

Addressing informal payments in the Greek health system



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Abstract

The Greek health system is facing major demographic, epidemiological and economic challenges and performance problems due to organizational and operational weaknesses such as pervasive fragmentation in pooling, purchasing and service delivery. Focusing on recommendations for action, this report addresses informal payments (IPs, known as *fakel(l)aki/φακελακι*) on the basis of a literature review; analysis of policy documents; and interviews with 13 key informants. The phenomenon is analysed in the so-called *inixit* framework (Gaál & McKee, 2004) which understands IPs as a product of health-system failures. The available evidence shows consistently that the bulk of IPs in the Greek health system can be considered informal fees for service, hence policy focus should be shifted from the public sector corruption approach to reform of those health-system characteristics which induce and maintain fee-type IPs. These can be addressed successfully only if reforms aim to eliminate their root causes. The strategy to address IPs should mix long-term and large-scale health-system reforms which focus on efficiency improvements and reallocate savings to shortage areas – particularly remuneration of health workers – and short-term measures which address the phenomenon directly. Among quick-fix policies, the only viable option appears to be formalization of IPs: removing choice of physician from the publicly financed patient pathway and introducing user charges for those who want to retain this choice. While this may be seen to create a barrier to access, in fact it aims to eliminate the access barrier that IPs create. The political risks of the quick-fix policy should be weighed against the detrimental impact of letting IPs persist, but such risks can be decreased by the application of change management and large-scale system transformation techniques and skills which appear to be critical success factors in driving change in the Greek health system.

Keywords

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Contents

Abbreviations.....	iv
Acknowledgements	v
Executive summary	1
Addressing Informal Payments in the Greek Health System: Analysis and recommendations	6
1 Introduction	6
2 Theoretical frameworks for understanding and addressing IPs for health care.....	8
3. Evidence on informal payments in the Greek health system	11
3.1 Scale of informal payments	11
3.2 Reasons and motivation for IPs	12
3.3 Impact of IPs on health-system performance	12
4 Evidence on successful and failed health-sector reforms	13
4.1 International examples.....	13
4.2 Measures introduced in Greece	15
5. Policy options for Greece.....	17
5.1 Approaches for reducing and eliminating IPs	18
5.2 Long-term measures	19
5.3 Quick-fix options.....	21
5.4 Politics and management of change.....	24
References	26
Annex.....	30
Presenters	30
Participants.....	30

Abbreviations

EOPYY	National Organization for Healthcare Provision
ELSTAT	Hellenic Statistical Authority
ESY	national healthcare service
IP	informal payment
NHIFA	National Health Insurance Fund Administration (Hungary)
OOP payment	out-of-pocket payment

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Executive summary

The Greek health system is a fascinating example of a public–private mix – in both financing and the provision of health services – which faces several challenges in its demographic, epidemiological and economic environments. Despite major health reform efforts, the system is plagued by fragmentation and informal payments (IPs), which have so far resisted all attempts to eliminate them or at least decrease their prevalence. **This report addresses the topic of IPs in the Greek health system (known as *fakel(l)aki – φακελακι*), focusing on recommendations for action**, on the basis of a review of the literature; analysis of policy documents; and interviews with 13 key informants. Initial findings were discussed in a workshop comprising more than 30 stakeholder participants whose comments have been incorporated in the study.

The health policy relevance of IPs depends on **the scale of the phenomenon and their impact on the performance of the health system** in terms of effectiveness, efficiency and equity. The impact of the phenomenon depends on what motivates the actors of the transaction: is the IP a product of lack of knowledge, a gift, a fee or a bribe (Gaál, 2006)?

Table 1. Types of IPs for health care

Type of IP	Motivation for IP	Underlying cause	Where to intervene?
1. Ignorance	Lack of knowledge about entitlement to health care	Failure of information	Health system (governance)
2. Gift	To thank for being cured	Sociocultural	Education system
3. Fee	To get adequate care	Economic (shortage)	Health system (financing & provision)
4. Bribe	To get priority care	Legal-ethical (unethical and illegal behaviour by patients and doctors)	Justice system

IPs are often interpreted exclusively in a public-sector corruption framework – that is, as a bribe. While acknowledging that corruption can be part of the phenomenon, the alternative explanatory framework suggested here puts fee-type IPs at the centre of the analysis, given that the underlying cause of IPs is the health system’s failure to deliver what is expected as part of the public-benefit package. The so-called inexit theory suggests that fee-type IPs can be addressed by a mix of interventions targeting the benefit package; the channels of exit and voice; and the social capital of the health system (Gaál & McKee, 2004).

The most recent research estimates that IPs in Greece are widespread and involve substantial amounts both per transaction and as an average across all households (Souliotis & Kyriopoulos, 2003; Kaitelidou et al., 2013; Economou, 2015; Souliotis et al., 2016) (18). Evidence on the motivation for IPs is extensive and consistent inasmuch as the bulk of IPs are a product of health-system failures and can be considered a fee for service, with all of its adverse impact on financial protection, equity in access and efficiency of service delivery. Evidence from the key informant interviews suggests that ignorance-type IPs are also prevalent, especially within the poorer, rural population (10). There is little evidence of financial protection but what is available implies that IPs constitute a very high share of household expenditures, and put a disproportionately large burden on poorer households. This finding is especially worrying because it is not possible to exempt the less well-off from a practice which is informal.

