



## Informal payments in public hospitals in Greece

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### Abstract

Informal payments are an ingrained social institution in Greece. In some cases, they are also part of corruption in the health area, which includes a variety of other forms.

*Objective:* The objective of this paper is to measure and analyze the size and nature of informal payments in the Greek public hospitals, concentrating on payments made to health personnel to facilitate access to services and preferred providers.

*Methods:* We used a randomized countrywide sample of 1616 households, amounting to 4738 individuals. The survey methodology was telephone interviews with a questionnaire supported by the software of Computer Assisted Telephone Interviewing.

*Results:* Out of the total number of those reporting treatment in public hospitals ( $N = 336$ ), 36% reported at least one informal payment to a doctor. Of these, 42% reported it was given because of the fear of receiving sub-standard care (if they did not pay) and another 20% claimed that the doctor demanded such a payment. None of the socio-economic characteristics of the family were related to the size of extra (informal) payments. The probability of extra payments is 72% higher for patients aiming to “jump the queue”, compared to those admitted through normal procedures. Also, surgical cases had a 137% higher probability for extra payments compared to non-surgical patients.

*Conclusions:* A very high percentage of informal payments are made in order to gain access to public hospitals and to receive a higher quality of services. Despite near universal coverage of the population by public health insurance, informal payments are widespread and a major source of inequity and inefficiency in the Greek health care system.

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## 1. Introduction

### 1.1. Informal payments in health: an overview

According to Transparency International (2006), in the beginning of the 21st century, more than US \$3 trillion are spent annually on health worldwide. In the US

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alone, it is estimated that 5–10% of the expenditures by Medicare and Medicaid, is lost to “overpayment” [1]. In another study, it was found that corruption boosted the price of hospital supplies by 15% [2]. Similar calculations for many countries show that money, which could save lives, suffering, and pain is wasted to “excessive” costs. At a time when public expenditure for health is becoming increasingly hard to secure, corruption in the health area assumes an added ethical significance, often connected directly with loss of life.

The issue of *informal payments* is inevitably linked to *corruption*, defined as “the use of public office for private gains” [1]. This includes deliberate under-performance as well as user corruption, in which staff solicits payments which are formally unnecessary or alter decisions to favour specific clients [3]. The most common type of informal payment is where providers exploit their power or market position in order to extract a payment from patients. Market power derives from a provider’s monopoly or near monopoly position combined with the principal-agent relationship between practitioner and patient. There are many ways in which this could occur. One is where providers hold up treatment until a payment is made. Another is where someone with power deliberately creates a bottleneck in the provision of a service, which can be exploited by rationing to those that pay [4].

Concerning the impact of informal payments on efficiency and equity, it is important to distinguish whether patients give voluntarily or feel obliged to pay. A voluntary gratitude payment is thought not to alter either resource allocation or the distribution of services. A ‘compulsory’ payment, on the other hand, may deter the poor from utilizing health services, or place a disproportionate cost burden on their shoulders. This is not just an equity problem, but it also adversely affects resource allocation, insofar as services are not consumed by those who would benefit most. In the best case, and due to the often-urgent nature of health needs, the need for informal payments may cause a person to forgo other essential expenditure in order to afford the health services required. Even if informal payments are given voluntarily, from the equity perspective any difference between paying and non-paying patients implies unequal access for equal needs. Furthermore, the relationship between

supply and demand (or need) determines the impact of informal payment on efficiency, and in this respect it becomes important if physicians manipulate supply (supplier-induced or reduced demand) [5]. This is clearly the case with caesarean sections, the rate of which in Greece is currently by far the highest in the world. Mossialos et al. have shown that 60% of deliveries by Greek women are through caesarean section in both public and private hospitals. Interestingly, this figure declines to 5% for Greek Roma women and 7% for immigrants, two categories with low incomes, accounting for 60% of all deliveries in public hospitals [6].

