical care, outpatient diagnostic services, outpatient dental care and inpatient services. In terms of medication, the MoH passes an Ordinance (No.7/6 November 2015) that establishes the criteria that determine for which diseases the medicinal products and medical devices are to be fully or partially funded by the NHIF. Based on the criteria from this Ordinance, the NHIF establishes a list of specific diseases. The Positive Drug List (PDL) specifies the drugs that are intended for the treatment of those diseases. Additionally, the state budget or other specially developed funds cover another range of services: emergency and inpatient mental health care, transfusion, in vitro fertilization and transplantations. Services and products such as "compulsory vaccines and vaccinations, outpatient treatment of dermato-venereal diseases, intensive care for uninsured individuals, and prophylaxis, diagnostics and maternity services for uninsured women" are outside of the scope of the benefit package and they are funded from the MoH's budget who transfers the needed funds to the NHIF. This series of services is not covered by the benefit package: long-term nursing care and care for the elderly, occupational health prevention and care, elective cosmetic surgery, alternative therapy, contraception, spa treatment and elective abortions (Dimova et al. 2018, 69-72).

User charges or fees (co-payments) are a form of cost sharing and have been in place in Bulgaria since 1998 regulated through the Health Insurance Act. These fees are paid directly to the providers, by the users, at the point of delivery. They usually apply to all users, but 13 patient groups are exempted: children, pregnant women, patients suffering from a chronic disease, medical professionals, individuals with an income below a set threshold and other groups. Before 2012, user charges used to be set as a fixed percentage from the minimum monthly salary (MMS) and varied with the type of health service, for example 1% of the MMS / outpatient visit. When the MMS increased from BGN 79 (€40.4) in 2000 to BGN 290 (€148.3) in 2012, user fees were set to have a fixed price of BGN 2.90 (€1.50) per outpatient visit and BGN 5.80 (€2.96) for each day of hospitalization (with a

cap of 10 days per year). Just like in Romania, these co-payments were intended to reduce inadequate demand for health care and increase the revenues of the providers (Dimova et al. 2018, 78-79).

Other types of out-of-pocket payments

Out-of-pocket payments are a private financing source for health care systems in both Romania and Bulgaria (Vlădescu et al. 2016, - page 45, Dimova et al. 2018, - page 53). However, the share of out-of-pocket payments varies between countries. Over time, Bulgaria has had a higher share of out-of-pocket payments than Romania. Out-of-pocket payments represented the largest source of financing of the health care system in Bulgaria in 2015 (Dimova et al. 2018, - page xviii), while in Romania they represented almost a fifth source of financing (Vlădescu et al. 2016, - page xv). More recent data confirm that out-of-pocket payments in 2017 represented around a fifth of Romania's total health care expenditure (20.5%) (OECD 2019b, 17); and still the largest (46.6%) in Bulgaria in 2017 (OECD 2019a, 17).

Besides the user charges, in Romania, there are other types of out-of-pocket payments such as direct payments from insured individuals for goods and services not included in the benefit packages, direct payments by uninsured individuals, direct payments made to private providers who do not have a contractual relationship with the DHIH as well as informal payments. Although data on the share of out-of-pocket payments was presented in the previous paragraph, it has been stated that the true estimation of these payments is difficult to achieve partly due to informal payments and underreporting of revenue by private health care providers. The range of services for which a full direct payment has to be made includes treatment services for occupational diseases, various dental services, aesthetic plastic surgeries for adults (>18 years), in vitro fertilization, some rehabilitation treatments and others. Moreover, patients that visit a specialist without a referral from the GP have to pay the full fee, which varies with the services provided and type of specialist (Vlădescu et al. 2016, 64-65).

User charges together with other direct payments and indirect payments also constitute Bulgaria's out-of-pocket payments for health. Direct payments occur when insured

individuals access services and goods that are not included in the benefit package such as dental services, long-term nursing care and some laboratory tests to name a few. The prices of these are set by the providers. Secondly, direct payments take place when insured individuals access services included in the benefit package, but they do it outside the SHI's system patient pathway. Meaning that patients who do not have referrals from their GP will have to pay for the specialist visit, a laboratory test, hospital or another GP. This occurs sometimes when patients wish to access the services more quickly. It is worth highlighting, however, that this mostly happens due to administrative and other impediments when following the standard patient pathway. This happens due to monthly limits set by the NHIF on the health care services that can be used, thus GPs sometimes refuse or delay referral to specialists, laboratory and hospital based on them being used up. The reverse can happen where GPs might make referrals to providers outside the contractual relationship, and unless the patient has a VHI to cover for the expense, he is obliged to pay out of pocket. In some other instances, partially covered drugs by the NHIF have a lower reimbursement level than the fixed used fee for a visit to the GP (to get a prescription). In such cases, patients prefer to purchase the drugs directly, at full retail price. And lastly, uninsured individuals have to pay the price in full for any health care goods and services they access (except emergency care) (Dimova et al. 2018, 80-81).

1.3.3.2 Legislation

This section includes an overview of the changes in legislation over time, in connection with user charges (**Table 1**).

Table 1. Legislative changes to user fees

Romania	**Bulgaria**
• 1983: Out-of-pocket payments were established for some ambulatory services (Vladescu, Radulescu, and Olsavsky 2000, 5)	• 1995: cost sharing for certain luxury services was introduced (Koulaksazov et al. 2003, 75) • 1997 Ordinance 22 for the Conditions and Processes for Payment for Health Services of Patient's Choice regulates

• 1997 Health Insurance Law, Article 58: formal co-payments for medication is introduced. Additionally, contracted providers have the liberty to set co-payments for other services (Vladescu, Radulescu, and Olsavsky 2000, 23). • 2002: Emergency Ordinance no.150/2002 stipulates that providers are permitted to receive co-payments for some services (Vlădescu et al. 2008, 57) • 2003: The introduction of a user charge under the form of co-payment for hospital admissions was being discussed. There was much debate around the size of the fixed charge, and it ended up not being implemented at this time (Vlădescu et al. 2008, 57). • 2006 Health Reform Law (95/2006) continued the allowance on providers to receive co-payments. The MoH was supposed to set some upper limits on the prices the providers could charge, but these were not established (Vlădescu et al. 2008, 57). • 2013 Government Decision no.117: co-payment for hospital admission was introduced with a rate of 5–10 lei (€1.1–2.3) / admission, with some patient groups being exempted (Vlădescu et al. 2016, 129)	charges for elective health care services such as choice of physician, hospital and luxury services (Koulaksazov et al. 2003, 75) • 1998 Health Insurance law extended the co-payment Ordinance 22 to fees on visits to dentists, physicians and inpatient care. A copayment for accessing outpatient and inpatient care without a referral was also introduced. The standard co-payment rate was established by the MoH in 1999 (Hinkov et al. 1999, 18-19) • 2000: Starting with this year the fixed co-payments rates were enforced. The rates represented fixed percentages of the minimum monthly salary (1% / outpatient visit and 2% / day of hospitalization. In 2006 the minimum monthly salary was set at a 160 BGN((€81.80) (Dimova, Popov, and Rohova 2007, 56) • 2012: The fixed fees as percentages from the minimum monthly salary were changed through a Decree of the Council of Ministries. The fees changed to BGN 2.90 (€1.50) /outpatient visit and BGN 5.80 (€2.96/ day of hospitalization (for up to 10 days / year) (Dimova et al. 2018, 79)

1.4 Aims

The aim of this study is to compare the prevalence of informal payments in the health care sectors in Romania and Bulgaria. Further, I wish to understand why the prevalence seems to be higher in Romania than in Bulgaria. Thus, the research questions are:

1. What is the prevalence of informal payments within the health care sectors in Romania and Bulgaria?

2. How can the variation in the prevalence of informal payments within the health care sectors in Romania and Bulgaria be explained?

To explore these two questions, I will perform a review study and present the results in a scientific paper.

The methods chosen to conduct this research consist of a scoping review that will help in identifying the relevant literature on the topic of informal payments in Romania and Bulgaria, a descriptive presentation of available data from surveys on trust and corruption and a descriptive comparison that will use information extracted from the articles identified through the scoping review and the overview of the situation on trust and corruption in Romania and Bulgaria.

As defined by Arksey and O'Malley, scoping reviews are a type of research that aim at mapping key concepts from a specific research area and what are the sources and type of evidence on the research question at hand. (Arksey and O'Malley 2005).

A scoping review on informal payments in the health care sector; comparative analysis between Romania and Bulgaria.

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Abstract

Objectives
Informal payments seem to be more widespread in Romania than in Bulgaria, despite the fact that the two neighboring countries share similarities in terms of their socialist past, their transition trajectories after the fall of communism in 1989/1990, and the development of their health care systems. Firstly, the study aims to assess the prevalence of informal payments in Romania and Bulgaria, and secondly to explore other factors in an attempt to explain the difference.

Methods
In order to identify the relevant literature, a scoping review was conducted. The framework of trust and corruption was used to guide in trying to explain the difference in prevalence. In this sense, a descriptive analysis was performed in order to construct an overview of the perceived corruption rates and the social and institutional trust levels in both countries. Lastly, a descriptive comparative approach was employed in identifying other possible explanations.

Results
The scoping review identified 30 articles from which the prevalence was extracted along with other key findings. This resulted in drawing the conclusion that more informal payments were reported by Romanians than Bulgarians in 2010, 2013 and 2017. Underfunding of the health care system and perceived norms for making informal payments were the main explanations suggested in the review. Underpayment of medical staff was a secondary explanation.

Conclusions
Consistent lower shares of GPD allocated for health care expenditures in Romania when compared to Bulgaria pose a possible explanation for differences in the prevalence of informal payments. A more widespread norm to make informal payments seems to be in place in Romania, which might contribute to the higher levels of informal payments. Differences in wage levels might also explain the differences between the countries. All three suggestions warrant further research for definitive conclusions.

2 Introduction

Informal payments in the healthcare sector pose challenges both to the distribution of healthcare resources and to the ethics of healthcare personnel. Due to the multifaceted nature of informal payments, there is no general definition of what an informal payment in the healthcare system is (Stepurko et al. 2010). Moreover, the latest systematic literature review conducted on this matter showcases the multitude of definitions found in the literature and points out the difficulties in achieving a generally accepted definition. However, the authors conclude that one of the definitions comes close to providing "a more general framework for informal payments" (Cherecheș et al. 2013, 113). That definition was proposed by Gaal et al, and is as follows: "a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to" (Gaal et al. 2006, 276). Lastly, Cherecheș et al chose this definition over others due to its neutrality in the sense that it does not seek to explain the motivation of patients or label informal payments as good or bad; and this aspect enables the use of the definition across different healthcare systems (Cherecheș et al. 2013). Considering the comparative nature of this research, this is how informal payments will be perceived in this paper.

2.1 Previous research

Apart from high-income countries in North America, Australia and North-West Europe (Stepurko et al. 2010, 9), informal payments have been confirmed in countries of all income levels and in different regions of the world (Khodamoradi, Ghaffari, et al. 2018, Table 1, Stepurko et al. 2010, Table 1). Former socialist countries, such as Romania and Bulgaria, and developing countries in Asia, Africa and Southern America are countries where informal payments are most often noticed (Stepurko et al. 2010). The occurrence of this phenomenon has also been confirmed in countries that are not former socialist, such as Turkey and Greece (Khodamoradi, Ghaffari, et al. 2018, Table 3).

The research field on informal payments is vast; there are many studies focusing on the determinants and contributing factors of this phenomenon (Horodnic and Williams 2018,

Horodnic, Mazilu, and Oprea 2018, Khodamoradi, Rashidian, et al. 2018, Williams, Horodnic, and Horodnic 2016, Pourtaleb et al. 2020, Meskarpour Amiri et al. 2019) and attitudes towards informal payments (Stepurko et al. 2013, Baji et al. 2013, Vafaei Najar et al. 2017). Other aspects of informal payments that have been studied relate to their prevalence and magnitude (Gaal, Evetovits, and McKee 2006, Horodnic and Williams 2018, Williams and Horodnic 2018a); methodologies and instruments that measure this phenomenon (Stepurko et al. 2010, Khodamoradi, Ghaffari, et al. 2018); definitions that conceptualize it (Chereches et al. 2013, Gaal et al. 2006); as well as strategies to reduce it (Zandian et al. 2019, Gaál et al. 2010, Miller and Vian 2010, Mokhtari and Ashtari 2012, Habibi Nodeh et al. 2017, Liu, Bao, and He 2020).

The published literature also documents several characteristics such as the initiator (provider/user), type (in cash/in kind), setting (outpatient/inpatient) and timing (before, during or after the service was provided) of the payment (Khodamoradi, Ghaffari, et al. 2018, Stepurko et al. 2010). The findings show that both patients and providers initiate the payment. Payments in cash and in kind (gifts) are equally reported, and a few earlier studies also mention payments under the form of various services. In terms of settings, a higher rate of informal payments was reported towards medical specialists like surgeons (inpatient), dentists and obstetrics-gynecologists (OBGYNs) while payments towards general practitioners (GPs) (outpatient) were also common. In terms of timing, the results show that payments in cash mainly occurred before or during the treatment, while gifts were usually offered after the treatment or service was provided (Stepurko et al. 2010, Table 4). Some of these findings are consistent with the results Khodamoradi et al. published in a more recent systematic literature review, with most studies reporting findings both for in cash and in kind (gifts) type of informal payment. The review also confirms that most of these payments occur in inpatient settings than outpatient; and that physicians were the main health care personnel category to receive informal payments (Khodamoradi, Ghaffari, et al. 2018, e30).

The effects of informal payments are varied, ranging from individual to system level. Informal payments can act as a financial barrier in accessing health services (Tambor et al. 2014); as well as a deterrent for individuals to seek medical services (Falkingham 2004);

moreover the economic burden of this phenomenon is distributed more in the direction of lower income groups than richer, and points to the inequitable nature of such payments (Szende and Culyer 2006, Liaropoulos et al. 2008, Tatar et al. 2007, Atanasova et al. 2013). In terms of system performance, informal payments can have a negative effect on the quality of care because they can pose as an incentive for health care workers to engage in rent-seeking behaviors, for example intentionally lowering the quality of care provided in order to gain extra payments (Mæstad and Mwisongo 2011); moreover, informal payments encourage a dishonest and corrupt environment that "in turn creates dissatisfaction, discomfort and demotivation among health workers"(Stringhini et al. 2009). Another adverse effect of informal payments is that it can provide incentives for individuals in instrumental positions to oppose reform endeavors (Balabanova and McKee 2002, Gaal and McKee 2005).

Although comparative research on informal payments can be challenging due to not having a generally accepted definition (Chereches et al. 2013) and due to the heterogeneity of methods used to measure these types of payments (Stepurko et al. 2010, 6, Khodamoradi, Ghaffari, et al. 2018, e30), more studies are taking on this challenge (Stepurko, Pavlova, Gryga, Murauskiene, et al. 2015, Stepurko et al. 2017). Informal payments have been well-recognized both in Romania and Bulgaria, with what seems to be a higher prevalence in Romania than in Bulgaria. Reported evidence in 2010 shows that 34.5% of respondents who used health care services in the last 12 months have paid informally in Romania, while a share of 12.2% of the respondents did so in Bulgaria (Stepurko, Pavlova, Gryga, and Groot 2015). Similarly, in 2013, the reported prevalence among the respondents who used medical services in the past 12 months was 30% in Romania and 8% in Bulgaria (Williams and Horodnic 2018a). Thus, informal payments seem to be more widespread in Romania than in Bulgaria, despite the fact that the two neighboring countries share similarities in terms of their socialist past, their transition trajectories after the fall of communism in 1989/1990 and the development of their health care systems (Vlădescu et al. 2016, Dimova et al. 2018). According to the World Bank Analytical Classifications, based on their Gross National Income (GNI) per capita, Romania was classified as a low-middle income country in 2004, upper-middle income between 2005 and 2018 and high-income in 2019; while

Bulgaria was classified as low-middle income in 2004 and 2005 and upper-middle income starting with 2006 (World Bank 2019). The GNI per capita had similar values for Romania and Bulgaria between 1992 and 2005, but Romania witnessed higher levels starting with 2005 (World Bank 2020c). A similar trend is also observed for the Gross Domestic Product (GDP) per capita (World Bank 2020a). The health care expenditure trend, however, is inversed with Bulgaria directing a higher share of their GDP towards health (8.1% in 2017) than Romania (5.2% in 2017) (World Bank 2020b). Moreover, high levels of perceived corruption are reported in both countries over the years (European Commission 2008, 2009, 2012, 2020, 2014, 2017).