International and local experiences of health-system reforms regarding IPs are mixed at best. A WHO study on health-financing reforms in former communist countries (Gaál, Jakab & Shiskin, 2010) has identified five critical success factors to address IPs at system level:

- comprehensive and well-sequenced policy instruments;
- clear and realistic entitlements (benefit package);
- restructuring of delivery system, and reinvestment of efficiency savings for remuneration of health workers;
- adequate, stable and predictable public funding; and
- absence of a blame culture.

Interventions to directly address IPs include:

- prohibition and punishment;
- pay rises for health workers;
- provision of information, awareness raising, increased transparency and establishment of channels of voice (complaint systems);
- establishment of a formal private alternative to IPs; and
- formalization of IPs in the public system.

In Hungary, both increases in health-sector salaries and formalization attempts have spectacularly failed to eliminate IPs. More successful, yet small-scale, formalization attempts have been reported from Albania and Cambodia (Vian, Feeley & Domente, 2014). In Kyrgyzstan, the so-called single payer reform (SPR) successfully reduced IPs by setting realistic entitlements and formalized user fees (Vian, Feeley & Domente, 2014), although the achievements could not be sustained in the long term (Jakab, Akkazieva & Kutzin, 2016). In Greece, pay rises for medical doctors were unsuccessful in eliminating IPs, and efforts to address the phenomenon through the legal-regulatory framework do not seem to bring tangible results. The surgical list is a more promising measure but it has the same vulnerabilities as the legal approach. The afternoon clinic initiative is an interesting attempt to formalize some of the informal transactions by creating a legal framework of exit within the boundaries of the public system, but implementation experiences are mixed.

IPs can be addressed successfully only if the reforms aim to eliminate the root causes of the phenomenon as presented in Table 1.

The strategy to address IPs should mix long-term and large-scale health-system reforms which focus on potential efficiency improvements (because the root causes are complex and some take a long time to change), and short-term measures which address the phenomenon directly (because the long implementation period enables key actors in IP transactions to adapt gradually to the changing context). It is very important to ensure that the two are compatible.

The following recommendations concern long-term reforms.

- It is recommended that the policy focus for addressing IPs is shifted from the legal-ethical approach to the reform of those health-system characteristics which induce and maintain fee- and ignorance-type IPs. This is because the corruption interpretation of IPs applies only to bribe-type IPs which comprise a small proportion of cases and are located at the margin of the phenomenon.
- The inexit theory suggests that IPs can be reduced by efficiency enhancing reforms in which savings are reallocated to shortage areas and, in particular, the remuneration of health workers. Despite significant progress, the Greek health system still has much potential to improve efficiency in pooling (merging the central government health budget with that of the National Organization for Healthcare Provision – EOPYY), developing EOPYY’s ability to engage in strategic purchasing, provider payment reforms with increased provider autonomy, territorial supply obligation with a progressivity-based referral system, and primary-care based care coordination. The Government’s 100 actions plan targets most of the suggested interventions (Ministry of Health Greece, internal document, 2015).
- The publicly financed benefit package is important for IPs but the priority setting process is complicated and usually fraught with high politics, therefore it is not recommended as a first-choice reform.
- The inexit theory suggests that opening up the channels of voice could help to reduce the prevalence of IPs and the government has also included voice-related policies in its 100 actions plan (Ministry of Health Greece, internal document, 2015, action 47, 49, 73). Yet these will work in the longer term by preventing the reappearance of IPs rather than in the short term by playing a significant role in the elimination of IPs.

Taking account of the mixed experiences, only one of the five short-term interventions described is recommended – formalization of IPs so that formal out-of-pocket (OOP) payments replace IPs rather than add to the burden of them.

- Prohibition and enforcement can address bribe-type IPs through the justice system but such interventions can be effective only if fee- and ignorance-type IPs are addressed at the same time. On their own, pay rises for medical doctors are also doomed to fail because they do not address the patient side of the transaction. Creating the conditions for exit works only if both parties consider the formal alternative to be almost as desirable as the informal option.

- Voice-related measures (provision of information, awareness raising, increased transparency, establishment of complaint mechanisms) can be used to address ignorance-type IPs but are ineffective for fee-type IPs.
- The inxist theory and the key informant interviews (I02, I04, I08, I09, I11, I13) suggest that IPs can be addressed by removing choice of physician from the publicly financed patient pathway and introducing a user charge for those who want to retain this choice. The policy of charging patients who want to be able to choose their doctor has three key ingredients: (i) each health problem has a clearly defined patient pathway free of user charges; (ii) medical doctors have two main sources of remuneration: fixed monthly salary and a performance-related bonus payment; (iii) the same (or at least similar) bonus payment is made after each patient in order to ensure that non-paying patients are not discriminated against.
- The acceptable (fair) level of the salary component could be set using two benchmarks: (i) EU average, and/or (ii) average remuneration in the private sector.
- Performance-based bonus payments for doctors treating non-paying patients should be covered from additional public financial resources. These can come from the reinvestment of efficiency savings.
- Adverse effects of the bonus payment – such as supplier induced demand (SID) and cost explosion – can be addressed either within the payment scheme (by decreasing the level of bonus payment through marginal graduated fees according to performance bands) or outside of it (by establishing referral-based care coordination).

Successful implementation of the recommended interventions depends much more on the political rather than the technical aspects of feasibility. Formalization of IPs may be seen as the creation of a barrier to access but in fact it aims to eliminate the access barrier they create. Political risks of the quick-fix policy should be weighed against the detrimental impact of letting IPs persist, but the following methods can be used to decrease such risks.