Some researchers have also documented positive aspects of informal payments in some countries. For example, studies have found that informal payments are thought to create continuous relationships between patients and providers, improve staff morale, keep health workers from leaving the public system altogether, and allow patients to show respect to providers who please them [7].

Informal payments are very common in sustaining health care systems in many countries of the Former Soviet Union and Central and Eastern Europe, although there is considerable variation between countries. While 91% reports paying for public care in Armenia, the proportion drops to 60% in the Slovak Republic and 22% in Albania [4]. Surveys of patients undertaken in Bulgaria, Poland and Turkmenistan found that 43%, 46% and 50%, respectively paid for services that were officially free. In another survey conducted at the place of work in Estonia, 15% of physicians reported receiving money from patients in the form of tips in the previous week [8].

### 1.2. An overview of the Greek health care system

Greece established a National Health System in 1983 with the aim to expand coverage and reduce inequities in finance, access, and resource allocation. Yet the system is still characterised by centralization, fragmentation of coverage, problematic access to health services, and heavy reliance on relatively expensive inputs [9]. The Greek health care system is a “mixed” system, with elements of both the Bismarck and the Beveridge models. Funding is open-ended and mainly demand-led [10]. According to the 2004 OECD

figures, 23.3% was funded by general taxation, 29.5% by social insurance, and 45.2% by private payments (out-of-pocket and private insurance). Private insurance coverage is low (2.1% in 2004) [11] despite high direct payments. One reason for this may be a reluctance of individuals, in addition to other cultural and historical factors [9].

Out of pocket payments account for 43.1% of total health expenditure in 2004 [11]. This is one of the highest levels of dependence on out of pocket payments in Europe. The majority of out of pocket expenditure is direct and informal payments for health services, as user charges represent a very small proportion of out of pocket expenditure [12]. In public hospitals, there is a charge of €15 per admission and €3 per visit in regular outpatient clinics. Also, there are extra charges for hospitalization in wards with advanced hotel facilities. All these kind of legal charges are well defined and well known to public.

The issue of informal payment deserves particular attention as they constitute one of the main problems in the Greek health care system. Because of the patchy development of health coverage and the fact that it has never been comprehensive, informal payments developed as a complement to public funding [13]. Although private practice for public hospital doctors has been forbidden since 1983 (they are employed as full time civil servants, paid on a salaried basis), many doctors have illegal private practices or ask for informal payments. The exact extent of the phenomenon is unknown, and in 2002 the government attempted to partly legalize private practice for public hospital doctors in order to formalize some of the informal payments. Although relatively few physicians have taken up this practice, the number is increasing. There have been few formal evaluations of this measure, offering several explanations for its limited uptake so far. Surgeons, for example, appear to have no incentive to enter this partial private practice since the legal fee level is lower than actual (tax-free) informal payments [9].

When a group of foreign experts, led by the late Brian–Abel Smith was invited to study the Greek health care system in 1994, one of the findings, recorded in the international literature, was the ubiquitous “fakellaki” (Greek for small envelope) [14]. It is not surprising that, according to our National Statistical Service data, concerning the 2007 recalculation

of the national GDP figures, private current expenditure for health was revised upwards from € 7128 million to € 10,981 in 2004. The inclusion of part of the previously unrecorded expenditure, often referred to the “black” economy, raised the share of private payments in health in 2004 from 46.1 to 55.4% after the revision.

### 1.3. Objective of the study

Informal payments in public hospitals amount to about 10% of the total “black” or “underground” economy” in the Greek health care system [15], albeit the most unacceptable from the ethical point of view. Surprisingly, there have been few attempts to study this phenomenon, only part of which is dealt with in this paper. Our objective is to describe and measure the practice of informal payments (extra fees/payments and gratuities) to doctors in public hospitals (only for inpatient care), presumably made to facilitate patient access to services and preferred providers. We also, studied the practice of tips to nurses and nurse assistants, both in public and private hospital. Other forms of private payments for amenities (TV sets, private phones) or other supplies were excluded, as their use is completely at the discretion of the patient.