Thus, Romania and Bulgaria represent an intriguing case for comparison. Stepurko et al. explored whether health care consumer's perception of informal payments and their socio-demographic characteristics could explain the prevalence of this phenomenon in six Central and Eastern European countries, including Romania and Bulgaria (Stepurko, Pavlova, Gryga, and Groot 2015). Similarly, Williams and Horodnic tried to explain the prevalence in these two and other four Southeastern European countries by the use of an institutional theory (Williams and Horodnic 2018a). And although some comparison points have been made in these two studies, a full comparative analysis on the matter of informal payments between Romania and Bulgaria has not been conducted yet. Thus, by exploring other dimensions of informal payments, the disparity in the prevalence of informal payments in the two cases (Romania and Bulgaria) might be better understood and in turn, the findings could provide insight for future comparative research on this phenomenon.

3 Theory and Framework

This section starts by discussing whether informal payments are a form of corruption or not. Then the concept of corruption is defined and an overview from published surveys is given on the levels of perception of corruption in general and in the health care system, in both countries. The last part of this section defines the concept of trust, presents the link between trust and corruption and provides an overview of institutional and social trust levels in Romania and Bulgaria.

3.1 Corruption or gratitude?

The global coalition against corruption, Transparency International, defines corruption as "the abuse of entrusted power for private gain" (TI - Transparency International 2020b). The same agency published a report on global corruption in 2006, and in the field of health care, at the point of health care service delivery, it identified, among others, that two forms of corruption occur when "extorting or accepting under-the-table payments for services that are supposed to be provided free of charge", as well as "soliciting payments in exchange for special privileges or treatment" (TI - Transparency International 2006, xviii). In her report on informal payments published in 2007, Maureen Lewis also states that informal payments are often made directly towards individual providers; which makes such payments fall under the definition of corruption (Lewis 2007, 985). Requested informal payments by providers (medical staff and other health workers) from patients for health care services have also been identified as a type of corruption at the service provision level by Taryn Vian in the book chapter "The sectoral dimensions of corruption: health care" (Vian 2005, 45 - 46). Thus, it is apparent that informal payments can be labeled as a form of corruption.

However, not all types of informal payments are easily distinguished as a corrupt practice, as some payments, like gifts for example, can be a form of gratitude expressed towards the provider. Lewis argues that "the level, the recipient and the timing" of such payments are important aspects to be considered in order to determine the nature of the payment. She mentions that the level of informality of payments that occur after the health care service or product was delivered is "particularly problematic" to assess, given the fact that "gratitude gestures after receipt of services are common and often expected" (Lewis 2007, 986).

In his research on the subject of informal payments in Hungary, Péter Gaál found that gratitude was the reason given by the majority of the respondents when motivating their payments to providers. He mentions, however, that surveys might not be the most suitable instrument to assess the true motivation of patients since a more comprehensive analysis showed "subtle contradictions". The follow-up interviews revealed that even in instances of gratitude payments, there is an underlying pressure to pay which can stem from patients

thinking there is an expectation to pay the physician something extra or from feeling that "they must give something, if the doctor pays more than usual attention", in some instances. The author concludes by arguing that the idea of "gratitude payment" is "no more than a convenient myth that has been used to make an unacceptable phenomenon acceptable" (Gaal 2006, 72 - 74).

Similarly, diagnostic surveys on corruption in Slovak Republic showed that "pozornost", which means "attention" in Slovak, but it is perceived as "some gift, money, or counter service that is provided in order to get better treatment", but also as an expression of gratitude; was prevalent in the health care sector (Anderson et al. 2002, 4). The authors highlight that this type of payment, when made because "the patient feels it is necessary to receive proper care", resembles a bribe; while in other cases it is just a small gesture of gratitude (Anderson et al. 2002, 23).

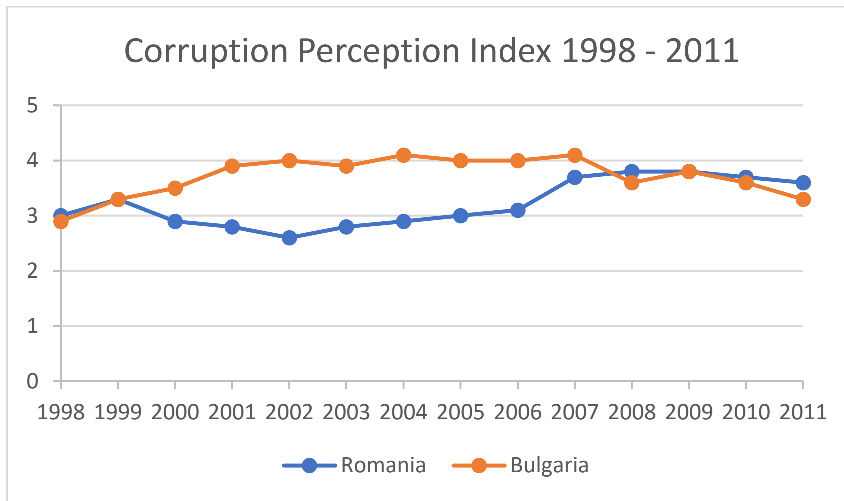
These aspects stress the multifaceted nature of informal payments and why, in some instances, it can be difficult in establishing the nature of such payments. Thus, in this thesis, informal payments are mostly perceived as a form of corruption, while also being sensitive to the instances where such payments can in fact be genuine acts of gratitude.

Perception of corruption – Corruption Perception Index (CPI)

The global coalition against corruption, Transparency International, launched the Corruption Perceptions Index in 1995 (CPI), a composite index based on several (13 in 1995) surveys and evaluations of corruption. The index is used to rank countries and territories based on scores that reflect the perceptions of experts and business executives on how corrupt the country's public sector is (Transparency International 2020a). Between 1995 and 2011, the score ranged on a scale from 0 (highly corrupt) to 10 (highlight clean), and after 2012 the scores range on a scale from 0 (highlight corrupt) to 100 (very clean). Thus, due to the methodology change, two separate tables were created based on the scores available online on TI's website in order to show the evolution over the years for Bulgaria and Romania.

Table 2 shows the evolution of the perceptions on corruption between 1998 and 2011, and based on the scale, higher scores mean perceptions of a cleaner country, thus Romania's public sector was perceived as more corrupt than Bulgaria's public sector, between 2000 and 2007.

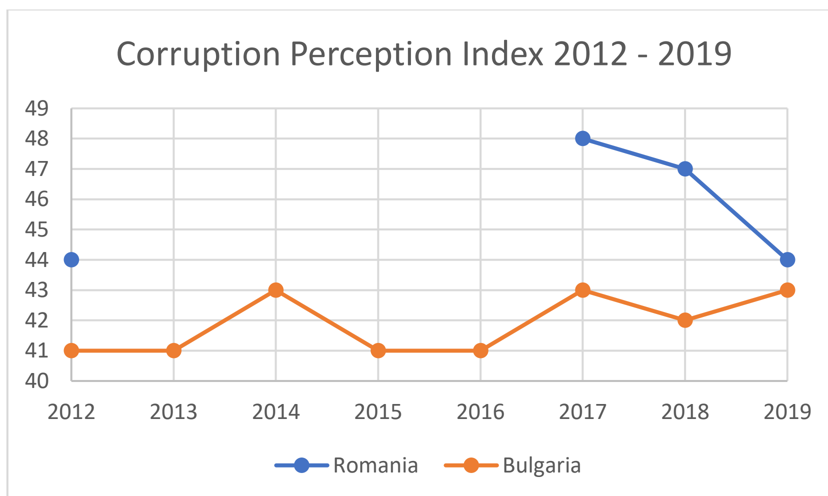
Table 2. Corruption Perception Index 1998 – 2011



Sources: Based on yearly datasets available on Transparency International's website

Table 3 depicts the evolution of the CPI between 2012 and 2019, however, it is apparent that data for Romania is missing between 2013 and 2016. A comparison can be made for the last three years, where it is observed that Romania has slightly higher scores, thus a perception that the public sector is slightly less corrupt than in Bulgaria.

Table 3. Corruption Perception Index 2012 – 2019



Sources: Based on yearly datasets available on Transparency International's website

Opinion on whether corruption is a major problem in the country

Starting with 2007, Romania and Bulgaria took part in the Special Eurobarometer surveys. The first report that included both countries was published in 2008 and it explored Europeans' attitudes towards corruption. 95% of the Romanian respondents and 92% of Bulgarian respondents agreed with the statement "Corruption is a major problem in our country". In countries like Sweden and Denmark, the views were shared by 44% of Swedish respondents and 22% Danish respondents. (European Commission 2008, 4). In 2009, 93% of Romanians and 97% of Bulgarians perceived corruption to be a major problem in the country, while 37% of Swedes and 22% of Danes believed so (European Commission 2009, 8). In the report published in 2011, 96% of the Romanians and 95% of the Bulgarians agreed that corruption is a major problem in the country, while 43% of Swedish and 19% of the Danish respondents agreed to this statement (European Commission 2012, 12). In 2014, 93% of Romanians and 84% of Bulgarians thought corruption to be widespread in the country, while 44% of Swedes and 20% of Danes thought so (European Commission 2014, 20). In the 2017 report, 80% of Romanians and 83% of Bulgarians thought corruption is widespread in the country, and only 37% of the Swedish and 22% of the Danish respondents agreed with the statement (European Commission 2017, 17). And the most recent report from 2020 shows that 83% of Romanians and 80% of Bulgarians perceive corruption to be widespread in the country, while in Sweden and Denmark 40% and 35% of the respondents perceived it to be so (European Commission 2020, 21).

These results showcase that the perceptions on corruption being a major issue in the country decreased by 12 percentage points both in Romania and in Bulgaria, but still remain high when compared to other countries. Moreover, no consistent trend can be observed on whether corruption is perceived as a problem by more Romanians than Bulgarians and vice-versa. One notable difference is seen in 2014, when 93% of Romanians thought corruption is a major problem, which was 11 percentage points more than Bulgarians (84%).

Perception of corruption in health care

The Special Eurobarometer surveys also collected data on the perception of which categories of people are likely to be corrupt, more specifically giving and taking bribe and abusing positions of power in favor of personal gain. For 2007, 65% of the Romanian respondents perceived corruption to be widespread among the people working in the public health care sector, while 48% of their Bulgarian counterparts believed so, while only 10% of the Swedish and 13% of the Danish respondents thought so (European Commission 2008, 11). In 2009, 57% of Romanians and 65% of Bulgarians thought corruption was widespread in the public health care sector, and only 12% of Swedes and 14% of Danes believed so (European Commission 2009, 30). The share in 2011 was 61% in Romania and 63% in Bulgaria, and 14% in Sweden and Denmark (European Commission 2012, 53). A notable difference in perception can be observed in 2007, when more Romanians than Bulgarians (65% vs. 48%) thought corruption was widespread in the health care sector.

3.2 Trust and corruption

Social trust does not have an exact definition. There is, however, a loose agreement on the concept being understood as the expectation we have that "another" will act in a certain way, more specifically, "A trusts B to do (or with respect to) X". The "another" actor can be represented by an individual, a group of individuals, an organization or institution and so on (Verducci and Schröer 2010, 1453 - 1454). From here, different levels of trust emerge such as interpersonal trust and institutional trust. Interpersonal trust, also labeled as social or generalized trust, is the trust between the members of the society, an expectancy of fair treatment; while institutional trust or political trust is the trust vested in governmental institutions or political parties (Kubbe 2014, 119). Institutional trust in the government can include institutions like courts, law enforcement agencies (police), but it can also apply to other public and quasi-public institutions, as well as to the private sector (Bornstein and Tomkins 2015, 3).

The Oxford Handbook of Social and Political Trust chapter on Trust and Corruption offers an overview of the published evidence on the link between trust and corruption. The evidence presented shows there is mutual causality between trust and corruption. More

specifically, corruption and institutional fairness have a causal effect on social and institutional trust and the evidence for this fact is "very strong and robust"; while the evidence for the causal effect of social trust on corruption seems to be less strong (You 2018, 14).

For example, a study on 24 European nations found on one hand, that corruption decreases interpersonal and institutional trust, and that corruption is nurtured by low levels of interpersonal trust on the other. Moreover, high levels of corruption can have a diminishing effect on individuals' trust in political institutions. The authors also highlight that the relationship between interpersonal trust and corruption is stronger in Western countries, while the relationship between institutional trust and corruption is stronger in Central and Eastern European countries (Kubbe 2014, 130 - 131). A study in Mexico has shown that there is also a mutually causal relationship between perception of corruption and levels of trust in political institutions (Morris and Klesner 2010).

Moreover, in an experimental study, Bo Rothstein and Daniel Eek showed that corruption is not only detrimental to institutional trust, but also leads to low social trust. The experiment showed that irrespective of the country the respondents have been brought up in (low trust and high corruption culture in Romania and high trust and low corruption culture in Sweden), the same effect of corruption was observed. More specifically, when individuals face public authorities that engage in corrupt behaviors, the trust in the authorities is lost but their perception on how trustworthy a society is, is also changed for the worse (Rothstein and Eek 2009).

Social or generalized interpersonal trust

The European Social Survey from 2008 assessed the interpersonal trust of respondents by posing a question on whether most people can be trusted or that they "can't be too careful in dealing with people". Respondents had to answer by giving a score on a scale from 0 (can't be too careful) to 10 (most people can be trusted). Both Romania and Bulgaria scored between 3 and 4, with Romania scoring slightly better (Kubbe 2014, Fig. 2).

Interpersonal trust is also measured in the World Value Surveys. The same question was used to assess the level of interpersonal trust, but not the same scale. In 1998 and 1997, 17.9% of the Romanian respondents and 23.7% of the Bulgarian respondents thought most people can be trusted, while 77.9% Romanians and 59.1% of Bulgarians thought "you need to be very careful". In 2005 and 2006, 19.3% of Romanians and 19.6% of Bulgarians thought most people can be trusted; and in 2017, 12.1% of Romanians and 17.1% of Bulgarians thought most people can be trusted (World Values Survey 2020).

Institutional Trust

In a study on corruption and trust, the authors constructed an index of institutional trust based on data and questions from the 2008 European Social Survey. The scale ranged from 0 to 10, where low scores meant low levels of institutional trust and high scores marking high levels of trust. Romania scored between three and four, while Bulgaria had a score of 2.1, which was the lowest in the countries included in their analysis (Kubbe 2014, 19).