- It is recommended that implementation initially focuses on the preconditions: implementation of a referral system setting out the standard patient pathways in the system, deviation from which has to be paid out of pocket; and introduction of an information system which identifies patients with a unique (national) identification number for all episodes of health-care utilization. These must be fully functional before the introduction of any interventions to address IPs.
- Implementation should be started on a small scale through a pilot in a few hospitals.
- If it is impossible for political parties to achieve consensus on a long-term health system transformation strategy, the change coalition should be established with the involvement of the relevant health-system stakeholders and civil society. Health-care managers could be an important stakeholder group and allies in health-system transformation but are currently relatively weak as managerial autonomy in hospitals is restricted.

- Stakeholder support could be built up by inviting relevant stakeholders to participate in the planning process.
- It appears that expertise in change management and experience of large-scale system transformations are much more necessary than technical assistance on what to do to make things happen in the Greek health system.

Addressing Informal Payments in the Greek Health System: Analysis and recommendations

1 Introduction

The Greek health system is a fascinating example of a public–private mix – in both the financing and the provision of health services. On the financing side, out-of-pocket (OOP) payments still comprise a very high share of total spending on health (around 36%). Public sources consist of social health insurance contributions and general taxes with a 29% and 30% share of total spending on health, respectively (ELSTAT, 2017). Voluntary health insurance is not a substantial source of health-care financing (Economou, 2010, 2015) at under 4% of total health expenditures in 2015 (ELSTAT, 2017), increasing from around 1.9% in 2009 (Economou, 2015). Absolute spending figures have stagnated with slight fluctuations at around €520 million between 2010 and 2015 (ELSTAT, 2017). Voluntary health insurance plays a mainly supplementary role, providing people with faster access to care and greater choice of provider (Economou, 2016). Coverage figures are conflicting, ranging from 11% (Economou, 2016) to 36% of the population (Souliotis et al., 2016) in 2012. Health services are delivered via 2008 primary health-care units and 126 national healthcare service (ESY) hospitals, in which 17 490 doctors perform around 12 million consultations and 460 000 operations per year. The extensive private sector comprises 145 for-profit hospitals providing 35.0% of the 4.23 per 1000 population bed capacity; 173 private outpatient clinics; 2690 private diagnostic centres; and 24 479 private physicians’ practices.¹ In addition, there are 14 public hospitals in universities and parallel public service delivery structures, such as the military health service run by the Ministry of Defence (Economou, 2010).

Despite major health reforms towards a more integrated system, fragmentation is still the most important source of inequities and inefficiencies in the performance of the Greek health system. Implementation of several important pieces of health reform has decreased fragmentation in both financing and service delivery. These include establishment of the ESY in 1983; amalgamation of 39 separate social insurance agencies to form the National Organization for Healthcare Provision (EOPYY) in 2011 (Souliotis et al., 2016); establishment of health regions (Economou, 2010) (I13); and, more recently, opening some military health-facility capacities to the general public (I08). The highly political nature of health-system reforms and the vested interests of established stakeholder groups prevented comprehensive implementation (Economou, 2010), but these steps can be considered important milestones towards a more integrated

¹ Data obtained from <https://healthatlas.gov.gr/HealthCareStats/#!/reports/05001>.

system. Yet, there is still a wide scope for efficiency and equity gains from pooling (especially the two main agencies – the Ministry of Health and EOPYY); purchasing (including, but not limited to, payment of health-care providers and physicians and development of organizational management); and care coordination (especially development of primary health care; establishment of a referral system, based on geographical location and medical need). These offer the possibility to free up resources and reallocate gains to shortage areas (I8, I9, I11, I13).

As one of the most tenacious and persistent features of the Greek health system, informal payments (IPs) for health care have so far resisted all attempts to eliminate them, or at least decrease their prevalence.

A considerable proportion of the high level of OOP payments arises from IPs, which adversely affect financial protection, access to care and the efficiency of service delivery – unlike formal OOP payments, for instance, poor people and other vulnerable population groups cannot be exempted from paying doctors informally. In addition, the informality of the phenomenon makes it very difficult to tackle (Kyriopoulos, Economou & Dolgeras, 2001) and it has become deeply ingrained in the system over decades (I2, I8). Hence, any attempts to address IPs should be based on understanding the motivations of participants in the transaction.

Transformation of the health system is inseparable from the wider social and economic context. In addition to the general European trend of an ageing society, the Greek population is facing a serious financial crisis which not only profoundly affects the feasibility of reforms in any sector, but also contributes to the development of performance problems and challenges that should be addressed by such reforms. In particular, public spending on health has declined by 45% – from €14.9 billion in 2010 to €8.2 billion in 2014 (ELSTAT, 2017). Despite an increase of 6% for 2015 (ELSTAT, 2017), the budget cuts were accompanied by corresponding salary decreases of around 40% (I1) and a sizeable indebtedness problem among ESY hospitals amounting to as much as 45% of public expenditures on health (Souliotis et al., 2016). Although overall numbers of physicians are sufficient, the unfavourable economic climate has triggered the emigration of specialists and young doctors, thereby aggravating problems of equity in access to health services (I1, I8). Further, the financial crisis, political unrest and frequently changing governments have had a deep impact on Greek society by eroding the social capital necessary for adequate functioning of public administration and the public sector in general. A special Eurobarometer survey implemented at the end of 2013 identified Greece among countries whose citizens had the least trust in their health system – only 25% of respondents perceived the overall quality of care to be good, and many thought it likely that patients could be harmed by hospital (78%) and non-hospital care (71%). Cyprus was the only EU Member State with even higher percentages (European Commission, 2014b). All of these factors play a key role in the evolution and persistence of IPs for health care.