## 2. Materials and methods

A telephone survey was conducted utilizing a questionnaire developed by specialists in the area of health systems and health economics. The questionnaire contained two main parts: (a) The first part had two sections designed to record the frequency of use and the magnitude of informal payments for hospital services for each member of the household during the last 12 months. The first section included questions on the frequency of hospital admissions (public or private) and the incidence and magnitude of voluntary tips and gratuities to nurses and nurses’ aides in public and private hospitals, as well as a question on whether a surgical procedure took place. This section also had questions relating to patient satisfaction with the use of a scale from 1 to 10. The second section concerned only patients treated in public hospitals. It included questions on admission procedures, access, waiting time for admission, the frequency and size

Table 1  
Socio-economic profile of respondents

	No of families	%	Cumulative total%
Urbanization of place of residence <sup>a</sup>	1616	100	
Rural area	372	23	23
Rurban area	237	14.7	37.7
Urban area without University Hospital	344	21.3	59
Urban area with University Hospital	80	5	63.9
Thessaloniki (second largest city of Greece)	121	7.5	71.4
Athens	462	28.5	100
Number of family members	1616	100	
1 member	118	7.3	7.3
2 members	530	32.8	40.1
3 members	312	19.3	59.4
4+ members	656	40.6	100
Sum	4738		
Net monthly family income	1616	100	
Less than €1000	590	36.5	36.5
€1000–2000	760	47	83.5
€2000–3000	209	12.9	96.4
€3000–€4000	36	2.22	98.62
More than €4000	21	1.3	100
Educational status of the family head <sup>b</sup>	1616	100	
Lower	599	37.1	37.1
Middle	504	31.2	68.3
Higher	513	31.7	100

<sup>a</sup> Rural area: population <2000 residents/Rurban area: population 2000–10,000 residents/Urban area: population >10,000 residents.

<sup>b</sup> Lower: None – primary school (0–6 years)/middle: high school, senior high or technical institutes (9–14 years)/higher: University or colleges (>14 years).

of informal payments to doctors, as well as the reasons for such payments. As informal payments we considered all payments (extra fees and gratuities) to doctors for services which are theoretically provided free-of-charge. (b) The second part of the questionnaire referred to the demographic and socio-economic characteristics of the household. We intentionally placed this part at the end of the interview, in order to facilitate answers to the first and more sensitive part.

The study sample was created by random stratified selection from the 2004 National Telephone Company Directory. All numbers were categorized according to the 2001 National Census by region, prefecture, municipality, and urbanization level. Telephone numbers were categorized by their distribution in professional and domiciliary categories, and we limited our search in the latter category. The ratio of the sum of non professional (domiciliary) numbers to the desired sam-

ple size was used to determine the “call step” out of the total pool of non-professional numbers. The process was supported by the specialized software CATI (Computer Assisted Telephone Interviewing). In total, 13,661 calls were made, from which resulted 1616 “successful” interviews (response rate 11.8%). The interviewers asked to speak with the head of household defined as the major income-earner or the housewife. If that person had made an informal payment on behalf of someone else (e.g. for a child), they would respond “yes”. For each member of the household reporting hospital treatment, a separate entry was made in the SPSS data base. The total survey sample was the sum of the members of the 1616 households, amounting to 4738 individuals. Data on the socio-economic profile of respondents are shown in Table 1.