A higher share of Bulgarians had very high trust (14.4% vs. 7%) and high trust (39% vs. 31.6%) in the police when compared to Romanians, and more Romanians mistrusted the police as compared to Bulgarians, reflecting data collected in 2005 and 2006. Similarly, more Bulgarians were trusting courts at a very high and high level than Romanians, and more Romanians had a lower level of trust in these institutions for the data collected in 2005 and 2006. Data collected in 2017, however, shows an opposite stance, with more Romanians than Bulgarians having very high and high levels of trust in the police, and more Bulgarians presenting low levels of trust. Similarly, very high and high levels of trust in courts was higher in Romania than in Bulgaria, where low and very low levels of trust in courts were more popular (World Values Survey 2020). Thus, Romanians were less trusting of the police and courts than Bulgarians in 2005 and 2006 while data for 2017 show a shift in these trust levels, with Bulgarians having less trust in courts and police than Romanians.

Given the lens through which this study is conducted, namely informal payments being viewed as a form of corruption, the framework of trust and corruption is used to guide the research in exploring whether the difference in the prevalence of these payments between Romania and Bulgaria can be attributed to different levels of trust in these two countries.

4 Aims

The aim of this study is to compare the prevalence of informal payments in the health care sectors in Romania and Bulgaria. Further, we wish to understand why the prevalence seems to be higher in Romania than in Bulgaria. Thus, the research questions are:

1. What is the prevalence of informal payments within the health care sectors in Romania and Bulgaria?

2. How can the variation in the prevalence of informal payments within the health care sectors in Romania and Bulgaria be explained?

To explore these two questions, we will perform a review study.

5 Methodology and Data

In order to answer the research questions, the paper employed two research methods: a scoping review and a descriptive comparison.

5.1 Scoping review

As defined by Arksey and O'Malley, scoping reviews are a type of research that aim at rapidly mapping key concepts from a specific research area and what are the sources and type of evidence on the research question at hand. The authors highlight four reasons for which scoping reviews might be conducted: a) to explore the scale, range and nature of a particular research field, b) to assess whether conducting a full systematic review might be worthwhile, c) to summarize and disseminate research findings and provide detail findings to different stakeholders and d) to identify research gaps (Arksey and O'Malley 2005). This method was chosen in order to map the existing literature on informal payments in Bulgaria and Romania. More specifically, the scoping review was conducted in order to assess the prevalence of informal payments in Bulgaria and Romania and map aspects related to such payments in the published literature that could explain the difference in prevalence. The scoping review followed the five-stage framework developed by Arksey and O'Malley (Arksey and O'Malley 2005); and kept in mind the recommendations made by

Levac on each stage (Levac, Colquhoun, and O'Brien 2010). The five stages are: (1) identifying the research question, (2) identifying relevant studies, (3) study selection, (4) charting the data and (5) collating, summarizing and reporting the results.

5.1.1 Identifying the research question(s)

The scoping review aimed at identifying the relevant literature published on the topic of informal payments in the context of Romania and Bulgaria. In doing so, the prevalence of this phenomenon as well as other factors related to the subject were mapped.

5.1.2 Identifying relevant studies

In order to identify the relevant literature, a search strategy was developed and was used to search for the literature from the following sources: *Ovid*, where the following resources were selected: UiO's Journals@Ovid, EBM Reviews - Cochrane Clinical Answers, Embase Classic+Embase, Global Health , International Political Science Abstract , Ovid MEDLINE(R) ALL , APA PsycInfo, *Taylor and Francis Online*, *Wiley Online Library*, *Springer Link*, *PubMed*, *Web of Science* and *Oria*. Additionally, the following grey sources of literature were used: *World Bank e-library*, *IMF elibrary*, *Social Science Research Network eLibrary Database (SSRN)* and *World Wide Science*. The searches were conducted on the 16th and 17th of July 2020. The reference lists of the included studies were also screened with the aim of identifying further relevant literature.

In trying to better understand the process of systematic searching and how to build a search syntax, the help of a librarian from the University of Oslo was sought. The knowledge acquired during the session with the librarian guided the search syntax creation process. The search syntax had three components: informal payments, health care and country (Romania/Bulgaria). The term informal payments and its synonyms and variations such as “under the table payment”, “envelope payment”, “under the counter payment”, “informal fee” etc. were used to capture the meaning of this transaction. The health care term was used in order to filter the results for the desired setting this research is focusing on. Various synonyms and related terms were used (“healthcare”, “health care services”, “health system”, “hospital” etc.). And the last component is used to differentiate the findings based

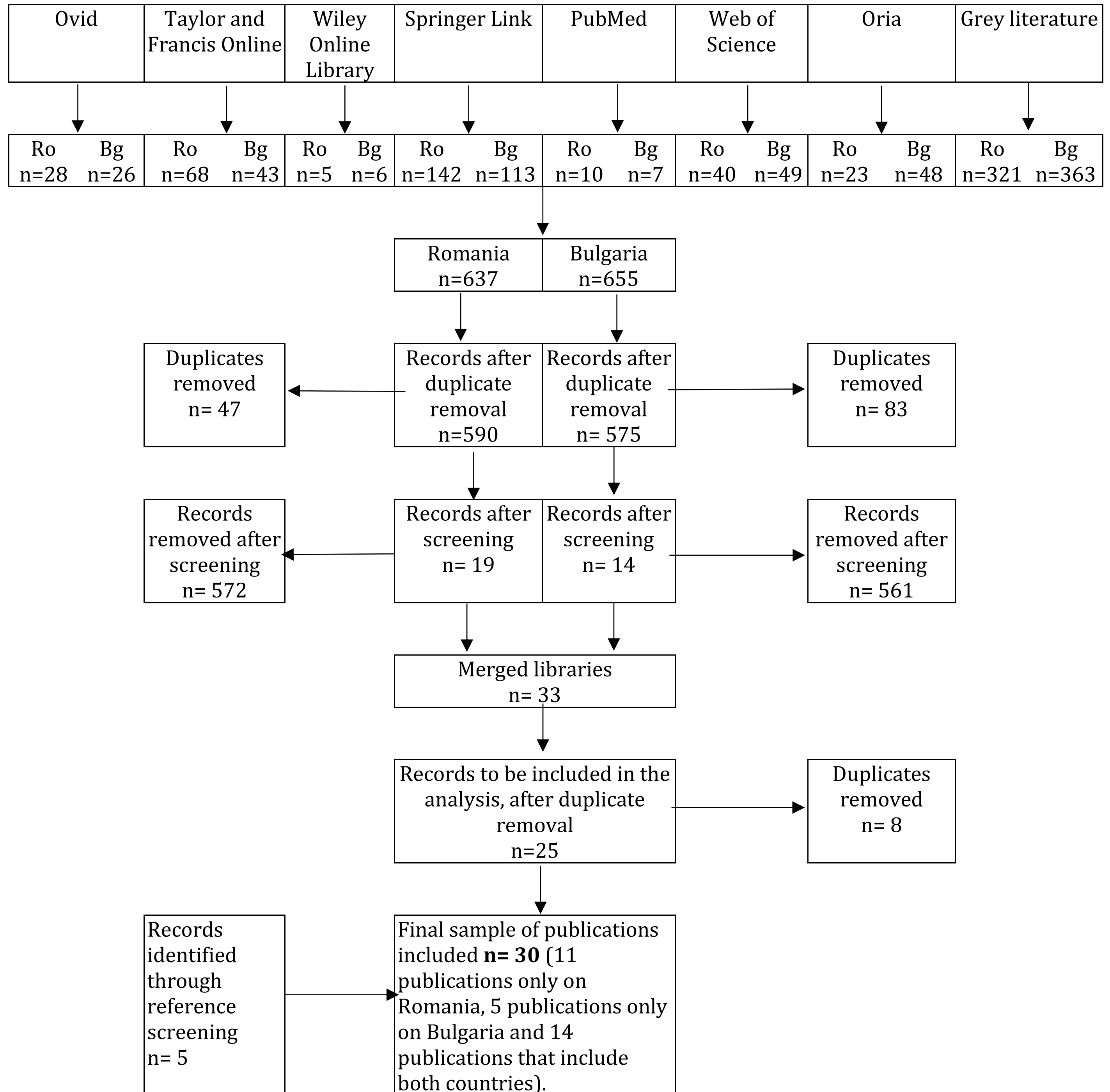
on the context of the two countries. After all the synonyms and variations of the first two terms were decided on, the search syntax was adapted for each database the search was performed in. The detailed search strategies can be found as an attachment to this paper, in **Appendix 1**. Search strategies.

The following eligibility criteria were applied: (1) literature published in English, (2) the finding is addressing informal patient payments in the health care sector and (3) the finding is related to Romania or Bulgaria. Time constraints were not used as an eligibility criterion, the research taking into account published literature in any year.

5.1.3 Study selection

The flow diagram in **Figure 1** illustrates the results of the searches conducted and the selection process of the literature that was included in the scoping review. Two separate searches were conducted, one for Romania and one for Bulgaria. A total number of 637 (Romania) and 655 (Bulgaria) published literature, including grey literature, were identified. EndNote X9 was used to created two separate libraries containing the references found through the searches. Duplicates were then removed using the function from EndNote and any duplicates that the software failed to identify, were manually removed. After the duplicates were removed, the literature from the two libraries was screened first by title, then by abstract and lastly by full text. The application of the eligibility criteria was conducted through the whole process of screening. The screening resulted in 19 records on Romania and 14 records on Bulgaria. The two libraries were then merged, given the fact that there were studies that addressed both countries in their research. Duplication removal was performed once again, and a total of 25 records were included in the analysis. Additionally, the references of these records were screened in order to identify further relevant literature. This process identified another 5 records. Thus, the total size of the sample of publications included is 30.

Figure 1. Results of the search and selection process of the scoping review



Ro = Romania, Bg = Bulgaria

5.1.4 Charting the data

The fourth stage of the scoping review is to chart the data and it consisted of extracting data on aspects such as the prevalence of informal payments in both countries; as well as other factors that were deemed relevant in explaining the difference in prevalence.

5.1.5 Collating, summarizing and reporting the results

This is the last stage of the scoping review in which the charted data is presented. This stage is presented in detail in the Results section of the paper.

6 Results

6.1 Identified literature

Table 4. Identified and included records

Author(s), year of publication and title	Country
Agheorghiesei and Poroch (2016). *The Informal Payments and their Managerial Implications in the Medical System. An Analysis from the Perspective of the Values and of the "Gift Culture" in the Romanian People*	Romania
Anderson et al. (2001). *Diagnostic surveys of corruption in Romania.*	Romania
Antal and Baba (2018). *Informal payments in Romania: the medical personnel point of view. A preliminary study.*	Romania
Atanasova et al. (2013). *Out-of-pocket payments for health care services in Bulgaria: financial burden and barrier to access.*	Bulgaria
Atanasova et al. (2014). *Informal payments for health services: the experience of Bulgaria after 10 years of formal co-payments.*	Bulgaria
Balabanova and McKee (2002). *Understanding informal payments for health care: the example of Bulgaria.*	Bulgaria
Cherecheș et al. (2011). *Informal payments in the health care system-research, media and policy.*	Romania
Delcheva, Balabanova, and McKee (1997). *Under-the-counter payments for health care: evidence from Bulgaria.*	Bulgaria
European Commission (2013). *Study on Corruption in the Healthcare Sector.*	Romania and Bulgaria
European Commission (2014). *Special Eurobarometer 397 / Wave EB79.1.*	Romania and Bulgaria
European Commission (2017). *Corruption report. Special Eurobarometer 470, Wave EB88.2.*	Romania and Bulgaria
Farcasanu (2010). *Population perception on corruption, informal payments and introduction of co-payments in the Public Health System in Romania.*	Romania

Habibov and Cheung (2017). *Revisiting informal payments in 29 transitional countries: The scale and socio-economic correlates.*	Romania and Bulgaria
Horodnic, Mazilu, and Oprea (2018). *Drivers behind widespread informal payments in the Romanian public health care system: From tolerance to corruption to socio-economic and spatial patterns.*	Romania
Manea (2015). *Medical bribery and the ethics of trust: the Romanian case.*	Romania
Moldovan and Van de Walle (2013). *Gifts or bribes? Attitudes on informal payments in Romanian health care.*	Romania
Onofrei and Gradinaru (2017). *The border between bribery and sponsorhsop of a medic-public servant, in the exercise of his duties.*	Romania
Pitea (2015). *Conceptual delimitations of informal payments in the Romanian health care system.*	Romania
Slot et al. (2017). *Updated Study on corruption in the healthcare sector.*	Romania and Bulgaria
Stepurko, Pavlova, and Gryga (2011). *Informal patient payments and public attitudes towards these payments: evidence from six CEE countries.*	Romania and Bulgaria
Stepurko et al. (2013). *Informal payments for health care services – Corruption or gratitude? A study on public attitudes, perceptions and opinions in six Central and Eastern European countries.*	Romania and Bulgaria
Stepurko, Pavlova, Gryga, and Groot (2015). *To pay or not to pay? A multicountry study on informal payments for health-care services and consumers' perceptions.*	Romania and Bulgaria
Stepurko, Pavlova, and Groot (2016). *Overall satisfaction of health care users with the quality of and access to health care services: a cross-sectional study in six Central and Eastern European countries.*	Romania and Bulgaria
Stepurko et al. (2017). *Patterns of informal patient payments in Bulgaria, Hungary and Ukraine: a comparison across countries, years and type of services.*	Bulgaria
Tambor et al. (2013). *The formal–informal patient payment mix in European countries. Governance, economics, culture or all of these?*	Romania and Bulgaria
Tambor et al. (2014). *The inability to pay for health services in Central and Eastern Europe: evidence from six countries.*	Romania and Bulgaria
Ungureanu et al. (2013). *A brief insight into the study of informal health care payments in Romania.*	Romania
Williams, Horodnic, and Horodnic (2016). *Who is making informal payments for public healthcare in East-Central Europe? An evaluation of socio-economic and spatial variations.*	Romania and Bulgaria
Williams and Horodnic (2018a). *Evaluating the prevalence of informal payments for health services in Southeast Europe: an institutional approach.*	Romania and Bulgaria
Williams and Horodnic (2018b). *Explaining informal payments for health services in Central and Eastern Europe: an institutional asymmetry perspective.*	Romania and Bulgaria

A total of 30 records were included in the analysis. 11 of these records focused on Romania, 5 on Bulgaria and the rest, 14, included both countries in their research. **Table 4** presents

the list of included findings, by authors. A summary of the characteristics of the included literature can be found in **Appendix 2**. Out of the 30 records, 24 were articles published in scientific journals, 5 reports and 1 preliminary study included in a conference presentation. 20 employed quantitative methods, 9 used qualitative methods and 1 used mixed methods in collecting the data.

6.2 Prevalence of informal payments

20 out of the 30 included records reported findings on the prevalence of informal payments. **Table 5** presents the prevalence from 5 studies that researched informal payments (IPs) in Bulgaria, **Table 6** presents the prevalence from 4 studies that researched IPs in Romania and **Tables 7** and **8** show the prevalence of informal payments from 11 studies that included both Romania and Bulgaria in their research. The most frequently used method of data collection was surveys administered through face-to-face interviews. Eight studies were financed by the European Commission under FP7 Theme 8 Socio-economic Sciences and Humanities, within the same Project ASSPRO CEE 2007 (Atanasova et al. 2013, 2014, Stepurko, Pavlova, and Groot 2016, Stepurko, Pavlova, and Gryga 2011, Stepurko et al. 2017, Stepurko et al. 2013, Stepurko, Pavlova, Gryga, and Groot 2015, Tambor et al. 2014). The project was undertaken over five years and aimed to "to identify a comprehensive set of tangible evidence-based criteria suitable for the assessment of patient payment policies and to develop a projection tool that can be used to analyze the efficiency, equity and quality effects of these polices." (ASSPRO CEE 2007 2007b). The project produced two datasets (first wave collected in 2010 and the second wave in 2011), which consist of survey data on "the use and payments for health care services" within the partnering countries, among them Romania and Bulgaria (ASSPRO CEE 2007 2007a). Consequently, these studies are using the same datasets.