This report addresses the topic of IPs in the Greek health system, focusing on the recommendations for action.

The IPs are analysed on the basis of information generated from three main data sources: (i) documents; (ii) scientific publications; and (iii) key-informant interviews. It is important to note that evidence referred to in this report is selected on the basis of relevance to policy formulation and implementation, and is by no means claimed to be exhaustive. Relevant documents and scientific publications have been identified with the help of local experts. Although the literature review and documentary analysis have not been systematic, the identified documents and scientific research are thought to cover all those pieces of work which have important implications for policy-making and analysis of IPs. Key informants have contributed to the research via personal interviews and a workshop

in which the initial findings of the study were discussed. The field visit took place between 17 and 21 July 2017. A total of 13 interviews were held with key informants and analysed – 12 interviews were carried out in person; one interview was carried out later via e-mail and Skype. Interviewees were stakeholders with knowledge of, experience of and insights into the phenomenon of IPs, including officials of the Ministry of Health, practising doctors, hospital managers and representatives of health regions and international organizations working in this area. In order to protect the identity of interviewees, this report refers to the major points of the interviews by referring to each interview with a different random number which conveys no further information on the interviewee or the sequence of interviews. These numbers, together with the letter I (e.g. I1, I2), are used in the main text solely for the purpose of referencing the source of the data (i.e. the key informant interview concerned). The workshop was held on 8 November 2017 with more than 30 participants. The report incorporates the comments and suggestions made by the participating stakeholders during the IP workshop.

This report begins with a review of the theories of understanding IPs, with special emphasis on the inxit theory. The latter is selected as the framework not only for interpretation and analysis but also for policy formulation. The theoretical discussion is followed by a summary of the empirical evidence on IPs in Greece in terms of their scale, motivating factors and impact on the performance of the health system with a special emphasis on financial protection. In a separate section, the empirical evidence on the implementation of successful and failed Greek and international health-sector reforms is summarized to inform policy-making aimed at addressing IPs in the Greek health system. Finally, a proposal of potential health reforms is put forward for both the short and the long term. Implementation of the suggested reform measures are also addressed in terms of political and technical feasibility, and the management of change.

2 Theoretical frameworks for understanding and addressing IPs for health care

Corruption is a priority topic of consecutive Greek governments and is frequently emphasized by international donor organizations, hence IPs are often interpreted in the public-sector corruption framework (I2, I3, I5). Nevertheless, there are several reasons why a framework rooted in the legal-ethical explanation of IPs (Gaál & McKee, 2005) is not very useful for health policy-making. First, it assumes that IPs are a behavioural problem of individuals who are morally weak or bad, implying that there is nothing wrong with the system itself. Consequently, the solution should lie outside the domain of health policy. Further, it is implicitly based on a blaming culture (problem due to bad/greedy/corrupt doctors and ignorant/corrupt patients) even though absence of the blaming culture seems to be one of the critical success factors of effective strategies against IPs (Gaál, Jakab & Shishkin, 2010). Second, even if the behavioural assumption were true, any type of regulatory enforcement is only feasible if there are only relatively few violators and the risk of being caught is relatively high, at a reasonable level of enforcement capacities. By contrast, regulatory enforcement cannot be implemented efficiently when the majority of society is involved in the corrupt practice – that is, there are more perpetrators than law-abiding citizens. Third, even if violations are relatively rare, enforcement works well if the majority of society considers the regulation fair and reasonable (i.e. legitimate) otherwise the process of detection and punishment will be sabotaged. Unfortunately none of these assumptions holds for IPs.

While not denying that corruption can be part of the phenomenon, an alternative explanatory framework is suggested to support policy-making for IPs, originating from the definition of IPs and the motivation of participants in the transaction. While there seems to be consensus on what are considered IPs in practice, there is no widely accepted definition for the phenomenon, given that not all forms of IPs described in the scientific literature and reported from all over the world are corrupt, illegal or even informal (Gaál, 2006). According to Gaál, Belli et al. (2006), the common distinctive feature of all types of IPs is that they are additional payments – formal OOP payments are stipulated in the terms of entitlement for health care but IPs are made in addition to these. The typical IP occurs when a patient pays the doctor for a service which should be provided free of charge at the point of use. In this case the whole amount paid by the patient is an IP but it is also possible that a formal user charge is levied on the service, and the patient pays more than that. In such a case the IP is the difference between the total amount paid by the patient and the amount of the formal user charge. Hence, a fee for service which the private practitioner does not register in order to avoid paying tax is not an IP provided that the patient does not pay more than the tariff set by the doctor. In-kind contributions (e.g. for clean bedlinen, drugs, syringes, other medical supplies) are IPs if they should have been made available by the health-care facility and not the patient or their relatives. Further, IPs are part of the broader category of informal economic activities which includes related phenomena such as the pilfering of drug supplies, inappropriate referrals, kickbacks or the tailoring of performance reports (Gaál, Belli et al., 2006; Economou, 2010; Avgoustatos & Economou, 2013). Nevertheless, if IPs are indeed additional payments then several questions arise: why do people pay, or contribute, more than required? Is it because they are ignorant of their entitlements to health services? Is it because they are grateful for being cared for, or cured? Or is it because the health system does not deliver what has been promised and patients are afraid that otherwise they will not have adequate care? The answers to these questions are important for figuring out not only what can be done to eliminate IPs, but also to decide whether they should be eliminated.