We recorded data on the SPSS statistical package specially designed for the data base analysis. We

Table 2  
Multivariate analyses that were performed

Independent variables	Dependent variables	Investigated hypotheses: dependent/independent variables
(a) Urbanization of place of residence Rural area Urban area Urban area without University Hospital Urban area with University Hospital Thessaloniki (second largest city of Greece) Athens	(1) Size of extra payments to doctors in public hospitals  (2) Probability of giving tips to nurses and nurse assistants in hospitals  (3) Probability of extra payments to doctors in public hospitals	1/a, b, c, d, e, f, g  2/a, b, c, d, i  3/a, b, c, e, f, g
(b) Net monthly family income Less than €1000 €1000–2000 €2000–3000 €3000–4000 More than €4000	(4) Probability of hospitalization in private hospital	4/a, b, c, h
(c) Educational status of the family head Lower Middle Higher		
(d) Satisfaction with the hospitalization (public–private hospital)		
(e) Waiting time for admission in public hospital		
(f) Surgery performance (0 = no, 1 = yes)		
(g) Method for gaining admission to public hospitals (0 = No intermediation, 1 = with intermediation)		
(h) Coverage from private health insurance (0 = no, 1 = yes)		
(i) Hospitalization in private hospital		

used the Student *t*-test to check whether the mean values of continuous variables between two groups varied significantly, after the necessary distribution normality checks with the Kolmogorov–Smirnov test. Where the normality assumption did not hold, we used the non-parametric Mann–Whitney test. To test for independence between two categorical variables we used the Pearson  $\chi^2$  test. We used linear regression analysis to determine the extent to which social and economic household characteristics had an influence on the frequency of use of certain health services and the size of household payments for such services. The influence of these characteristics on informal payments was investigated with the use of logistic regression. The hypotheses tested appear in Table 2. In all statistical analyses we used the  $p < 0.05$  level of significance. In the Tables below we show the final

results of the linear or logistic regressions carried out.

### 3. Results

Out of 336 patients treated in public hospitals, 36% reported at least one informal payment to a doctor. Of those treated in public hospitals, 19% consider these informal payments as extra fees and 17% reported informal payments as a voluntary “tip or gratuity (Table 3)”. According the reports of the respondents, it is remarkable to note the low resistance of doctors to informal payments, as only in 4% of the cases the doctor refused to receive a payment, when offered. An equally low (4%) number of patients refused to pay an additional fee, even when one was demanded.

Table 3

The incidence of informal payments in Greek public hospitals as a % of those admitted in the last year ( $N=336$ )

I was neither asked nor offered to pay	56%
I gave additional payment (extra fee)	19%
I gave a gratuity	17%
I offered but the doctor refused	4%
I was to pay but I refused	4%

### 3.1. The reasons for informal payments

Respondents were asked to choose the “best” response among the choices shown in Table 4. In the majority of the cases, the patient seems to seek better quality of care. In 42% of the cases (Table 4) the answer was “because of the fear I will receive sub-standard care, if I don’t pay”. In 20% of the cases it is reported that the “doctor demanded payment”. For almost a fifth (18%) of the cases, additional payments to doctors seem to be an ingrained part of the Greek culture. Those making such a payment report that they did it “because everybody does it”. Another 18% of respondents seem to consider such payments as a necessary and fitting expression of gratitude at the end of their stay in the hospital (Table 4). A very small number (2%) of patients pay department directors to validate Social Security reimbursement for treatment abroad.

A very high percentage of informal payments seem due to access problems. Admission times are restricted to certain days and certain hours. Very often, admission is facilitated by intermediation by a third party, usually a hospital doctor or administrator (“jumping the queue”). Although no reliable data exist, the phenomenon is considered to be widespread, and it usually occurs when admission is labelled as “urgent”. Our results show that 48.5% of admissions were considered “urgent”, and for almost 40% of those treated in a public hospital, intermediation to gain access by a “third party”, usually another doctor was involved (Table 5).