Table 5. Prevalence by setting – individual studies on Bulgaria

<table>
<tr><th rowspan="2">Year*</th><th colspan="3">Bulgaria</th><th rowspan="2">Reference</th></tr>
<tr><th>Outpatient</th><th>Inpatient</th><th>Methods</th></tr>
<tr><td>1994</td><td colspan="2">42.9% of the respondents paid cash for officially free services in the last 2 years.
The study did not differentiate between settings when measuring the prevalence of IPs.</td><td>Survey administered through face-to-face interviews
N=706 (NR)
Recall period: 24 months</td><td>Delcheva, Balabanova, and McKee (1997)</td></tr>
<tr><td rowspan="2">1997</td><td colspan="2">19% (M) and 22%(F) answered they have ever paid or given a gift for at least one service in a public health setting. The qualitative side of this study, however, suggests that the survey underestimated the extent of the IPs.</td><td rowspan="2">Survey administered during face-to-face interviews
N= 1547 (R)
Recall period: lifetime</td><td rowspan="2">Balabanova and McKee (2002)</td></tr>
<tr><td>Some IPs are also reported at primary care facilities</td><td>IPs are reported to be almost universal for surgeries and obstetrics (childbirth).</td></tr>
<tr><td>2010</td><td>12.8% of the health care users made IPs in the previous 12 months</td><td>32.9% of the users paid informally in the previous 12 months</td><td>Survey administered through face-to-face interviews
N = 1003 (R)
Recall period: 12 months</td><td>Atanasova et al. (2014)[a]</td></tr>
<tr><td rowspan="2">2010 and 2011</td><td>12.65% of health care users made IPs in the last 12 months (2010)
9.7% made IPs (2011)</td><td>31.8% made IPs (2010)
18.3% made IPs (2011)</td><td>Survey administered during face-to-face interviews
N = 1003 (2010 – R)
N = 817 (2011 – R)
Recall period: 12 months</td><td>Atanasova et al. (2013)[a]</td></tr>
<tr><td>9.7% made IPs (2010)
8.2% made IPs (2011)
IP for last physician visit between 2009-2011: 4.0%</td><td>21.6% made IPs (2010)
11.5% made IPs (2011)
IP for the last hospitalization between 2009-2011: 14.4%</td><td>Survey administered during face-to-face interviews
N = 1003 (2010 – R)
N = 817 (2011 – R)
Recall period: 12 months</td><td>Stepurko et al. (2017)[a]</td></tr>
</table>

* Year of data collection, IPs = Informal payments, M = Male, F = Female, NR = Non-Representative sample, R = Representative sample, a- Project ASSPRO CEE 2007, N= sample size

Table 6. Prevalence by setting – individual studies on Romania

Year*	Romania			Reference
	Outpatient	Inpatient	Methods	
2000	17% (NV), 32% (V) for GP visit paid "atenție"[1]	33% (NV), 52% (V) for medical specialist 37% (NV), 66% (V) for hospital stay	Secondary data analysis of 3 large scale governance and corruption surveys. N = 1050 (household sample)	Anderson et al. (2001)
2009	9.6% of the respondents declare unofficial payments to the GP 3.9% to GP nurse	25.1% of the respondents declare unofficial payments to the hospital physicians, 23.4% to the hospital nurses 17.4% to the hospital attendant	Survey administered during face-to-face interviews N = 1213 (R) Recall period: 12 months	Farcasanu (2010)
2013	Not reported	Surgery is reported to be the setting where most IPs are offered (44.2%), where most expensive gifts are offered (58.8%) and where the largest amounts of monetary payments are made (55.31%)	Telephone-administered questionnaires. N = 647 – subsample from a larger sample of 1500 individuals	Ungureanu et al. (2013)
	28% of the respondents made IPs Results by setting are not reported.		Secondary data analysis from the Special Eurobarometer No. 397 N = 1030 Recall period: 12 months	Horodnic, Mazilu, and Oprea (2018)

* Year of data collection, IPs = Informal payments, NR = Non-Representative sample, R = Representative sample, 1 – "atenție" a Romanian word that can mean bribe, but it can also be understood by some individuals as tips or an expression of gratitude. NV = non-voluntary – either the payment was explicitly requested or the patients "just knew this is the way it goes", V = voluntary, GP = General Practitioner, N=sample size

Table 7. Prevalence by setting - studies that included both Romania and Bulgaria

Year *	Romania		Bulgaria		Methods	Ref.
	Outpatient	**Inpatient**	**Outpatient**	**Inpatient**		
2010	54.2% of the respondents who visited an outpatient physician during the last 12 months made an informal payment (either cash or in kind)	Not reported	12.6% of the respondents who visited an outpatient physician during the last 12 months made an informal payment (either cash or in kind)	Not reported	Survey administered during face-to-face interviews N = about 1000 per country, precise sample size not specified (R) Recall period: 12 months	Stepurko, Pavlova, and Gryga (2011)[a]
	58.8% of the respondents ever made payments in cash 62.4% of the respondents have ever given a gift in kind 21.7% were personally asked to pay informally or offer a gift in kind		19.5% of the respondents ever made payments in cash 45.6% of the respondents have ever given a gift in kind 17.1% were personally asked to pay informally or offer a gift in kind		Surveys administered through face-to-face interviews N_{RO} = 1000 (R), N_{BG} = 1003 (R) Recall periods: lifetime Prevalence by setting not reported.	Stepurko et al. (2013)[a]
	36.2% of the respondents made IPs	48.4% of the respondents made IPs	9.5% of the respondents made IPs	19.8% of the respondents made IPs	Surveys administered through face-to-face interviews N_{RO} = 1000 (R), N_{BG} = 1003 (R) Recall period: 12 months	Tambor et al. (2014)[a]
	34.5% of the respondents made IPs -last 12 months 71.2% of Romanian respondents have ever paid informally (cash or in-kind) 21.7% of Romanian respondents have ever been asked to pay informally		12.2 % of the respondents made IPs - last 12 months 49.9 % of Bulgarian respondents have ever paid informally (cash or in-kind) 17.1 % of Bulgarian respondents have ever been asked to pay informally		Surveys administered through face-to-face interviews N_{RO} = 1000 (R), N_{BG} = 1003 (R) Recall period: 12 months and lifetime. Prevalence by setting not reported.	Stepurko, Pavlova, Gryga, and Groot (2015)[a]
	34.6% of the respondents made IPs	56.8% of the respondents made IPs	12.4% of the respondents made IPs	26.3% of the respondents made IPs	Surveys administered through face-to-face interviews N_{RO} = 1000 (R), N_{BG} = 1003 (R) Recall period: 12 months	Stepurko, Pavlova, and Groot (2016)[a]

* Year of data collection, IPs = Informal payments, NR = Non-Representative sample, R = Representative, a- Project ASSPRO CEE 2007, N_{RO} =sample size Romania, N_{BG} = sample size Bulgaria

Table 8. Prevalence by setting - studies that included both Romania and Bulgaria continued

Year *	Romania		Bulgaria		Methods	Ref.
	Outpatient	Inpatient	Outpatient	Inpatient		
2010	44.05% of the respondents made IPs. Results by setting not reported.		13.61 % of the respondents made IPs. Results by setting not reported.		Data used from 2010 Life-in-Transition (LTS) country survey. N_{RO} = 1065 (R), N_{BG} = 966 (R) Recall period: 12 months	Habibov and Cheung (2017)
2013	28% (highest in the EU) of Romanian respondents made an extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees).		8% of Bulgarian respondents made an extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees).		Surveys administered through face-to-face interviews N_{RO} = 1030, N_{BG} = 1000 Recall period: 12 months Prevalence by setting not reported.	European Commission (2014)
	28% of respondents who used medical services made IPs. Results by setting not reported.		8% of respondents who used medical services made IPs. Results by setting not reported.		Used data from the Special Eurobarometer No. 397 ('Corruption'). Sample size per country not specified in the article (around 1000 per country).	Williams, Horodnic, and Horodnic (2016)
	30% of health care users made IPs Results by setting not reported.		8% of health care users made IPs Results by setting not reported.		Used data from the Special Eurobarometer No. 397 ('Corruption'). N_{RO} = 465, N_{BG} = 631 (health care users) Recall period: 12 months.	Williams and Horodnic (2018a)
	30% of those using healthcare services made IPs. Results by setting not reported.		9% of those using healthcare services made IPs. Results by setting not reported.		Used data from the Special Eurobarometer No. 397 ('Corruption'). N_{RO} = 465, N_{BG} = 631 (health care users) Recall period: 12 months.	Williams and Horodnic (2018b)
2017	19% (highest in the EU) of Romanian respondents made an extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees).		8% of Bulgarian respondents made an extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees).		Surveys administered through face-to-face interviews. N_{RO} = 1055, N_{BG} = 1027 Recall period: 12 months. Results by setting not reported.	European Commission (2017)

* Year of data collection, IPs = Informal payments, NR = Non-Representative sample, R = Representative, N_{RO} =sample size Romania, N_{BG} = sample size Bulgaria

6.3 Corruption

The Special Eurobarometer survey presented earlier included questions about perception of acceptability of corruption. Respondents were asked how acceptable they thought it was to give money, a gift or do a favor in case they wished to obtain something from the public administration or public services. Doing a favor was viewed as acceptable by 20% of Romanians and 29% of Bulgarians, giving a gift was considered acceptable by 35% of Romanians and 37% of Bulgarians, and offering money was thought of as acceptable by 20% of Romanians and 14% of Bulgarians (European Commission 2014, 13 - 15). Thus, more Bulgarians were finding offering a gift or doing a favor acceptable, while more Romanians thought of giving money as acceptable.

Horodnic et al. used the data from the survey mentioned above to report on the prevalence of informal payments in Romania, and specifically used the three questions on gifts, money and favor to construct a Tolerance of Corruption Index, ranging from 1 to 3, where 1 means corruption is always acceptable and 3 means corruption is never acceptable. Romania's score was 2.67 this translating into higher levels of corruption acceptability compared to the European average EU28 (2.77), to Western Europe score (2.80) and the Nordic nations (2.87). Moreover, the authors found that the prevalence of IPs are "strongly associated with higher levels of tolerance to corruption" (Horodnic, Mazilu, and Oprea 2018, e605).

In the Special Eurobarometer reports from 2017 and 2019 (only the first report was included in this review since the latest report was published after the end of the inclusion process), they also computed a Tolerance of Corruption Index based on the three question. Thus, in 2017, 58% of Romanians and 61% of Bulgarians viewed corruption as unacceptable, as compared to the European average of 70% (European Commission 2017, 14). And in 2019, 49% of Romanians and 63% of Bulgarians considered corruption to be unacceptable, as compared to the European average of 69% (European Commission 2020, 17). Thus, more Romanians than Bulgarians thought corruption is acceptable.

One of the articles identified through the scoping review asked the respondents (Romanians) what are the main reasons for the presence of corruption in the health system. 73.4% said because of the society is accustomed to the offering and receiving of bribes and

70.9% because of the absence of penalties (Farcasanu 2010). This study, however, was conducted only on the Romanian population and a Bulgarian counterpart was not identified.

In terms of trust, only article on Romania researched this area and identified low trust institutions to be one of the factors that might give rise to bribery (Manea 2015).

6.4 Other key findings

This section presents other key findings that have been identified in the included literature. They are grouped under the following themes: timing, reasons and determinants, attitudes and perceptions.

6.4.1 Timing

Several studies reported findings on the timing of the payment. Balabanova and McKee, for example, found for the data collected in 1997 in Bulgaria, that three quarters of the gifts were offered after the service was provided, while monetary payments mostly took place before or during the treatment. The authors pointed out that the timing of the payments is perceived by the respondents to be crucial in determining the nature of the payment (bribe or gratitude), and that the type of payment is less relevant in making this distinction. (Balabanova and McKee 2002).

Farcasanu reported findings on the timing of the payment in Romania for 2009 to be the following: 50% of the respondents in the sample made in cash or in kind payments before the treatment, 25.5% did so at the end of them and 17.7% paid both before and after the services were provided (Farcasanu 2010). Results of the secondary data analysis performed by Williams et al. on the data from the Special Eurobarometer No. 397 (‘Corruption’) collected in 2013 showed a similar share for Romania, with 50% of the payments occurring before care was received and 28% after. In Bulgaria, 15% of the payments occurred before the treatment and 28% after. (Williams, Horodnic, and Horodnic 2016).

6.4.2 Reasons and determinants

Making IPs when illness is serious or with the purpose to obtain a visit to a well-known specialist, expressing gratitude for a successful treatment, for receiving special attention or for high quality services were among the reasons reported by Balabanova and McKee for Bulgaria in 1997 (Balabanova and McKee 2002). In 2000, the Diagnostic Survey on Corruption in Romania identified receiving proper or speedy care (45%), out of tradition (21%) and expressing gratitude (11%) to be the reasons for Romanian respondents to offer "atenție" (a Romanian word that can mean bribe, but it can also be understood as an expression of gratitude). The author pointed out that although some of such payments occur for the first two reasons mentioned, most often they resemble bribes since they were motivated by want of better quality treatment (Anderson et al. 2001). The same reasons were reported by Farcasanu in 2009 in Romania, to receive more attentive care (46.2%), out of custom or because everybody does it (30.8%) and out of gratitude (29.9%) (Farcasanu 2010).

The Special Eurobarometer 397 conducted in 2013 asked the respondents who said they made IPs to identify the circumstance of how it happened, by choosing from a list of answers. 50% of Romanians and 15% of Bulgarians felt they had to give an extra payment or valuable gift before the treatment was received, while 28% of Romanians and 32% of Bulgarians felt they had to make such a payment after the treatment. 28% of Romanians and 11% of Bulgarians made such a payment because it was expected of them from the doctor or nurse, after the care was given, and 6% of Romanians, 24% of Bulgarians did so because it was requested by the doctor or nurse in advance (European Commission 2014, 93).

Balabanova and McKee concluded that, in Bulgaria, informal payments are derived from low salaries of the health care staff, patients in seek of better care, acute funding shortages in the health care system and tradition (Balabanova and McKee 2002). The Updated Study on Corruption in the Health Care Sector conducted by Slot et al. commissioned by the European Commission found that IPs, in Romania are partly motivated by the custom of gift giving, paradoxically such payments are given in advance for (faster) access or better health

care. Stakeholders suggested that low salaries of the medical staff are a trigger to accept bribes and raising the wages would convince physicians to refuse bribes. The stakeholders highlighted, however, the fact that raising salaries would not solve the issue, as it is very common to offer bribes (particularly gifts after the health care service was provided), which is a cultural factor (Slot et al. 2017). Similarly, a study from the medical staff's point of view, found that underpayment was the main factor for accepting informal payments identified by the medical personnel. The other two reasons for accepting were because of custom and that patients offer IPs as an expression of gratitude. Another relevant finding is that the medical staff does not believe accepting IPs to be "a determinant factor for quicker access or better quality of health care services" (Antal and Baba 2018, 39).

Agheorghiesei tested the assumption that IPs do not stem from the low-income levels of medical staff, but rather constitute a phenomenon deeply rooted in socio-cultural characteristics. Gift giving of Romanians is a national-cultural feature that is intensely debated by authors cited in his article. The assumption the authors made in the paper is that this cultural trait (giving gifts) coupled with other factors such as certain values relating to safety, sacrifice, hospitality, kindness and tolerance, as well as hierarchical submission, the importance of group opinion and attitude towards risk could represent aspects that explain IPs and their magnitude (Agheorghiesei and Poroch 2016).