On the basis of the different reasons for their use, four main types of IP can be distinguished: (i) ignorance; (ii) gift; (iii) fee; and (iv) bribe (Gaál, 2006). Each type has a different motivation and root cause which determines the health-policy relevance of the phenomenon: should the government intervene? If so, where (in which sector) and how? The various types of IPs can (and usually do) co-exist in a health system, but none can be considered a policy issue if their scale is so small that they are not able to distort the performance of the health system (Table 1).

Table 1. Types of IPs for health care

Type of IP	Motivation for IP	Underlying cause	Where to intervene?
1. Ignorance	Lack of knowledge about entitlement to health care	Failure of information	Health system (governance)
2. Gift	To thank for being cured	Sociocultural	Education system
3. Fee	To get adequate care	Economic (shortage)	Health system (financing & provision)
4. Bribe	To get priority care	Legal-ethical (unethical and illegal behaviour by patients and doctors)	Justice system

Two main characteristics determine the health-policy relevance of IPs: (i) the scale of the phenomenon; and (ii) their impact on health-system performance in terms of effectiveness, efficiency and quality. The impact depends on what motivates the actors of the transaction – is IP a product of lack of knowledge, a gift, a fee or a bribe? Although empirical studies show a multifaceted motivation for IPs, it can be summarized in two contrasting hypotheses on the impact on system performance (Gaál, 2004b). If IPs are a gift, a way of saying thank you, motivated by gratitude for being cared for, or cured (gratitude payment, gratuity or gift-type IP), by definition they have no adverse impact on quality, access to care or efficiency. Gratitude payments can even have a beneficial influence on performance by improving providers' responsiveness to those who make the payments. By contrast, if IPs are motivated by various external and internal pressures to pay, they behave similarly to the fee-for-service provider payment method (the fee-type IP), with all of its well-known adverse effects on the equity and efficiency of the health system (Gaál & McKee, 2005). The same applies to bribe- and ignorance-type IPs with the difference that the place of intervention for bribe-type IPs lies primarily outside the health system. Therefore, the question of whether or not IPs should be a concern for health policy ultimately depends on whether IPs are rather a fee/product of ignorance, or a gift. Also, when these coexist in a health system, which is the more dominant form? The fee-for-service versus donation dilemma, however, is less important if small amounts are involved in the transaction, having a negligible distorting effect. Consequently, the scale of IPs must first be established in order to justify attention to the phenomenon.

The so-called inxit theory of IPs combines the entitlement-based definition of IPs; legal-ethical and economic explanations of the phenomenon; fee-for-service hypothesis of the motivation for making these payments; and Hirschman's theory of exit, voice, loyalty, the behavioural responses to "decline in organizations and systems" (Hirschman, 1970) into one common explanatory framework for understanding the emergence and persistence of IPs (Gaál & McKee, 2004). The inxit theory is a cognitive-behavioural model of IPs insofar as it explains their emergence as a third potential behavioural response (in addition to exit and voice) to real or perceived shortages in health systems. If a health system promises more than it can deliver in terms of quality and access then patients (who do not get what they want and what they were promised) and doctors (whose salaries are low and well below a reasonable expectation) reassess the official entitlements. Where this reassessment coincides for the majority of patients and doctors then a new unwritten and unspoken consensus on entitlements emerges, provided that the channels of exit and voice are blocked. Given the informality of this process, and the individual nature of the reassessment, there can be extreme differences between the content of the reassessed personal-benefit packages in terms of excluded services. It is also important to note that, due to the information asymmetry between lay people and professionals, the shortage does not have to be real to trigger this reassessment process. It is more than enough that the patients lose trust in the system, a key factor not only in the emergence and persistence of IPs but also in their elimination. The latter cannot be envisaged without rebuilding of the lost social capital.

The inxit theory of IPs suggests that the fee-type can be addressed by a mix of interventions targeting the benefit package, the channels of exit and voice, and the social capital of the health system. Fee-type IPs are the focus of the inxit theory but the framework can also guide policy-making for ignorance- and bribe-type IPs. In particular, it implies that the boundaries between fee- and bribe-type IPs are blurred, so bribe-type IPs are unlikely to be addressed effectively without first addressing fee-type IPs. Also, revision and clarification of the entitlement to publicly funded health services is a key policy measure to tackle both fee- and ignorance-type IPs.

3. Evidence on informal payments in the Greek health system

IPs for health care in Greece are frequently discussed in a public-sector corruption framework in which a wide range of informal economic activities are interlinked with, or considered to be, IPs. Among these, fakel(l)aki (φακελακι) seem to be the one that best corresponds with real IPs, as defined previously.

In particular, IPs are often mixed with unregistered undeclared OOP payments in private practices (Economou, 2015; Souliotis, et al., 2016), or corruption in the procurement of equipment and medical supplies (I3). According to the Gaál (2006) definition, none of these phenomena shares the distinctive feature of IPs, therefore this report only addresses fakelaki in health service provision, and touches upon these related phenomena inasmuch as is necessary for analysis of true IPs.