Table 4

The reasons for informal payments to doctors in Greek public hospitals as % of those reporting such payments ( $N=122$ )

Because of the fear, that I will receive sub stand care if I don’t pay	42%
Doctor asked for money in order to operate me	20%
As an expression of gratitude	18%
Because everybody does it	18%
Certificate for treatment abroad	2%

Table 5

Method for gaining admission to public hospitals as % of total admissions to public hospitals ( $N=336$ )

No intermediation	61%
Recommended by a doctor outside the hospital	13%
Personal friendship with hospital doctor	12%
Through a friend who recommended me to a hospital doctor	11%
Through another person (not a hospital doctor)	3%

Table 6

Logistic regression coefficients (b), odds ratios (OR), 95% confidence intervals (CI), and  $p$ -value

Waiting time for admission	$b$	OR (95% CI)	$p$ -Value
1 day (reference category)			
10 days	1.22	3.38 (1.13–10.1)	0.029
15 days	1.33	3.8 (1.3–11.1)	0.015

Probability for admission in a public hospital through normal procedures compared to the independent variable of waiting time (in days).

Logistic regression showed that patients waiting for 10 or 15 days for admission had 3.3 and 3.8 times, respectively, higher probability to be admitted through normal procedures, without intermediation, compared to those waiting for a day or less (Table 6).

Logistic regression also showed that the odds of making an extra payment to public hospital doctors is 1.72 times higher for patients admitted with some form of intermediation compared to those admitted through normal procedures. We also found that the odds of making an extra payment is 2.37 times higher for surgical cases compared to non-surgical patients (Table 7). Additionally, we found that none of the socioeconomic characteristics seem to be related with the probability of extra payments to doctors in public hospitals.

Concerning the amounts of informal payments to doctors, the average sum requested as an extra pay-

Table 7

Logistic regression coefficients (b), odds ratios (OR), 95% confidence intervals (CI), and  $p$ -value

Independent variables	$b$	OR (95% CI)	$p$ -Value
Surgery			
No (reference category)			
Yes	0.865	2.37 (1.34–4.18)	0.003
Method for gaining admission to public hospitals			
No intermediation (reference category)			
With intermediation	0.545	1.72 (0.99–2.99)	0.054

Probability of extra payments to doctors for the independent variables of “surgery” and “method for gaining admission to public hospitals”.

Table 8

Amounts paid as extra fees/payments and gratuities to doctors in public hospitals out by those reporting such payments (for inpatient care only)

	N	Mean sum	95% CI	Standard deviation	Median sum	Min.–Max.
Extra fees/payments	66	€535	253.4–816.6	1091.2	300	€50–8000
Gratuities	56	€279.38	173.66–385.1	299.041	200	€20–1500

ment is €535. The distribution is skewed, as we note payments up to €3500 or even €8000, but in 81.7% of the cases, they do not exceed €500. The mean sum for gratuities is €280 (Table 8), with 65.6% of the cases under €250.

We used linear regression to determine the factors affecting the size of extra payments by those hospitalized in public hospitals and reporting such payments. We found that none of the socio-economic characteristics of respondents is related to the size of extra payments. We also found that the size of the extra payment is not significantly correlated either with the level of satisfaction (mean = 7.67), or with the waiting time (and the method of gaining admission, with or without intermediation) for admission (mean = 5 days), even though both of these variables display a wide range of values.

Besides doctors, informal gift payments are made to nurses, nurse assistants, and other para-medical personnel, usually in the form of *Baksheesh* (originally a Persian word, meaning alternatively “tip”, “alms”, and “bribe”). Out of those reporting at least one hospital admission, 11% ( $N=41$ ) gave such a tip to a nurse at least once, and 8.5% ( $N=32$ ) gave a tip to a nurse assistant or other employee. The average tips were €37 and €24 (Table 9). In these cases, however, there is a problem with memory recall, as small sums are easier to forget, and these tips to nurse assistants, are probably underestimated.

Logistic regression showed that the odds of offering a tip to a nurse are 2.7 times higher for a member of a family headed by a person with higher education relative to one with lower education. We also found that the odds of such tips are 2.1 times higher in a private hospital compared to a public hospital (Table 10).