6.4.3 Attitudes and perceptions

Results from Bulgaria in 2002, showed that when initiated by the patient, payments in cash or in kind were viewed as generally acceptable, while payments that are demanded are viewed in a strong opposing light (Balabanova and McKee 2002). Later results differentiated by type of payment, showed that most health care users are against monetary payments but 27% of the respondents considered offering gifts acceptable (Atanasova et al. 2014). Similar attitudes were reported by Pitea's qualitative study (13 patients) in Romania, where IPs in cash are perceived as a positive thing is they are not requested by the physician, but rather offered as means of gratitude, while if they are requested, they are considered a bribe and should be punishable. IPs in kind are viewed as a way to show gratitude and should not be punished. Moreover, respondents are aware they do not have

to make IPs for services they are freely entitled to, but they point out the cultural tie to the act (Pitea 2015). These results were not, however, consistent with the findings of another qualitative study (20 patients who had been hospitalized in the past 12 months or had relatives who were), where overall, participants consider offering and asking informal payments (in kind such as gifts or services and in cash) as unacceptable. However, many confessed on making such payments. This translates to a weak link between attitudes and actual behavior (Moldovan and Van de Walle 2013). A quantitative study based on a nationally representative sample, also found that 82.8% of the respondents did not agree with any form of IPs (in cash or in kind), and only 6.3% agreed with them (Farcasanu 2010).

Stepurko et al. reported results on attitudes towards IPs both in form of cash and gifts, from nationally representative samples in Romania and Bulgaria. 72.3% of Romanian respondents and 84.8% of Bulgarians had negative attitudes towards monetary IPs, 18.0% Romanians and 10.4% Bulgarians were indifferent to them and 9.7% Romanians and 4.9% of Bulgarians felt positively about cash payments. Regarding giving gifts, 65.0% of Romanians and 54.5% of Bulgarians felt negatively about them, 20.4% of Romanians and 18.7% of Bulgarians were indifferent and 14.7% Romanians and 26.8% Bulgarians felt positively about them (Stepurko, Pavlova, and Gryga 2011). Using the same data, in an article published in 2013, Stepurko et al. reported identical results and one of their regression analysis revealed that Romanians "are more inclined to associate informal payments with gratuity and to accept the low health care funding as an excuse for their existence", and that Bulgarians are less positive about IPs owing to anti-corruption policies. Moreover, although the respondents showed, overall, that they are in favor of eliminating IPs, around half of the respondents in each country, including Romania and Bulgaria, consider such payments to be unavoidable on account of the low funding of the state health care sector (Stepurko et al. 2013, 426).

In another article, using same data collected through nationally representative surveys in 2010, Stepurko et al. reported on the respondents' perception on five behavior statements. 22.1% of Romanian respondents and 6.8% of Bulgarian respondents agreed with the statement that they would feel uncomfortable leaving without giving gifts. 65.2% of

Romanians and 64.7% of Bulgarians say they would be able to recognize hints of IPs. 35.8% of Romanians and 54.8% of Bulgarians say they would be able to refuse IPs if asked to pay. 49.4% Romanians and 50.7% Bulgarians would prefer to use private health care owing to IPs and lastly 60.4% Romanians and 42.7% Bulgarians admit they would be willing to pay informally in case of serious health issues (Stepurko, Pavlova, Gryga, and Groot 2015).

7 Discussion

7.1 Prevalence

The first research question of this paper is to evaluate what is the prevalence of informal payments within the health care sectors in Romania and Bulgaria. In order to answer it, this section compares the data on prevalence extracted from the studies identified through the scoping review. First comparison points are made based on individual studies published on Romania and Bulgaria and second comparison points are described based on studies that included both countries in their research. This approach is chosen due to the different levels of comparability. The prevalence from studies in the first instance are compared with caution given the different years the data was collected in, as well as different methodologies / instruments used to measure the extent of informal payments.

7.1.1 Data from individual studies

Table 5 shows the prevalence identified in studies addressing Bulgaria. Delcheva et. al reports for 1994 that 42.9% of the respondents in the non-representative sample have paid in cash in the last 2 years (Delcheva, Balabanova, and McKee 1997). Balabanova and McKee report findings for 1997, but their results are differentiated between genders, making comparison with the previous study difficult (Balabanova and McKee 2002). In **Table 6,** the first study identified in the scoping review to report prevalence of IPs in Romania collected data six years later (Anderson et al. 2001), but comparisons with the rates reported by the two previous studies on Bulgaria do not seem to be possible. What can be observed, however, is the higher prevalence in inpatient settings than outpatient settings identified both in Romania (Anderson et al. 2001, Farcasanu 2010) and in Bulgaria (Balabanova and McKee 2002, Atanasova et al. 2013, 2014, Stepurko et al. 2017). These

findings are consistent with the findings from two systematic reviews that synthetized evidence from studies on this aspect of informal payments (Khodamoradi, Ghaffari, et al. 2018, Stepurko et al. 2010).

Atanasova et al. published two articles that used the same data sets, and reports findings for 2010 in one article (Atanasova et al. 2014) and for 2010 and 2011 in the other (Atanasova et al. 2013), the prevalence rates in 2010 presenting a slight, but negligible variation in the two articles. Stepurko et al., although they use the same survey data, report rates of 9.7% (2010) and 8.2% (2011) for outpatient settings and 21.6% (2010) and 11.5% (2011) for inpatient settings (Stepurko et al. 2017), which are fairly lower than the rates reported by Atanasova et al. (Atanasova et al. 2013, 2014). This difference might be attributed to the authors removing "0.5–4% of the questionnaires per country" based on poor quality and inconsistencies detected in the answers (Stepurko et al. 2017, 455).

Farcasanu's results for 2009 on Romania show that respondents made payments in shares of 9.6% to GP and 3.9% to GP nurse within the outpatient setting and 25.1% to the hospital physicians, 23.4% to the hospital nurses and 17.4% to the hospital attendant for the inpatient setting (Farcasanu 2010). If these results from Romania for 2009 were to be compared with the results from Bulgaria for 2010, published by Atanasova et al. (2013, 2014), the conclusion that slightly higher rates are observed in Bulgaria could be drawn. However, if they were to be compared with the rates reported by Stepurko et al. (2017) for 2010, the prevalence in both countries would seem to be similar. Although all these results are based on nationally representative samples collected through surveys administered during face-to-face interviews and thus justify the comparison; the strength of this comparison is, however weak, given that the results for Bulgaria are reported at a general level, while the results for Romania are differentiated between various health care professional, in each setting, towards which IPs were made.

7.1.2 Data from the studies that include both countries

Table 7 presents the prevalence of informal payments identified in the studies that included both Romania and Bulgaria in their research. The first five studies used the same nationally representative survey data collected in 2010 within the ASSPRO CEE 2007

project (ASSPRO CEE 2007 2007a), however each study differed in which prevalence they reported. The survey asked respondents whether they made informal payments (either in cash or in kind) in the previous 12 months, and this question was differentiated by outpatient and inpatient setting but not by type (in cash or in kind). The survey also explored the respondents' past experience of ever paying informally in cash and in kind. This question was differentiated by type (in cash/in kind), but not by setting (Stepurko, Pavlova, Gryga, and Groot 2015, 2993). From here two types of prevalence emerge, one that has a recall period of 12 months and offers information about the setting in which it took place but not the type of payment that was given. And one that has a recall period of lifetime and offers information on the type of payment but not the setting.

Thus, in the series of these five studies, the first one reports only the prevalence for the outpatient setting in the previous 12 months, with 54.2% of Romanian health care users and 12.6% of Bulgarian health care users saying they have made an informal payment (in cash or in kind) (Stepurko, Pavlova, and Gryga 2011). The next study reports on the results related to ever making an informal payment, by type with 58.8% of Romanian respondents and 19.5% of Bulgarian respondents ever making a monetary informal payment and 62.4% of Romanians, 45.6% Bulgarians ever offering a gift for health care services. Another finding of this study reflects that 21.7% of Romanian respondents and 17.1% of Bulgarian respondents have been personally asked to make an informal payment (either in cash or in kind) (Stepurko et al. 2013). Stepurko et al.'s next published article does not differentiate reported results by setting or by type of payment, one prevalence being 34.5% and 12.2% in Romania and Bulgaria respectively in the past 12 months and the other 71.2% and 49.9% of Romanians and Bulgarians respectively have ever engaged in IPs (either in cash or in kind) (Stepurko, Pavlova, Gryga, and Groot 2015). Both Tambor et al. and Stepurko et al. report the prevalence by setting, with some variation between them. A prevalence of 36.2% Romanians and 9.5% Bulgarians making payments towards the outpatient setting and 48.4% Romanians and 19.8% Bulgarians making such payments in the inpatient setting is reported by Tambor et al.(Tambor et al. 2014), while Stepurko et al. have the following prevalence: 34.6% Romanians and 12.4% Bulgarians IPs in the outpatient setting and

56.8% Romanians and 26.3% Bulgarians IPs in the inpatient setting(Stepurko, Pavlova, and Groot 2016).

Thus, given the results above and the fact that the data collection process and instrument was the same for both countries, the following comparisons points can be made for 2010. In terms of setting, Romanians pay more informally than Bulgarians both in outpatient and inpatient settings. Moreover, more payments in cash and in kind are reported in Romania than Bulgaria and more Romanians were personally asked to pay informally than Bulgarians. The aspect of more payments taking place in inpatient settings than in outpatient is also apparent in both countries.

Table 8 presents the next series of articles that give information on the scale of informal payments. Habibov and Cheung also analyzed the extent of informal payments by using the nationally representative data from the 2010 Life-in-Transition (LTS) country survey and found that 44.05% of Romanians and 13.61% of Bulgarians reported making informal payments in the previous 12 months (Habibov and Cheung 2017). These results are slightly higher than the ones reported by Stepurko et al. in 2016 (Stepurko, Pavlova, and Groot 2016).

The prevalence in 2013 found by the Special Eurobarometer survey No.397 is that 28% of Romanian respondents and 8% of Bulgarian respondents made either an extra payment or offered a valuable gift to a physician or a nurse that were outside the scope of official fees in the previous 12 months. The reported prevalence for Romania was also the highest in the European Union (EU) (European Commission 2014). Williams and Horodnic use the data from the survey in their research and report almost identical prevalence (Williams and Horodnic 2018b, a, Williams, Horodnic, and Horodnic 2016). Another wave from the Special Eurobarometer survey No.470 was conducted in 2017 and found that 19% of Romanian respondents (still highest in the EU) and 8% of Bulgarian respondents made either an extra payment or offered a valuable gift to a physician or a nurse that were outside the scope of official fees in the previous 12 months (European Commission 2017).

Thus, it is apparent that, although a decrease in the prevalence of informal payments can be observed for both countries over the years, they are more common in Romania than in Bulgaria.

7.2 Possible explanations

In this part, the paper aims at answering the second research question of this research, namely how can this difference in prevalence be explained. Several possible explanations are suggested.

7.2.1 Trust and corruption

Two studies on Romania (Farcasanu 2010, Horodnic, Mazilu, and Oprea 2018) and two reports that include both countries (European Commission 2014, 2017) that reported data on corruption were identified through the scoping review. The findings on trust consist only from one study, and only for Romania (Manea 2015). Thus, given that not enough sources of information relating to trust were identified through the scoping review, no conclusion can be drawn based on the link between trust and corruption. More specifically, the paper cannot make a conclusion on whether different levels of trust between Romania and Bulgaria can explain the difference in informal payments.

7.2.2 Methodology

Khodamoradi et al. point towards differences in the data collection methods to be one of potential the reasons the studies included in their systematic literature review found a wide range in the prevalence of informal payments (2%-80%)(Khodamoradi, Ghaffari, et al. 2018). Thus, we explored the idea whether the difference in the methodology used to measure informal payments could explain the difference in prevalence between Romania and Bulgaria. However, considering that the studies this paper based the comparison points on share quite similar methodological aspects such as multi-stage, random probability sampling approach, samples around 1000 participants which are nationally representative in most studies and mostly using a recall period of 12 months, it seems unlikely that the difference in prevalence between Romania and Bulgaria could be explained by methodological differences.

7.2.3 Factors related to health care systems

Two aspects related to the financing and organization of the health care systems were identified as possible explanations to the variation in prevalence between Romania and Bulgaria, namely underfunding of the system and underpayment of medical staff.

7.2.3.1 Underfunding of the health care system

Both in Romania and Bulgaria underfunding of the health care systems can be traced back to the communist period, when in both countries the Semashko-type health care system was in place, characterized by lack of competition, rigid norms, inefficiency and poor quality of health services (Georgieva et al. 2007, 15 - 16, Vlădescu et al. 2008, 22). Acute funding shortages of the health care system was one of the drivers of informal payments identified by Balabanova and McKee (2002). Moreover, in one of the articles both Romanians and Bulgarians despite their shown support for the elimination of such payments, consider informal payments to be unavoidable on account of the low funding of the state health care sector (Stepurko et al. 2013, 426). In addition, in two of the identified articles from the scoping review, Williams and Horodnic found that informal payments are considerably higher in nations that have low levels of expenditure on health, as a % of their GDP (Williams and Horodnic 2018a, b). The observed expenditure on health care as a share of the GDP is consistently higher in Bulgaria than in Romania (World Bank 2020b), which could explain to some extent why informal payments are more prevalent in Romania than in Bulgaria.

7.2.3.2 Underpayment of medical staff

The low levels of payment for the medical staff as a reason for informal payments have been invoked by health care users (Balabanova and McKee 2002, Moldovan and Van de Walle 2013), providers (Antal and Baba 2018) and stakeholders alike (Slot et al. 2017). These findings are consistent with what Pourtaleb et al. identified in their systematic review of the

literature, more specifically low income for physicians and medical personnel was one of the factors under the sustainable financing and social protection weakness theme (Pourtaleb et al. 2020, Table 4).

Romania is one of the countries with the fewest physicians and nurses per capita in the EU owing to significant migration of health care professionals (OECD 2019b). Bulgaria is also facing a shortages of nurses (OECD 2019a). In an effort to tackle the shortage of health professionals in the public health care facilities (specifically hospitals), the Romanian government raised the salaries in 2015 and 2016, but it was a modest raise. Strikes that took place in 2017 however pushed for further raises and in March 2018 a junior doctor's net salary increased from around EUR 344 to EUR 902 per month and the salary of a senior doctor from EUR 913 to EUR 2112. This measure, however, was applied only for physicians working in public hospitals (OECD 2019b, 20). In Bulgaria, the Collective Labour Agreements set the minimum basic monthly salary, and in 2016 the starting salary was between EUR 358 and EUR 455 per month. The average payment of specialists in 2007 was EUR 619 and EUR 986.30 by 2016. In addition, specialists receive substantial income from user charges. Physicians that work in specialized hospitals, centers for oncological diseases and university hospitals are the highest earners, in 2016, with the average monthly salary ranging between EUR 1125–1227 (Dimova et al. 2018, 96 - 98). Considering that health care workers in Bulgaria had average salaries in 2016 higher than ones in Romania before the raise in 2018, it could be assumed that Bulgarian health professionals earned slightly more than Romanians. Thus, the difference in income levels between Romania and Bulgaria could potentially be one of the explanations for the difference in the prevalence of informal payments, but more research is needed around this subject.