3.1 Scale of informal payments

According to the most recent research estimates, IPs are widespread and involve substantial amounts both per transaction and as the average across all households. A nationally representative survey implemented in 2012 estimated that IPs were made in about one third (32.4%) of all public hospital admissions with an average payment of €276 per year among those who utilized publicly funded health services in 2011 (Souliotis et al., 2016). This amounts to an annual total of €566 million, about 3% of total health expenditures in 2011 (Souliotis et al., 2016; ELSTAT, 2017) (I12). On the basis of these figures IPs seem to be an insignificant source of health financing. However, their importance as a perverse financial incentive does not come primarily from their overall magnitude, but rather their uneven distribution among health workers which concentrates a very large amount in the hands of a relatively small number of practising medical doctors. In Hungary, the magnitude of IPs was estimated to be a similarly small share (1.5%–4.5%) of total health expenditures. Yet they added at least two thirds, and as much as 2.5 times, to the official net salary of the average family doctor and specialist in 2001 (Gaál, Evetovits & McKee, 2006). Further, the survey by Souliotis et al. (2016) estimated unregistered, undeclared fees in the private sector to amount to an additional €1 billion per year. The majority of these are not IPs but it is possible that some arose from patients paying more than the set tariff when they utilized private health services. It is interesting to note that another study, aimed at estimating the hidden (black) economy in the health system, arrived at the same figure of €1.5 billion, but for 1999 (Tatsos, ELSTAT internal document, 2001, cited in Economou, 2010). The uneven distribution of IPs is also underpinned by evidence on the amount per payment. This was found to be as high as an average of €848 per delivery in maternity hospitals in 2010 (Kaitelidou et al., 2013) and ranged from as little as €20 to as high as €8000 per transaction in public hospitals in 2004 (Liaropoulos et al., 2008).

Numerous studies have confirmed that IPs are a long-standing deeply ingrained tradition in the Greek health system but it seems that the scale of IPs is shrinking somewhat in parallel to the financial crisis as citizens exhibit a growing inability and unwillingness to pay informally. At the same time, service providers show increasing demand for such payments (Souliotis & Kyriopoulos, 2003; Kaitelidou et al., 2013; Economou, 2015; Souliotis et al., 2016) (I8). The trends in the scale of IPs are determined by several factors, among which the economic context is one of the strongest. Well-designed and successfully implemented health-sector reforms could also influence the scale of IPs. Yet changes are more likely to be attributable to the financial crisis and the resulting aggravation of shortage rather than any policy

measures aimed at addressing some of the determinants of IPs. This is especially true for regulation and enforcement which do not seem to have been very effective to date, despite the emphasis on the development of appropriate public administration capacities, structures and processes (I3, I8, I10, I13).

3.2 Reasons and motivation for IPs

There is scarce quantitative evidence on the impact of IPs for health care in Greece. Yet there is extensive and consistent evidence on the motivation for IPs in that the bulk of such payments can be considered as fees for service, with all of their adverse impacts on financial protection, equity in access and efficiency of service delivery. Among the users of public hospitals in 2004, only 17% responded that they gave IPs as an expression of gratitude (Liaropoulos et al., 2008). In other studies, this was reported by 40.3% of mothers giving birth in maternity hospitals in 2010 (Kaitelidou et al., 2013), and ranged from 4% to 13.6% among respondents in a national representative survey in 2011 (Souliotis et al., 2016), depending on the type of service utilized (from private hospitals to public hospitals, respectively). Key informants in the current study have confirmed the lower figures, citing mostly direct (e.g. demanded by the doctor; patient wanted to ensure better quality and faster care, choice of doctor) and indirect (e.g. fear of not getting adequate care; others also pay) coercive motives as the main reason for IPs (I2, I4, I8, I9, I11, I13). Further, it is important to note that surveys are a rather unreliable tool for capturing the motivation for IPs as closer examination of gratitude-payment cases reveals several factors concerning internal and external pressures to pay during the transaction. This suggests that the true proportion of purely gratitude-motivated IPs is probably much lower than what can be captured by questionnaire-based surveys, if gratuities exist at all (Gaál, 2004b).

Evidence from the key informant interviews suggests that ignorance-type IPs are also prevalent, especially among the poorer, rural population (I10). These are mostly related not to insufficient knowledge regarding user charges for publicly funded health services, but rather to what services are included in the benefit package, and whether or not there are exclusions – for instance, when a physician refers patients to private diagnostic centres even though the diagnostic service concerned is included in the publicly funded benefit package.

3.3 Impact of IPs on health-system performance

The key informant interviews have consistently confirmed the pervasive detrimental impact of IPs on the performance of the health system, which is corroborated by some findings from other studies. Key informants have explained how the current organizational structure of the health system and patient pathways are interwoven by an informal referral network, driven mainly by IPs (I8). Given that money is the underlying logic, this leads to inefficiencies such as the provision of unnecessary services (supplier induced demand) or suboptimal use of existing capacities (I9, I11). Further, there are sometimes even fatal consequences as access to care is hampered for those who cannot afford, or do not want, to pay (I1, I2, I6, I10, I12) (Economou, 2015). This role as a serious barrier to accessing care is also confirmed indirectly by the large share of cases reported in surveys in which IPs have been demanded upfront, prior to the service. Among the users of public hospitals in 2004, 20% responded that they gave IPs because the doctor had asked for it as a prerequisite for medical intervention (Liaropoulos et al., 2008). Corresponding figures in other studies were 56.3% among mothers giving birth in maternity hospitals in 2010 (Kaitelidou et al., 2013) and ranged from 11.5% to 40.5% among respondents in a national

representative survey in 2011 (Souliotis et al., 2016), depending on the type of service utilized (from private practitioners and dentists to public hospitals, respectively).