This is probably due to higher satisfaction in private hospitals (mean = 8.63, 95% CI: 8.3–8.96) compared to public hospitals (mean = 7.67, 95% CI: 7.45–7.89), a difference found to be statistically significant ( $p=0.000$ ). However, the odds of being treated in a private hospital is much higher for families with monthly income of more than €1000 compared to families with a monthly income of less than €1000 (Table 11). This probably also influences the probability of a tip to a nurse.

Finally, we found that the probability of offering a tip to nurse assistants is not related to the type of hospital (public or private) or to the socio-economic characteristics of the family.

#### 4. Discussion and conclusions

Informal payments to doctors in public hospitals were reported by four out of ten respondents reporting at least one admission to public hospitals. The percentage is somewhat lower than the 48% reported in a previous study [16], concerning patients in the Greater Athens Area where per capita incomes are higher. The most frequently cited reasons for informal payments are related to the quality of care, “because of the fear that I will receive sub-standard care, if I don’t pay”—42%, and a request by the doctor, “he asked me to operate on me—20%. Only 18% of those reporting an informal payment did so as an expression of “gratitude”.

None of the socioeconomic characteristics of the respondents seem to be related either with the probability or the size of extra payments. This agrees with previous research findings [17] that the educational level or the economic condition of the family head is not related to the probability of additional infor-

Table 9

Average tips to nurses and nurse assistants for the respondents who gave one

	N	Mean value	95% CI	Standard deviation	Median value	Min.–Max.
Nurses	41	€37	28.88–45.12	21.86	30	10–100
Nurse assistants	32	€23.24	17.62–28.6	11.58	20	5–40

Table 10  
Logistic regression coefficients (*b*), odds ratios (OR), 95% Confidence Intervals (CI), and *p*-value

Independent variables	<i>b</i>	OR (95% CI)	<i>p</i> -value
Hospitalization in a private hospital			
No (reference category)			
Yes	0.743	2.1 (1.016–4.37)	0.045
Educational status of the family head			
Lower (reference category)			
Middle	−0.071	0.93 (0.35–2.45)	0.887
Higher	0.997	2.7 (1.201–6.11)	0.016

Probability of offering a tip to a nurse for the independent variables of “hospitalization in a private hospital” and “educational status of the family head”.

mal payments and that even very poor and vulnerable patients are still expected to make informal payments. A study in Albania [7] showed that the poor and pensioners must borrow money to pay for treatments, diagnostics, and surgeries, which can be economically catastrophic. These findings are similar with those in another study in Hungary, showing that individuals with low incomes pay proportionally more for public health services through informal payments than the relatively rich [18]. This also means that extra payments are highly regressive.

The time waiting for admission is related to the probability of extra payments but not with the size of these payments. We also found that the size of extra payments is not related with satisfaction with the care offered.

Table 11  
Logistic regression coefficients (*b*), odds ratios (OR), 95% confidence intervals (CI), and *p*-value

	<i>b</i>	OR (95% CI)	<i>p</i> -Value
Net monthly family income			
Less than €1000 (reference category)			
€1000–2000	1.119	3 (1.427–6.565)	0.004
€2000–3000	1.272	3.57 (1.398–9.11)	0.008
€3000–4000	0.875	2.399 (0.384–14.97)	0.349
Private health insurance coverage			
No (reference category)			
Yes	0.791	2.207 (1.135–4.289)	0.02
Educational status of the family head			
Lower (reference category)			
Middle	0.28	1.028 (0.46–2.26)	0.944
Higher	0.847	2.332 (1.12–4.83)	0.023

Probability of hospitalization in a private hospital for the independent variables of “net monthly family income”, “private health insurance coverage” and “educational status of the family head”.