7.2.4 Gratitude and tradition

Gratitude as a reason for making IPs was given both by Bulgarian respondents in Balabanova and McKees's research (Balabanova and McKee 2002) and by Romanian respondents in Anderson et al. (2001) and Farcasanu (2010) (Anderson et al. 2001). As pointed out in the results section, the Updated Study on Corruption in the Health Care Sector show that although Romanians were perceived to make informal payments partly

out of gratitude, such payments occur in advance, before the health care service is provided (Slot et al. 2017). Thus, an assessment on whether there is a stronger culture of gift giving in Romania than in Bulgaria, and whether such payments are indeed motivated by genuine gratitude is difficult to make, but this is an area that could be explored by further research.

Another aspect linked to payments made out of gratitude is that they might mask underlying causes for IPs. In the example of Hungary as given in the introduction, Péter Gaál makes a strong point that gratitude payments might occur because of an underlying pressure to pay stemming from what patients perceive they are expected to do. He also points out that surveys might not be the best tool to capture these underlying factors (Gaal 2006, 72 - 74).

This aspect is also apparent in the findings of this paper. For example, when the prevalence of informal payments in Romania was measured in 2000, respondents that made informal because they "just knew this is the way it goes" were categorized as non-voluntary by the author (Anderson et al. 2001, 13). Moreover, the results from the Special Eurobarometer 397 conducted in 2013 show that more Romanians than Bulgarians (50% vs. 15%) felt they had to make an IPs (in cash or in kind) before the treatment was received and more Romanians than Bulgarians (28% vs. 11%) felt they had to do so because it was expected of them by the physician or nurse. In turn, slightly more Bulgarians than Romanians (32% vs. 28%) felt they had to make an IPs after the treatment was provided (European Commission 2014, 93). These findings point towards how informal payments might be influenced by what is the perceived norm.

On this note, Stepurko et al.'s results show that more Romanians than Bulgarians (22.1% vs. 6.8%) said they would feel uncomfortable leaving without giving gifts and less Romanians than Bulgarians (35.8% vs. 54.8%) said they would be able to refuse IPs if asked to pay. The results of their analysis also show, for both countries, that those who feel uncomfortable leaving without giving a gift and are unable to refuse IPs requests more often engage in IPs. The researchers also point out that these perceptions of Bulgarians might have been influenced by the emphasis on the need to tackle corruption shown by the elected

government in 2009, which was also mirrored in public debates and mass media (Stepurko, Pavlova, Gryga, and Groot 2015).

The results on requested payments by providers show that more Romanians than Bulgarians (21.7% vs. 17.1%) were personally asked to pay informally (Stepurko et al. 2013). Similarly, in 2013, more Romanians than Bulgarians (22% vs. 7%) were asked or expected to pay a bribe in the health care sector. However, more Bulgarians than Romanians (24% vs. 6%) made an informal payments because the physician or nurse requested it in advance (European Commission 2014).

Thus, it can be argued the higher expectation to pay faced by Romanians coupled with stronger perceptions that they have to follow an unwritten norm might be a plausible explanation why there are more informal payments than in Bulgaria, where respondents faced a slightly lower expectation to pay and felt more confident in their ability to refuse requested IPs.

7.2.5 Perceptions and attitudes

The data from 2010 shows that a higher share of Bulgarians than Romanians (84.8% vs. 72.3%) felt negatively about IPs in cash, while more Romanians than Bulgarians (9.7% vs. 4.9%) had positive attitudes towards them. In terms of attitudes towards informal payments in kind fewer Bulgarians than Romanians (54.5% vs/ 65%) felt negatively about them and a higher share of Bulgarians felt positive about them (26.8% vs. 14.7%) (Stepurko, Pavlova, and Gryga 2011). Thus, a conclusion cannot be drawn from these results, not only because the attitudes towards the different types of payments differ between the countries, but also because attitudes might not necessarily reflect the actual behavior, as Moldovan and Van de Walle showed in their research presented in the results section (Moldovan and Van de Walle 2013).

7.3 Methodology discussion (strengths and limitations)

This research is not without limitations. Levac et al. suggest that at least two reviewers should independently select articles for inclusion (Levac, Colquhoun, and O'Brien 2010). Here, only one author conducted the selection and screening process of the literature in the

scoping review and only one author extracted the information from these search findings. However, this process was tutored and monitored closely by the second author.

8 Conclusion

The first aim of this paper was to explore what is the prevalence of informal payments in Romania and Bulgaria. For data collected in 2010, the prevalence of informal payments was higher in both outpatient and inpatient setting in Romania than in Bulgaria. For 2013 and 2017, the prevalence in the health care sector in general was again observed to be higher in Romania than in Bulgaria. A decreasing trend was observed for both countries, but the prevalence remained higher in Romania than in Bulgaria.

Once the first research question was answered, possible explanations for the observed difference were suggested. As mentioned in the Theory and Framework section, there is a mutually causal relationship between trust and corruption. The direction of that relationship, of interest for this paper, was the effect of trust on corruption. Following this reasoning, in theory, if the higher prevalence of informal payments (a form of corruption) in Romania than in Bulgaria was to be explained by the causal relationship of trust on corruption, we should observe lower levels of institutional and general trust in Romania when compared with Bulgaria. And while data on corruption and trust levels is available in the general literature and was presented in the Theory and Framework section, the scoping review conducted in this study resulted in scarce findings on this matter. Thus, no conclusion can be drawn on this matter. However, future research on how trust levels influence this form of corruption might be worthwhile.

The main suggested aspects that might explain the difference in prevalence relate to the underfunding of the health care system and an underlying perceived and actual pressure to pay informally. The underfunding of the health care system was identified to be one of the factors of informal payments, and Romania has consistently allocated lower shares from the GDP towards health care expenditures than Bulgaria. A more widespread norm to make informal payments seems to be in place in Romania which might contribute to the higher levels of informal payments in the country. Another possible, but weaker explanation

relates to the difference in income levels of physicians. Both countries invoked the low wages of health professionals as a reason for informal payments, and it would seem that Romanian health care workers earn slightly less than Bulgarians, but this finding should be interpreted with caution. All three proposed explanations represent suggestions, further research being needed in order to draw definitive conclusions.

Another aspect that was explored in order to explain the different rates of informal payments between Romania and Bulgaria, related to methodology used to measure the phenomenon. The conclusion that more informal payments take place in Romania than in Bulgaria is based on studies that had similar sampling strategies, sample size, measuring instrument and recall periods. Thus, it seems unlikely that the difference in prevalence could be explained by the variation in methodology, since the variation was limited. Another idea that was discussed, based on the findings from the scoping review, relate to the culture of gift giving. However, no assessment could be made on whether this culture is more deeply rooted in Romanian society than in Bulgarian. Future research could explore this idea.

The present paper showcases that although comparative research can be challenging in the informal payments research field, there are some comparison points that can be drawn up. Moreover, for Romania and Bulgaria, quite a handful of publications have been identified, pointing out that the literature in this field is rich. In terms of future research, one interesting point that could be explored is the effect of trust on informal payments as a form of corruption. The suggested explanations also pose as possible areas to be further explored. More specifically, in terms of the underfunding of the health care system, a more detailed comparison between the financing of both health care system as a reason for different rates of informal payments could be conducted. Lastly, future endeavors might focus on exploring whether Romanians share a more widespread norm of making informal payments than Bulgarians, as an explanation for the difference in prevalence.

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Appendix 1. Search strategies and hits

UiO's Journals@Ovid **EBM Reviews - Cochrane Clinical Answers** May 2020 **Embase Classic+Embase,** 1947 to 2020 June 15 **Global Health** 1973 to 2020 Week 23**,** **International Political Science** Abstract 1989 to April 2020**,** **Ovid MEDLINE(R) ALL** 1946 to June 15, 2020**,** **APA PsycInfo** 1806 to June Week 2 2020		**(16/06/2020)**
1	(((gratitude or in formal* or informal* or unofficial* or un official* or under the table or under the counter or envelope or gratitude* or unlawful or unethical or corrupt* or illegal or solicited or illicit) adj5 (pay* or charg* or fee?)) or bribe).mp.	7,803
2	(health care or healthcare or health service* or health care service* or healthcare service* or health procedure* or healthcare system or health care system or primary care or hospital or health system or medic* or physician* or doctor* or general practitioner* or nurse*).mp.	15,377,141
3	1 and 2	6,476
4	Romania.mp. [mp=ti, ab, tx, ct, sh, hw, tn, ot, dm, mf, dv, kw, fx, dq, bt, id, cc, an, ui, jn, tt, nm, kf, ox, px, rx, sy, tc, tm, mh]	42,130
5	Bulgaria.mp. [mp=ti, ab, tx, ct, sh, hw, tn, ot, dm, mf, dv, kw, fx, dq, bt, id, cc, an, ui, jn, tt, nm, kf, ox, px, rx, sy, tc, tm, mh]	27,207
6	3 and 4	38
7	3 and 5	45
8	Remove duplicates from 6 (Has Abstract – Deduping preference)	28
9	Remove duplicates from 7 (Has Abstract – Deduping preference)	26
Taylor and Francis Online		**16/06/2020**
1	(gratitude payment* OR informal payment* OR unofficial payment* OR under-the-table payment* OR under-the-counter payment* OR envelope payment* OR unlawful payment* OR unethical payment* OR corrupt payment* OR illegal payment* OR solicited payment* OR illicit payment* OR informal fee* OR unofficial fee* OR under-the-counter fee* OR under-the-table fee* OR envelope fee* OR unlawful fee* OR illegal fee* OR unethical fee* OR illicit fee* OR corrupt fee* OR bribe*) AND (health care OR healthcare OR health service* OR health care service* OR healthcare service*	68

	OR health procedure* OR healthcare system OR health care system OR primary care OR hospital OR health system* OR medic* OR physician* OR doctor* OR general practitioner* OR GP OR nurse*) AND Romania	
2	(gratitude payment* OR informal payment* OR unofficial payment* OR under-the-table payment* OR under-the-counter payment* OR envelope payment* OR unlawful payment* OR unethical payment* OR corrupt payment* OR illegal payment* OR solicited payment* OR illicit payment* OR informal fee* OR unofficial fee* OR under-the-counter fee* OR under-the-table fee* OR envelope fee* OR unlawful fee* OR illegal fee* OR unethical fee* OR illicit fee* OR corrupt fee* OR bribe*) AND (health care OR healthcare OR health service* OR health care service* OR healthcare service* OR health procedure* OR healthcare system OR health care system OR primary care OR hospital OR health system* OR medic* OR physician* OR doctor* OR general practitioner* OR GP OR nurse*) AND Bulgaria	43
Wiley Online Library		**16/06/2020**
1	(“informal payment” OR “unofficial payment” OR “under the table payment” OR “under the counter payment” OR “envelope payment” OR “gratitude payment” OR “unlawful payment” OR “unethical payment” OR “corrupt payment” OR “illegal payment” OR “solicited payment” OR “illicit payment” OR “informal fee” OR “unofficial fee” OR “under the table fee” OR “under the counter fee” OR “envelope fee” OR “unlawful fee” OR “unethical fee” OR “corrupt fee” OR 6“illegal fee” OR “solicited fee” OR “illicit fee” OR “informal charge” OR “unofficial charge” OR “under the table charge” OR “under the table charge” OR “envelope charge” OR “unlawful charge” OR “unethical charge” OR “corrupt charge” OR “illegal charge” OR “solicited charge” OR “illicit charge” OR bribe*) in Abstract and (“health care” OR “healthcare” OR “health service” OR “healthcare service” OR “health care service” OR “health procedure” OR “primary care” OR hospital OR “health system”) in Abstract and Romania anywhere	5
2	(“informal payment” OR “unofficial payment” OR “under the table payment” OR “under the counter payment” OR “envelope payment” OR “gratitude payment” OR “unlawful payment” OR “unethical payment” OR “corrupt payment” OR “illegal payment” OR “solicited payment” OR “illicit payment” OR “informal fee” OR “unofficial fee” OR “under the table fee” OR “under the counter fee” OR “envelope fee” OR “unlawful fee” OR “unethical fee” OR “corrupt fee” OR “illegal fee” OR “solicited fee” OR “illicit fee” OR “informal charge” OR “unofficial charge” OR “under the table charge” OR “under the table charge” OR “envelope charge” OR “unlawful charge” OR “unethical charge” OR “corrupt charge” OR “illegal charge” OR “solicited charge” OR “illicit charge” OR bribe*) in Abstract	6

	and ("health care" OR "healthcare" OR "health service" OR "healthcare service" OR "health care service" OR "health procedure" OR "primary care" OR hospital OR "health system") in Abstract and Bulgaria anywhere	
Springer Link		**16/06/2020**
1	("informal payment" OR "unofficial payment" OR "under the table payment" OR "under the counter payment" OR "envelope payment" OR "gratitude payment" OR "unlawful payment" OR "unethical payment" OR "corrupt payment" OR "illegal payment" OR "solicited payment" OR "illicit payment" OR "informal fee" OR "unofficial fee" OR "under the table fee" OR "under the counter fee" OR "envelope fee" OR "unlawful fee" OR "unethical fee" OR "corrupt fee" OR "illegal fee" OR "solicited fee" OR "illicit fee" OR "informal charge" OR "unofficial charge" OR "under the table charge" OR "under the table charge" OR "envelope charge" OR "unlawful charge" OR "unethical charge" OR "corrupt charge" OR "illegal charge" OR "solicited charge" OR "illicit charge" OR bribe*) AND ("health care" OR "healthcare" OR "health service" OR "healthcare service" OR "health care service" OR "health procedure" OR "primary care" OR hospital OR "health system" OR medic* OR physician* OR doctor* OR "general practitioner" OR "GP" OR nurse*) AND Romania	142
2	("informal payment" OR "unofficial payment" OR "under the table payment" OR "under the counter payment" OR "envelope payment" OR "gratitude payment" OR "unlawful payment" OR "unethical payment" OR "corrupt payment" OR "illegal payment" OR "solicited payment" OR "illicit payment" OR "informal fee" OR "unofficial fee" OR "under the table fee" OR "under the counter fee" OR "envelope fee" OR "unlawful fee" OR "unethical fee" OR "corrupt fee" OR "illegal fee" OR "solicited fee" OR "illicit fee" OR "informal charge" OR "unofficial charge" OR "under the table charge" OR "under the table charge" OR "envelope charge" OR "unlawful charge" OR "unethical charge" OR "corrupt charge" OR "illegal charge" OR "solicited charge" OR "illicit charge" OR bribe*) AND ("health care" OR "healthcare" OR "health service" OR "healthcare service" OR "health care service" OR "health procedure" OR "primary care" OR hospital OR "health system" OR medic* OR physician* OR doctor* OR "general practitioner" OR "GP" OR nurse*) AND Bulgaria	113
PubMed		**16/06/2020**
1	((gratitude*[tiab] OR in formal[tiab] OR informal*[tiab] OR unofficial*[tiab] OR un official[tiab] OR illegal[tiab] OR under the counter[tiab] OR unethical[tiab] OR fals*[tiab] OR unlawful[tiab] OR illicit[tiab] OR corrupt*[tiab]) AND (pay*[tiab] OR charg*[tiab] OR fee[tiab] OR fees[tiab])) OR bribe*[tiab]	2,397
2	health service[tiab] OR health services[tiab] OR health care service[tiab] OR health care services[tiab] OR healthcare service[tiab] OR healthcare services[tiab] OR procedure*[tiab] OR	4,224,013

	health system[tiab] OR health care system[tiab] OR healthcare system[tiab] OR primary care[tiab] OR hospital[tiab] OR medic*[tiab] OR physician*[tiab] OR doctor*[tiab] OR general practitioner*[tiab] OR nurse*[tiab]	
3	1 and 2	1,134
4	Romania	37,722
5	Bulgaria	20,557
6	3 and 4	10
7	3 and 5	7
Web of Science		**16/06/2020**
1	ALL= (gratitude payment* OR informal payment* OR unofficial payment* OR under-the-table payment* OR under-the-counter payment* OR envelope payment* OR unlawful payment* OR unethical payment* OR corrupt payment* OR illegal payment* OR solicited payment* OR illicit payment* OR informal fee* OR unofficial fee* OR under-the-counter fee* OR under-the-table fee* OR envelope fee* OR unlawful fee* OR illegal fee* OR unethical fee* OR illicit fee* OR corrupt fee* OR bribe*)	14,827
2	ALL= (health care OR healthcare OR health service* OR health care service* OR healthcare service * OR health procedure* OR healthcare system OR health care system OR primary care OR hospital OR health system* OR medic* OR physician* OR doctor* OR general practitioner* OR GP OR nurse*)	15,992,163
3	#1 AND #2	3,978
4	ALL=Romania	291,288
5	ALL=Bulgaria	139,994
6	#3 AND #4	40
7	#3 AND #5	49
Oria		**16/06/2020**
	(in title) ("informal payment" OR "unofficial payment" OR "under the table payment" OR "under the counter payment" OR "envelope payment" OR "gratitude payment" OR "unlawful payment" OR "unethical payment" OR "corrupt payment" OR "illegal payment" OR "solicited payment" OR "illicit payment" OR "informal fee" OR "unofficial fee" OR "under the table fee" OR "under the counter fee" OR "envelope fee" OR "unlawful fee" OR "unethical fee" OR "corrupt fee" OR "illegal fee" OR "solicited fee" OR "illicit fee" OR "informal charge" OR "unofficial charge" OR "under the table charge" OR "under the table charge" OR "envelope charge" OR "unlawful charge" OR "unethical charge" OR "corrupt charge" OR "illegal charge" OR "solicited charge" OR "illicit charge" OR bribe*)	23