There is little evidence on financial protection but what is available implies that IPs constitute a very high share of household expenditures, and put a disproportionately large burden on poorer households. This finding is especially worrying as it is not possible to exempt the less well-off from a practice which is informal. Evidence from a secondary analysis of a special Eurobarometer study on corruption carried out in early 2013 (European Commission, 2014a) shows that a slightly higher percentage of those who reported difficulties paying bills most of the time gave IPs when they utilized health services (12% as opposed to the average of 11%), albeit the difference was not proven to be statistically significant (Horodnic et al., 2017). The study found no association between any of the analysed socioeconomic characteristics of the population, which suggests that the frequency of giving is similar across all socioeconomic groups (Horodnic et al., 2017). Further, the study on public hospitals in Greece found that none of the socioeconomic status characteristics of the interviewed households (including variables such as the monthly net income of the household) were associated with the size of IPs. This not only reinforces the earlier finding that IPs behave like fees for service, but also implies that poorer households shoulder a disproportionate financial burden from IPs (Liaropoulos et al., 2008). This finding is further corroborated by the fact that households are willing to take out loans to cover IPs (102). Souliotis et al. (2016) provide a more precise quantification of this problem, finding that, on average, hidden payments (including unregistered and informal) were equivalent to 27% of the income of the households that utilized health services.

Another study examined financial protection of those insured against hospital costs in EOPYY contracted private hospitals in three main cities in 2013. This found that the SHI system covered only 47.3% of the total cost of hospitalization, with a mean OOP payment of €1655; that 43.3% of surgical cases paid informally; and that OOP payments exceeded 25% of the annual wage or pension income of 10% of the respondents (Grigorakis et al., 2014). According to the preliminary results of a new study, just under 10% of households in Greece suffered catastrophic health expenditures in 2016 (Chletsos & O'Donnell, in press). Further, in the Souliotis et al. (2016) study, respondents who reported that hidden payments have a large impact on their income and living conditions comprised 55.8% of those who rated their financial status as bad or very bad and 32.3% of those who considered their financial status good or very good. Although based on self-assessment – a subjective and therefore limited measure of the variables concerned – the evidence suggests that IPs negatively affect financial protection, especially among the less well-off. This is a cause for concern and provides strong justification for policy actions.

4 Evidence on successful and failed health-sector reforms

4.1 International examples

A WHO study on health financing reforms in former communist countries identified five critical success factors of reform strategies to address IPs for health care (Gaál, Jakab & Shishkin, 2010). On the basis of comparative analysis of the country experiences of Kyrgyzstan, Tajikistan, the Russian Federation, and

Hungary the study concluded that the features shared by health-system transformations successfully reducing the scale of IPs and their adverse effects on health system performance include: (i) comprehensive and well-sequenced policy instruments (not individual measures in isolation); (ii) setting of clear and realistic entitlements (benefit package); (iii) restructuring of the delivery system, but with the important precondition that any efficiency gains from reforms are reinvested in the health system (possibly for remuneration of health workers); (iv) adequate and stable (predictable) public funding for the health system as a whole; and (v) absence of a blame culture.

Hungary provides Greece with an interesting and instructive example of failure, given the similarities in terms of country size and the longstanding tradition of IPs in health care. Following the change of regime in 1990, Hungary implemented a well-sequenced and large-scale transformation of its health system, from Semashko to Bismarck (with a single-payer national health insurance fund) (Gaál, Rekassy & Healy, 1999; Gaál, 2004a; Gaál, Szigeti, Csere et al., 2011). Despite such comprehensive health-system reform, attempts to reduce IPs have generally failed as the country has not created clear and realistic entitlements for publicly funded health services; efficiency gains realized as a result of payment reforms and delivery-system restructuring were taken out of the health sector (for fiscal stabilization of the state budget); and public financing of health care has remained inadequate, unstable and erratic. In particular, long periods of austerity have been combined with short periods of increased spending, usually in election years. For example, the 50% pay rise for health workers in 2002 punched a big hole in the central government budget yet had very little impact on the prevalence of IPs.

Attempts to formalize IPs in the Hungarian health system failed because they did not address the root causes. The government of 2006–2010 used two policy interventions to explicitly target IPs. First, introduction of a small user charge (HUF 300, equivalent to €1) for all patient–doctor encounters in outpatient care and a per diem payment for inpatient care in 2007 (abolished later in 2008 following national referendum). Second, introduction of a quite high user charge for choice of hospital and medical doctor: 30% of the reimbursement tariff of the National Health Insurance Fund Administration (NHIFA), with a ceiling of HUF 100 000 (equivalent to €330). These measures failed because formal user charges add to the burden of IPs if the causes of IPs (real or perceived shortage) are not tackled (in the context of ability to pay). In addition, the introduction of a user charge for those wanting choice of doctor was not a bad idea because it tried to address the cause of IPs by formalizing what patients had been willing to pay for anyway. However, it was implemented badly. Firstly, revenue from the new user charge went to the hospital (rather than the medical doctor) so neither patient nor doctor had any interest in changing from IPs to formal OOP payments. Secondly, the user charge had to be deducted from the NHIFA reimbursement so hospitals had no interest in collecting them as, far from gaining any additional revenue, they incurred extra costs for administering the user charges for both patients and the NHIFA.

More successful but small-scale formalization attempts have been reported from Albania and Cambodia (Vian, Feeley & Domente, 2014). The director of a university maternity hospital in Tirana prohibited IPs and introduced official user charges which, importantly, were used to quadruple doctors' salaries and double the salaries of other hospital staff. These two measures proved successful in reducing IPs and increasing hospital utilization (Miller & Vian, 2010). In Cambodia, where 82% of total health expenditures in 1999 were OOP payments, the introduction of official user charges with an exemption scheme for the very poor proved to be successful in two hospitals (Akashi et al., 2004; Barber, Bonnet & Bekedam,

2004). This shows that formal schemes can make it possible to exempt those in need while IPs, by definition, make such exemptions impossible.