Odds of making an extra payment (extra fee) to public hospital doctors is 1.72 times higher for patients admitted with the intermediation of a third party (usually a doctor), compared to normal admissions. Odds of admitted through normal procedures is 3.38 times higher for patients waiting for 10 days compared to those waiting a day or less. The most frequent method of “jumping the queue” was putting the patient on an “emergency” list. It is, therefore, not surprising that 48.5% of admissions were labeled as emergencies. By comparison, the percentage of patients admitted as emergencies, even in countries where national health insurance is not prevalent, as in the U.S., does not exceed 35%. For example, a study at Harvard University, found that emergency admissions in Boston hospitals, with a high accident incidence, were only 34% of total admissions [19].

One final point concerns patients who undergo surgery. Odds of making an extra payment (extra fee) to public hospital doctors is 2.73 times higher for patients undergoing a surgery procedure compared to non surgical cases. These findings are in accordance to earlier research results [16] which show that patients admitted to surgical wards have a higher probability to make additional payments. The high prevalence of extra payments to surgeons perhaps explains the tendency of young doctors to specialize in surgery.

Informal and, especially, outright extra payments, run contrary to equity in health care. Besides burdening lower income patients with payments which they can ill afford, they contribute to tax evasion, which is another source of inequity. Our results show that informal payments in Greek hospitals are not so much a cultural characteristic or a conscious luxury choice, but an established forced social behavior made necessary in the course of seeking easier access to quality treatment. It is, therefore, important to find means to change this behavior. Our study is an attempt to measure the extent of the problem and to provide the government and other social institutions with an incentive to seek a solution.

The implications from our study are that the main factor responsible for the problem with informal payments is the inadequacy of the public hospital system. The considerable queuing problems in public hospitals [9,10] are the main reason for seeking ways to sidestep admission procedures. Besides streamlining admission procedures, a considerable effort in *social marketing*



is required in order to change entrenched beliefs that informal payments are necessary even when they are not.

Yet, equally important is increasing the accountability of the health system through creating a climate of transparency and accountability and ensuring greater public participation so that these issues can be openly debated and strategies can be identified that have a broad measure of support [3].

A second major impediment to the efficient functioning of the health care sector in Greece is the fragmentation of the public sector with 35 Social Security funds, providing both health insurance and (mostly outpatient) care. At the same time, the government provides hospital care and primary health care in the rural areas, as well as health insurance to government employees and farmers [20]. This fragmented system causes serious overlaps, referral problems, and major uncertainties as to the quality of care and the accessibility to health services. In some circles, and especially in academia [21], there are calls for a major restructuring of health financing with the establishment of national health insurance for all, the abolition of independent health care funds and the separation of health insurance from health care provision [22].

On the other hand, medical associations blame informal payments on low medical salaries and fees [23]. While doctors' incomes are indeed low [24], it is not at all certain that a substantial increase in fees and salaries by itself would have serious impact on an entrenched social institution. Evidence from the past, when hospital doctor salaries increased by 250% with the enactment of the National Health System in 1985, shows that it did not have a major impact in doctor behavior [12].

Further research will be required to analyze the nature and the extent of the phenomenon of informal payments in Greek hospitals and all its implications. It is likely that a range of policy tools will be necessary to rid systems of the negative effects of informal payments. An effective approach towards limiting informal payments will require the support of health workers and their professional associations [8]. We need to examine proposals such as the establishment of new admission procedures and extensive medical audit on the nature of "emergency" admissions. Beyond this, the development of a clear system of patient rights and simple procedures of complaints help to reduce

the prevalence of informal payments [4]. Other suggested strategies include spending some revenue from user fees on incentives for staff and establishment of official, but flexible channels for voluntary contributions by patients such as sponsorship, advertising or subscription contracts [3].

Above all, what is required is the political will to face up to a serious problem of injustice. "Corruption isn't a natural disaster: it is the cold, calculated theft of opportunity from the men, women, and children who are least able to protect themselves", said David Neussbaum, Transparency International's Chief Executive. And he concludes: "Leaders must go beyond lip service and make good on their promises to provide the commitment and resources to improve governance, transparency and accountability."