	AND **(in title)** ("health care" OR "healthcare" OR "health service" OR "healthcare service" OR "health care service" OR "health procedure" OR "primary care" OR hospital OR "health system" OR medic* OR physician* OR doctor* OR "general practitioner" OR GP OR nurse*) AND **(in any field)** Romania	
	(in title) ("informal payment" OR "unofficial payment" OR "under the table payment" OR "under the counter payment" OR "envelope payment" OR "gratitude payment" OR "unlawful payment" OR "unethical payment" OR "corrupt payment" OR "illegal payment" OR "solicited payment" OR "illicit payment" OR "informal fee" OR "unofficial fee" OR "under the table fee" OR "under the counter fee" OR "envelope fee" OR "unlawful fee" OR "unethical fee" OR "corrupt fee" OR "illegal fee" OR "solicited fee" OR "illicit fee" OR "informal charge" OR "unofficial charge" OR "under the table charge" OR "under the table charge" OR "envelope charge" OR "unlawful charge" OR "unethical charge" OR "corrupt charge" OR "illegal charge" OR "solicited charge" OR "illicit charge" OR bribe*) AND **(in title)** ("health care" OR "healthcare" OR "health service" OR "healthcare service" OR "health care service" OR "health procedure" OR "primary care" OR hospital OR "health system" OR medic* OR physician* OR doctor* OR "general practitioner" OR GP OR nurse*) AND **(in any field)** Bulgaria	48
Grey literature		
World Bank e-library		**16/06/2020**
	"informal payment" OR "informal payments" OR corruption OR bribe OR bribes OR gift **(anywhere)** AND health **(in Abstract)** Filtered by region: Europe and Central Asia OBS: the search function only allows for 7 search terms	
	Country filter: Romania	5
	Country filter: Bulgaria	3
IMF eLibrary		**16/06/2020**
	"informal payment" OR "informal payments" OR corruption OR bribe OR bribes OR gift OR gifts (full text) AND health (in title)	
	Country filter: Romania	1
	Country filter: Bulgaria	5
SSRN (Social Science Research Network eLibrary Database)		**16/06/2020**

	informal payment (Title, Abstract, Keywords & Full Text) – search within health	15
	Romania (after eligibility criteria screening)	4
	Buulgaria (after eligibility criteria screening)	2
WorldWideScience		**17/06/2020**
	Title: ((“informal payment” OR “unofficial payment” OR “under the table payment” OR “under the counter payment” OR “envelope payment” OR “gratitude payment” OR “unlawful payment” OR “unethical payment” OR “corrupt payment” OR “illegal payment” OR “solicited payment” OR “illicit payment” OR “informal fee” OR “unofficial fee” OR “under the table fee” OR “under the counter fee” OR “envelope fee” OR “unlawful fee” OR “unethical fee” OR “corrupt fee” OR “illegal fee” OR “solicited fee” OR “illicit fee” OR “informal charge” OR “unofficial charge” OR “under the table charge” OR “under the table charge” OR “envelope charge” OR “unlawful charge” OR “unethical charge” OR “corrupt charge” OR “illegal charge” OR “solicited charge” OR “illicit charge” OR bribe*)) AND Romania	310
	Title: ((“informal payment” OR “unofficial payment” OR “under the table payment” OR “under the counter payment” OR “envelope payment” OR “gratitude payment” OR “unlawful payment” OR “unethical payment” OR “corrupt payment” OR “illegal payment” OR “solicited payment” OR “illicit payment” OR “informal fee” OR “unofficial fee” OR “under the table fee” OR “under the counter fee” OR “envelope fee” OR “unlawful fee” OR “unethical fee” OR “corrupt fee” OR “illegal fee” OR “solicited fee” OR “illicit fee” OR “informal charge” OR “unofficial charge” OR “under the table charge” OR “under the table charge” OR “envelope charge” OR “unlawful charge” OR “unethical charge” OR “corrupt charge” OR “illegal charge” OR “solicited charge” OR “illicit charge” OR bribe*)) AND Bulgaria	352

Appendix 2. Summary of the literature included

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Bg	Delcheva, Balabanova, and McKee (1997)	Under-the-counter payments for health care: Evidence from Bulgaria	"To measure the extent of 'under-the-counter' payments for outpatient and inpatient care in Bulgaria;"	Article, quantitative, data collected through surveys administered during face-to-face interviews, in 1994 N=706 (non-representative sample) Recall period: 24 months Perspective: health care user	42.9% of the respondents paid cash for officially free services (outpatient and inpatient settings) Size (% of mean monthly income): Outpatient: 3%-8%, Inpatient: 3% (nursing care, auxiliary staff), 14% (drugs or dressing, hospital admission, physician) and 83% for surgery.
Bg	Balabanova and McKee (2002)	Understanding informal payments for health care: the example of Bulgaria	To estimate the extent and determinants of IPs, identify the benefactors of such payments, the characteristics and timing of these payments, as well as reasons for paying.	Article, mixed methods (quantitative and qualitative), data collected through nationally representative surveys administered during face-to-face interviews and semi-structured interviews in 1997, N= 1547 individuals (quantitative) (broadly representative population) N= 58 (25 physicians and 33 recent users) (qualitative). Recall period: lifetime Perspective: health care user and provider	19% (M) and 22%(F) answered they have ever paid or given a gift for at least one service in a public health setting. The qualitative interviews suggest, however, that these levels are underestimated. Timing of the transaction is key in distinguishing between a bribe or a gratitude gesture. Low income of staff, patients seeking better treatment, acute funding shortages and tradition are the main drivers of IPs. The authors, highlight that IPs are a product of socio-economic reality, rather than tradition.
Bg	Atanasova et al. (2013)	Out-of-pocket payments for health care services in Bulgaria: financial burden and barrier to access	To explore the scale of out-of-pocket payments (including IPs) and their affordability.	Article, quantitative, data collected in two nationally representative surveys, in 2010 and 2011, administered through face-to-face interviews N= 1003 (2010) nationally representative. N= 817 (2011) nationally representative. Recall period: 12 months Perspective: health care users	Outpatient 2010: 12.65% made IPs Outpatient 2011: 9.7% made IPs Inpatient 2010: 31.8% made IPs Inpatient 2011: 18.3% made IPs

Bg = Bulgaria, IPs = Informal payments, M = Male, F = Female

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Bg	Atanasova et al. (2014)	Informal payments for health services: the experience of Bulgaria after 10 years of formal co-payments	Determine the scale and type of IPs and public attitudes towards these payments.	Article, quantitative, data collected through a nationally representative survey, in 2010 administered through face-to-face interviews N = 1003 (nationally repr.) Recall period: 12 months Perspective: health care users	Outpatient: 12.8% made IPs Inpatient: 32.9% of the users paid informally More than 50% of the respondents have negative attitudes towards payments in cash, but 27% had positive attitudes towards in kind (gift) payments.
Bg	Stepurko et al. (2017)	Patterns of informal patient payments in Bulgaria, Hungary and Ukraine: a comparison across countries, years and type of services	Determine the scale and patterns of IPs in the outpatient and inpatient settings in three former socialist countries: *Bulgaria*, Hungary and Ukraine.	Article, quantitative, data collected in two nationally representative surveys, in 2010 and 2011, administered through face-to-face interviews N= 1003 (2010) (nationally repr.) N= 817 (2011) (nationally repr.) Recall period: 12 months Perspective: health care users	Outpatient 2010: 9.7% made IPs Outpatient 2011: 8.2% made IPs Inpatient 2010: 21.6% made IPs Inpatient 2011: 11.5% made IPs Outpatient 4.0% (IP for last physician visit between 2009-2011) Inpatient 14.4% (IP for the last hospitalization between 2009-2011)
Ro	Anderson et al. (2001)	Diagnostic Surveys of Corruption in Romania	To provide information on perceptions of the level of corruption as well as experiences of corruption.	Report, quantitative, secondary data analysis of 3 large scale governance and corruption surveys undertaken in 2000 by the World Bank and Management Systems International (MSI), data collected in 2000, three sample groups. *N = 1050 (households)* N = 417 (enterprises) N = 353 (public officials) Recall period: not stated Perspective: health care users	Results present from the household sample group. Perception: 47% of respondents believe that all or most officials in the health care sector are corrupt. Experience: paying “atenție”*: Outpatient (GP visit): 17% nonv, 32 v Inpatient (medical specialist): 33% nv, 52% v Inpatient (hospital stay): 37% nv. and 66% v. Reasons for paying: 45 % to receive proper or speedy care, 21 % out of tradition, 11 % to express gratitude

Ro = Romania, Bg = Bulgaria, IPs = Informal payments, * “atenție”, a Romanian word that can mean bribe, but it can also be understood by some individuals as tips or an expression of gratitude. nv = non-voluntary - either the payment was explicitly requested or the patients “just knew this is the way it goes, v = voluntary

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro	Farcasanu (2010)	Population perception on corruption, informal payments and introduction of co-payments in the public health system in Romania	To explore the public's opinion regarding the evolution of the health system in Romania, with a focus on access to medical services, and to identify how the population's needs and expectations are met in terms of health services.	Article, quantitative, data collected using a questionnaire that was administered through face-to-face interviews in 2009. N = 1213 (nationally repr.) Recall period: 12 months Perspective: health care users	20.5% of the respondents consider that corruption is the main "defect" of the Romanian healthcare system Most reported payments occurred in hospital setting (25.1% to physicians, 23.4% to nurses and 17.4% to hospital attendants). Some IPs are also reported to outpatient settings (9.6% to GP, 3.9% to GP nurse). Reasons: 46.2% receive more attentive care, 30.8% custom/ everybody does it 29.9% gratitude.
Ro	Cherecheş et al. (2011)	Informal Payments in the Health Care System - Research, Media and Policy	To explore how IPs "are approached in the media reports, in the specialized literature, as well as in the present policies related to this type of payments."	Article, document analysis, three sources: data from literature review, online media and legislative and public policy sources. N = 16 articles	The authors found that although IPs are recognized as being ubiquitous in the health care sector by the population and stakeholders alike (including the Health Ministry and National Insurance Fund officials), consistent and assumed regulations to address this issue are absent.
Ro	Moldovan and Van de Walle (2013)	Gifts or Bribes? Attitudes on Informal Payments in Romanian Health Care	To explore attitudes towards IPs and how individuals explain these attitudes.	Article, qualitative, vignettes combined with in-depth interviews. data collected in 2011. N = 41 (20 patients who had been hospitalized in the past 12 months or had relatives who were and 21 medical students). All participants were presented with the vignette scenarios that they had to score. Afterwards they were asked to explain their answers in the interview phase. The study reports quantitative analysis on the score of the vignettes for both groups, and qualitative analysis from the interviews with only the "patient" group.	Qualitative findings from the patient group: Overall, participants consider offering and asking informal payments (in kind such as gifts or services and in cash) as unacceptable. However, many confessed on making such payments. This translates to a weak link between attitudes and actual behavior. Many participants suggested that the reasons for making such payments relate to necessity and made reference to the low salaries of the medical personnel and lack of funding.

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro	Ungureanu et al. (2013)	A Brief Insight into the Study of Informal Health Care Payments in Romania	To offer a picture of IPs in Romania from patients' perspective.	Article, quantitative, data collected through telephone-administered questionnaires. N = 647 Recall period: Perspective: health care user	18.1% of the respondents made informal payments under the form of gifts and or services 29.8% of the payments were cost of medicine and 22.4% for food. The amount paid ranges from 2 EUR to 3000 EUR. Surgery was the place where most informal payments were directed to, as well as the most expensive gifts given to surgeons and highest amounts.
Ro	Manea (2015)	Medical Bribery and the Ethics of Trust: The Romanian Case		Article, qualitative.	The author identifies the following factors that may generate bribery (understood as a primate form of individual contractualism between patient and physician): - highly prices value of health - asymmetric relationship between patient and physician - low trust in institutions
Ro	Pitea (2015)	Conceptual delimitations of informal payments in the Romanian health care system	To analyze patients' perception on IPs, how they define IPs and the perceived consequences of such payments	Article, qualitative, data was collected through semi-structured interviews, between 11.2014 and 01.2015. N = 13 patients Recall period: Perspective: health care user	IPs in kind (gifts) are defined by respondents such as "little something, gift, sign of gratitude, gratitude, protocol". IPs in cash are defined as "bribe, stimulus, little something, sign of gratitude, blackmail". Respondents are aware they do not have to make IPs for services they are freely entitled to, but they point out the cultural tie to the act. IPs in cash are perceived as a positive thing is they are not requested by the physician, but rather offered as means of gratitude, while if they are requested, they are considered a bribe and should be punishable. IPs in kind are viewed as a way to show gratitude, and should not be punished.

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro	Agheorghiesei and Poroch (2016)	The Informal Payments and their Managerial Implications in the Medical System. An Analysis from the Perspective of the Values and of the "Gift Culture" in the Romanian People	To explore whether IPs can be explained by cultural factors specific to Romania	Article, qualitative. Data comprised of: Articles and studies on the topic of the Romanian cultural specificity.	Gift giving of Romanians is a national-cultural feature that is intensely debated by authors cited in the research. The assumption the authors made in the paper is that this cultural trait (giving gifts) coupled with other factors such as certain values relating to safety, sacrifice, hospitality, kindness and tolerance, as well as hierarchical submission, the importance of group opinion and attitude towards risk could represent aspects that explain IPs and their magnitude.
Ro	Onofrei and Gradinaru (2017)	The border between bribery and sponsorship of a medic-public servant, in the exercise of his duties	To analyze the situation of a medic (civil servant doing their duty) who has to request money from the patient for the provided medical services.	Article, qualitative, the paper does not have a methods section.	The authors conclude that by signing a sponsorship contract between a patient and a medical unit, from a legal point of view, does not have criminal connotations. Thus, there is no criminal responsibility that can be attributed to the physician.
Ro	Horodnic, Mazilu, and Oprea (2018)	Drivers behind widespread informal payments in the Romanian public health care system: From tolerance to corruption to socio-economic and spatial patterns	To evaluate the relationship between extra payments or valuable gifts (apart from official fees) and the level of tolerance of corruption, socio-economic and spatial patterns in order to explain IPs.	Article, quantitative. Secondary data analysis from the Special Eurobarometer No. 397 ("Corruption"), conducted as part of wave 79.1 of Eurobarometer Series. Data was collected through surveys administered during face-to-face interviews in 2013. A Tolerance Index to Corruption (TIC) was constructed by the authors based on the responses to 3 questions from the survey. N = 1030 Recall period: 12 months Perspective: health care user	28% of the respondents made IPs The mean tolerance of corruption score was 2.67 in Romania (where 1 is always acceptable and 3 never acceptable), while the score for Nordic nations was 2.87. Prevalence of IPs was strongly associated with higher levels of tolerance of corruption. Moreover, patients with high socio-economic risk, living in rural areas or less affluent areas are more likely to offer extra payments or valuable gifts for health care services.

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro	Antal and Baba (2018)	Informal payments in Romania: The medical personnel point of view. A preliminary Study	To determine the factors that generate IPs from the providers' point of view.	Preliminary study presented during the Transylvanian International Conference in Public Administration (11.2017). Quantitative, data collected via e-mail and social networks. N = 140 (74.6% doctors, 23.6% nurses working in public health care settings) Perspective: provider	Medical staff do not consider acceptance of IPs to be a determinant factor for quicker access or better quality of health care services. The main factor for acceptance of IPs recognized by the medical personal was their underpayment. The second two main reasons were because of the custom of accepting such "gifts" and that such practices (patients offering IPs) are an expression of gratitude. Findings were inconclusive on whether increasing the wages would decrease the levels of IPs.
Ro & Bg	Stepurko, Pavlova, and Gryga (2011)	Informal patient payments and public attitudes towards these payments: evidence from six CEE countries	"To compare public attitudes towards in formal patient payments and payment experience in six Central and Eastern European: *Bulgaria*, Hungary, Lithuania, Poland, *Romania*, and Ukraine."	Article, quantitative, data collected through nationally representative surveys administered through face-to-face interviews in 2010. N = about 1000 per country, precise sample size not specified, (nationally repr.) Recall period: 12 months Perspective: health care user	**Romania**: 65.2% visited a physician, and 54.2% made an informal payment (either cash or in kind) Attitude towards informal cash payment: negative 72.3 %, indifferent 18.0%, positive 9.7% Attitude towards giving gifts in kind: negative 65.0%, indifferent 20.4%, positive 14.7%
					Bulgaria: 75.5% visited a physician and 12.6% made an informal payment (either cash or in kind) Attitude towards informal cash payment: negative 84.8%, indifferent 10.4%, positive 4.9% Attitude towards giving gifts in kind: negative 54.5%, indifferent 18.7%, positive 26.8%

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	European Commission (2013)	Study on Corruption in the Healthcare Sector	To provide a better understanding of the size, nature and impact of corrupt practices in the health care setting across the EU.	Report, qualitative Desk research, interviews with European Commission officials and other representatives and field research where 3-4 interviews were conducted with health care and anti-corruption stakeholders. Desk research and filed work conducted between 12.2012 and 03.2013. Specific number of interviews per country was not reported	**Romania**: Findings on corruption on the side of medical service delivery are scarce. IPs seem to be the largest problem **Bulgaria**: According to the interviewees, Bulgarian patients do not know what is covered by the health insurance package, what part of a treatment they can receive for free and what fees they have to pay. Health care providers often take advantage of information asymmetry thus resulting in a large number of IPs
Ro & Bg	Stepurko et al. (2013)	Informal payments for health care services – Corruption or gratitude? A study on public attitudes, perceptions and opinions in six Central and Eastern European countries	"To compare the public perceptions towards informal patient payments in six Central and Eastern European countries (*Bulgaria*, Hungary, Lithuania, Poland, *Romania* and Ukraine)"	Article, quantitative, data collected through nationally representative surveys administered through face-to-face interviews in 2010 N = 1000 (Romania) (nationally repr.) N = 1003 (Bulgaria) (nationally repr.) Recall period: 12 months Perspective: health care user	**Romania**: 58.8% payments in cash ,62.4% gift in kind, 21.7% were personally asked to pay informally or offer a gift in kind Attitude towards informal cash payment: negative 72.3 %, indifferent 18.0%, positive 9.7% Attitude towards giving gifts in kind: negative 65.0% indifferent 20.4% positive 14.7% Romanians are more likely to associate IPs with gratuity and accept low health care funding as an excuse for it. **Bulgaria**: 19.5% payments in cash, 45.6% gift in kind, 17.1% were personally asked to pay informally or offer a gift in kind. Attitude towards informal cash payment: negative 84.8%, indifferent 10.4%, positive 4.9%. Attitude towards giving gifts in kind: negative 54.5%, indifferent 18.7%, positive 26.8%. The less positive attitudes and perceptions towards IPs can be attributed to anti-corruption policies in the country.

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
					Bulgarians less often agree that IPs are inevitable and have a stronger support for their eradication.
Ro & Bg	Tambor et al. (2013)	"To review the formal–informal patient payment mix in European countries."	To review the formal-informal payment mix in European countries and outline factors associated with it.	Article, quantitative, secondary country-level data was used for 35 European countries. Countries were classified into groups based on the data on patient IPs in the countries. The classification was guided by three dimensions of the formal-informal payment mix: scope of formal payments, spread of IPs and level of total out-of-pocket expenditure.	**Romania** was put in Group 7, with OOP payments <= median, narrow scope of formal payments (obligatory/unavoidable charges for services in the basic insurance package are not present) and widespread informal payments. **Bulgaria** is in Group 9, with OOP > median, broad scope of formal payments (obligatory/unavoidable charges for services in the basic insurance package are present) and widespread informal payments.
Ro & Bg	European Commission (2014)	Special Eurobarometer 397 / Wave EB79.1 "Corruption"	To assess the anti-corruption efforts of EU Member States	Report, quantitative, data was collected through face-to-face interviews using a survey, between 23 Feb and 10 March 2013. N = 1030 (Romania) N = 1000 (Bulgaria) Recall period: 12 months Perspective: health care user	**Romania**: was asked or expected to pay a bribe (healthcare: 22%) Made extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees) 28% (highest in the EU) *Circumstances*: Felt that they had to give an extra payment or valuable gift and did so before care was given: 50%. Felt that they had to give an extra payment or valuable gift and did so after care was given 28%. Doctor/nurse expected an extra payment or valuable gift following the procedure 28% Asked to go for private consultation in order to be treated in public hospital 19% Doctor/nurse requested an extra payment or valuable gift in advance 6%

					Bulgaria: was asked or expected to pay a bribe (healthcare: 7%). Made extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees) 8% *Circumstances*: Felt that they had to give an extra payment or valuable gift and did so before care was given: 15% Felt that they had to give an extra payment or valuable gift and did so after care was given 32% Doctor/nurse expected an extra payment or valuable gift following the procedure 11% Asked to go for private consultation in order to be treated in public hospital 7% Doctor/nurse requested an extra payment or valuable gift in advance 24%

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	Tambor et al. (2014)	The inability to pay for health services in Central and Eastern Europe: evidence from six countries	"To explore the inability to pay for health services in six CEE countries: *Bulgaria*, Hungary, Lithuania, Poland, *Romania* and Ukraine."	Article, quantitative, data collected through nationally representative surveys administered through face-to-face interviews in 2010 N = 1000 (Romania) N = 1003 (Bulgaria) Recall period: 12 months Perspective: health care user Nationally repr. samples	**Romania**: 36.2% of the respondents made IPs in the outpatient setting 48.4% of the respondents made IPs in the inpatient setting Amount in EUR (median value): outpatient: 23.3 EUR, inpatient: 46.5 EUR The results show that Romania and Ukraine face the greatest burden of payment. **Bulgaria**: 9.5% of the respondents made IPs in the outpatient setting 19.8% of the respondents made IPs in the inpatient setting Amount in EUR (median value): outpatient: 15.0 EUR, inpatient: 10.0 EUR OOP payments are common in Bulgaria, however most of them are formal and small.
Ro & Bg	Stepurko et al. (2015)	To pay or not to pay? A multicountry study on informal payments for health-care services and consumers' perceptions	To examine the association between informal payments for health-care services and perceptions of health-care consumers about paying informally as well as socio-demographic characteristics.	Article, quantitative, data collected through nationally representative surveys administered through face-to-face interviews in 2010 N = 1000 (Romania) N = 1003 (Bulgaria) Recall period: 12 months Perspective: health care user. Nationally representative samples	**Romania**: 34.5% of the respondents made IPs -last 12 months Amount -either cash or in-kind (EUR) -median 36.6 Ever paid informally (cash or in-kind) 71.2% Ever been asked to pay informally 21.7% *Behavior statements (perceptions):* Uncomfortable to leave without giving gifts -22.1%% Recognize hint of IPs - 65.2% Refuse to pay if asked to give IPs -35.8% Prefer to use private health care because of IPs - 49.4% Ready to pay informally in case of serious health problems 60.4% **Bulgaria**: 12.2% of the respondents made IPs – last 12 months Amount -either cash or in-kind (EUR) -median 12.8 Ever paid informally (cash or in-kind) - 49.9% Ever been asked to pay informally - 17.1% *Behavior statements (perceptions):* Uncomfortable to leave without giving gifts - 6.8% Recognize hint of IPs -64.7% Refuse to pay if asked to give IPs - 54.8% Prefer to use private health care because of IPs 50.7% Ready to pay informally in case of serious health problems 42.7%

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	Stepurko, Pavlova, and Groot (2016)	Overall satisfaction of health care users with the quality of and access to health care services: a cross-sectional study in six Central and Eastern European countries	To compare the satisfaction of health care users with outpatient services and inpatient services.	Article, quantitative, data collected through nationally representative surveys administered through face-to-face interviews in 2010 N = 1000 (Romania) (nationally repr.) N = 1003 (Bulgaria) (nationally repr.) Recall period: 12 months Perspective: health care user	**Romania**: outpatient -34.6% of the respondents made IPs inpatient -56.8% of the respondents made IPs **Bulgaria**: outpatient -12.4% of the respondents made IPs inpatient -26.3% of the respondents made IPs
Ro & Bg	Williams, Horodnic, and Horodnic (2016)	Who is making informal payments for public healthcare in East-Central Europe? An evaluation of socio-economic and spatial variations	To report a survey conducted in 11 CEE countries and identify who is more likely to make IPs.	Article, quantitative, used data from the Special Eurobarometer No. 397 ('Corruption'), conducted as part of wave 79.1 of Eurobarometer Series. Data for the survey was collected through face-to-face interviews using a survey, between 23 Feb and 10 March 2013 Sample size per country not specified in the article (around 1000 per country).	**Romania**: 28% of respondents who used medical services made IPs *Situations for IPs occurrence:* Before care was given – 50% After care was given – 28% Requested in advance – 6% Expected following the procedure – 28% For a privileged treatment – 7% **Bulgaria**: 8% of respondents who used medical services made IPs *Situations for IPs occurrence*: Before care was given – 15% After care was given – 28% Requested in advance – 24% Expected following the procedure – 11% For a privileged treatment – 11%

CEE = Central and Eastern Europe

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	European Commission (2017)	Special Eurobarometer 470 – Wave EB88.2 “Corruption”		Report, quantitative, data was collected through a survey administered during face-to-face interviews in 2017. N = 1055 (Romania) N = 1027 (Bulgaria) Recall period: 12 months Perspective: health care user	**Romania**: 19% (highest in the EU) made and extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees 58% of Romanians find corruption unacceptable Belief that bribery and the abuse of power for personal gain were widespread in the health care system: 58%
					Bulgaria: 8% made and extra payment or valuable gift to a nurse or doctor, or make a donation to the hospital (apart from official fees) 61% of Bulgarians find corruption unacceptable Belief that bribery and the abuse of power for personal gain were widespread in the health care system: 60%
Ro & Bg	Habibov and Cheung (2017)	Revisiting informal payments in 29 transitional countries: The scale and socio-economic correlates	To assess IPs in 29 transitional countries using a fully comparable household report.	Article, quantitative, data used from 2010 Life-in-Transition (LTS) country survey. Data was collected through face-to-face interviews where the questionnaire was administered. N = 1065 (Romania) N = 966 (Bulgaria) Recall period: 12 months Perspective: health care user	**Romania**: 44.05% of the respondents made IPs
					Bulgaria: 13.61 % of the respondents made IPs

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	Slot et al. (2017)	Updated Study on Corruption in the Healthcare Sector - Final Report	To analyze and report on the development of corruption since the previous study and to provide an in-depth analysis for selected issues.	Report, qualitative. The data comprised of desk research, online survey sent to stakholders, thematic interviews with various organization in the field of health care and a fact-finding mission focused on 6 countries (Romania among them). N = 5 surveys and 7 interviews (Romania) N = 2 surveys	**Romania**: IPs are among the most common types of corruption in the country. IPs are partly motivated by the custom of gift giving, paradoxically such payments are given in advance for (faster) access or better health care. IPs are not limited to physicians, nurses, catering people and cleaners may also receive such payments. Stakeholders suggest that low salaries of the medical staff are a trigger to accept bribes and raising the wages would convince physicians to refuse bribes. The stakeholders point, however, the fact that raising salaries would not solve the issue, as it is very common to offer bribes (particularly gifts after the health care service was provided), which is a cultural factor.
					Bulgaria: According to the Bulgarian patients' organization, young physicians are pressured by older physicians to ask patients for informal payments. This is widespread in Bulgaria.

	Auhtor(s) (Year)	Title	Aim	Research type, methods and sample	Key Findings
Ro & Bg	Williams and Horodnic (2018a)	Evaluating the prevalence of informal payments for health services in Southeast Europe: an institutional approach	"To explain the prevalence of IPs in SE Europe through the lens of institutional theory as resulting from formal institutional failures which lead to an asymmetry between the laws and regulations (formal institutions) and the unwritten rules (informal institutions), making informal payments acceptable."	Article, quantitative, used data from Special Eurobarometer No. 397 ('Corruption'), conducted as part of wave 79.1 of the Eurobarometer survey. Data for the survey was collected through face-to-face interviews between 23 Feb and 10 March 2013 N = 465 (Romania) N = 631 (Bulgaria) Recall period: 12 months Perspective: health care user	**Romania**: 30% of respondents made IPs Amount (EUR): 1-50 EUR 54% 51-100 EUR 14% 101-200 EUR 28% >200 EUR 4% **Bulgaria**: 8% of the respondents made IPs Amount (EUR): 1-50 EUR 45% 51-100 EUR 22% 101-200 EUR 11% >200 EUR 22%
Ro & Bg	Williams and Horodnic (2018b)	Explaining informal payments for health services in Central and Eastern Europe: an institutional asymmetry perspective	To propose and evaluate a new institutional theory in order to explain why patients make IPs in CEE.	Article, quantitative?, data used from the Special Eurobarometer No. 397 ('Corruption'), conducted as part of wave 79.1 of the Eurobarometer survey. . Data for the survey was collected through face-to-face interviews in 2013 N = 470 (Romania) N = 806 (Bulgaria) Recall period: 12 months Perspective: health care user	**Romania**: 30% of those using healthcare services made IPs Institutional asymmetry score: 2.40 of patients who make IPs and 2.74 of patients who do not pay informally **Bulgaria**: 9% of those using healthcare services made IPs Institutional asymmetry score 2.48 of patients who make IPs and 2.70 of patients who do not pay informally

SE= Southeastern Europe, CEE = Central and Eastern Europe