## References

- [1] Transparency International. Global Corruption Report. Executive Summary, 2006; p. xvi.
- [2] The Economist. How to grease a palm. December 23rd 2006.
- [3] Balabanova D, McKee M. Understanding informal payments for health care: the example of Bulgaria. *Health Policy* 2002;62(3):243–73.
- [4] Ensor T. Informal payments for health care in transition economies. *Social Science & Medicine* 2004;58:237–46.
- [5] Gaal P, McKee M. Fee-for-service or donation? Hungarian perspectives on informal payment for health care. *Social Science & Medicine* 2005;60:1445–57.
- [6] Mossialos E, Allin S, Karras K, Davaki K. An investigation of Caesarean sections in three Greek hospitals. The impact of financial incentives and convenience. *European Journal of Public Health* 2005;15(3):288–95.
- [7] Vian T, Grybosk K, Sinoimeri Z, Hall R. Informal payments in government health facilities in Albania: results of qualitative study. *Social Science & Medicine* 2006;(62):877–87.
- [8] Thompson R, Witter S. Informal payments in transitional economies: implications for health sector reform. *International Journal of Health Planning and Management* 2000;(15):169–87.
- [9] Mossialos E, Allin S, Davaki K. Analyzing the Greek health system: a tale of fragmentation and inertia. *Health Economics* 2005;14:S151–068.
- [10] Tountas Y, Karnaki P, Pavi E, Souliotis K. The "unexpected" growth of the private health sector in Greece. *Health Policy* 2005;74(2):167–80.
- [11] Organization for Economic Co-operation and Development. OECD Health Data. Paris. Various years.
- [12] Mossialos E, Davaki D. Health care developments in Greece: looking back to see forward? LSE Health and Social Care 2002.
- [13] Davaki K, Mossialos E. Plus ca Change: health sector reforms in Greece. *Journal of Health Politics, Policy and Law* 2005;30(1–2):143–68.

- [14] Brian–Abel Smith et al. Restructuring the Greek NHS. The Report of the Experts, Ministry of Health, Athens. 2004.
- [15] Siskou O. An Analysis of Private Health Expenditure in Greece. Ph.D. dissertation. Department of Nursing. University of Athens. 2006 (in Greek).
- [16] Kyriopoulos J, Ktenas E. Factors affecting additional out of pocket payment in health services. *Society Economy and Health* 1994;3(4):185–95 [in Greek].
- [17] Beazoglou T, Heffley D, Kyriopoulos J. Human resources supply and cost containment in the health system. Athens: Exandas; 1997.
- [18] Szende A, Culyer A. The inequity of informal payments for health care: the case of Hungary. *Health Policy* 2006;75: 262–71.
- [19] Sox CM, Bursin HR, Edwards RA, O’Neil AC, Brennan TA. Hospital admissions through the emergency department: does insurance status matter? *The American Journal of Medicine* 1998;105(6):506–12.
- [20] Liaropoulos L, Kaitelidou D. Changing the public–private mix: an assessment of the health reforms in Greece. *Health Care Analysis* 1998;6:277–85.
- [21] Souliotis K. Financing the Greek health care system: allocation of resources and private health expenditure. Ph.D. dissertation Panteion University of Athens. 2000 (in Greek).
- [22] Liaropoulos L. “Public health funds should be abolished”. *The Investors’s World*. 2005; July 16–17 (in Greek).
- [23] Tsoukalos S. Article of the President of the Association of Hospital Doctors’: the possibility of choosing a doctor as a human right. *Kathimerini* (Newspaper). 12-02-2006 (in Greek).
- [24] Krikke M., Van Der Sloot O. Remuneration of Medical Specialists and GPs in Europe. Report of the Ministry of Health, Welfare and Sport of the Netherlands. 2004.