In Kyrgyzstan, the so-called single payer reform (SPR) also successfully reduced IPs by setting realistic entitlements (free care benefit package) and formalized user charges (co-payment schedule for hospital referrals) (Vian, Feeley & Domete, 2014), although the achievements could not be sustained in the long term (Jakab, Akkazieva & Kutzin, 2016). The revenue from the co-payment could be retained by the hospital and used to supplement salaries (20%) and cover medicines and food (80%). Unfortunately, some problems have arisen related to theft of co-payment revenue. Further, IPs have started to rise again since 2006, mainly due to payments made to health-care personnel, despite the substantial salary increase implemented in 2011 (Jakab, Akkazieva & Kutzin, 2016). The Kyrgyz experience suggests that measures to tackle IPs through pay rises for medical doctors alone are unlikely to be successful as the patient side of the transaction is ignored.

4.2 Measures introduced in Greece

Several health-system interventions implemented in Greece are directly related to the practice of IPs, yet so far none of these has brought about a breakthrough in the fight against the hidden health economy. Although not exhaustive, and in non-chronological order, the list of relevant measures (including pay rises for medical doctors, enforcement of regulations, the surgical list and afternoon clinics) is discussed in the following paragraphs.

The pay rise for medical doctors did not prove successful in eliminating IPs for health care. The low salaries of health workers, especially physicians, are frequently cited as a key factor in the emergence and persistence of IPs but there is evidence that even a relatively large pay rise is, in itself, not enough to address the problem. Prominent examples include the new deal with the medical profession that accompanied the establishment of the ESY in Greece in the 1980s and which tripled wages (I1, I13). In Hungary, a 50% (on average) pay rise was implemented as part of the election promises of the new government in 2002 (Gaál, Jakab & Shishkin, 2010). More recently, similar failures have been reported from Kyrgyzstan (Jakab, Akkazieva & Kutzin, 2016), and a study of 33 hospitals in Argentina found that salary increases did not decrease procurement corruption (Savedoff, 2008). While not denying that low salaries should be tackled as part of a comprehensive reform plan against IPs, pay rises alone are not enough because they ignore the other participants – the patient side. In order to achieve lasting results the motivation of patients should also be taken into account and addressed, especially (real or perceived) shortages and lack of trust in the system. Public awareness is an important part of this (I2, I13). Making people aware that they are entitled to receive care without IPs, or that what they do is wrong, is unlikely to prevent them from making IPs unless they are convinced that IPs are not needed to ensure proper care.

So far, efforts to address the phenomenon through the legal-regulatory framework do not seem to have brought tangible results in Greece. IPs have become part of the fight against public-sector corruption and the legal approach is emphasized by both the government and international organizations, yet the key informant interviews suggest that current arrangements are ineffective in catching and punishing perpetrators in even the most extreme cases of extortion (I1, I2, I3, I4, I6, I8, I9, I10, I12). Key informants cite several reasons for this apparent failure, including: lack of cooperation from patients and relatives;

insufficient enforcement capacities; the long and complicated process of serving justice; lack of proper coordination and cooperation between authorities; and the lack of trust and even corruption in the legal system. But the most important problem is that this approach does not address the root causes of IPs which lie in the failures of the health system and not in unprecedented immorality of Greek doctors and patients. While not denying that corruption is part of the phenomenon of IPs (bribe-type) and efforts to curb extortion and malfeasance are important and should continue, the legal approach is unlikely to bring about significant change without addressing health-system failures. Without clear and realistic entitlements in the health system individual interpretation of entitlements can, and will, differ; the boundaries between what is and what is not acceptable will remain blurred; and legitimacy (an indispensable ingredient of an efficiently functioning legal system) will remain insufficient.

Taking account of international experience, introduction of the surgical list seems to be an important step towards achieving greater transparency in the operation of the Greek health system even though it has the same vulnerabilities as the legal approach in addressing IPs for health care. For example, publication of the waiting lists together with effective complaint mechanisms for two Croatian hospitals brought about noticeable improvements in waiting times (Vian, Feeley & Damente, 2014). Given the relatively short time since its introduction, it is not possible to provide a thorough evaluation of this policy (I7). Key informants report positive first experiences with the list, with some difficulties in the technical aspects of implementation such as the hospital-based allocation of registration numbers; handling of old cases; internet access to the list; and the role, workload and remuneration of surgical committees (I7, I9, I11). The mixed reception from both patients and doctors is not unexpected; the unhappiest stakeholders are those who have lost the most from greater transparency in the allocation of capacities (I7).

Nevertheless, the extent to which the waiting order can be tampered with is a key issue. Some key informants (I8, I9, I12) report that waiting lists can be bypassed easily by making the cases urgent. The same practice can be observed in hospital admissions of private patients (Liaropoulos et al., 2012). Similarly to all other cases of regulation and enforcement, effective implementation can be ensured only if the majority of involved parties – including patients, doctors, other health workers and hospital managers – consider the policy reasonable and legitimate and consequently comply voluntarily so that enforcement is needed only on the margin. In terms of technical implementation, the policy could be developed further by using a country-based identification of patients. This has lots of other potential to improve care coordination and ensure more efficient allocation of resources and utilization of public services. Hungary provides a good example of the exploitation of unique patient identification on the basis of which an innovative care coordination pilot was implemented between 1999 and 2008 (Gaál, 2004a; Gaál, Evetovits & Sinkó, 2006; Gaál, Szigeti, Panteli et al., 2011).

The afternoon clinic initiative² is an interesting attempt to formalize some informal transactions by creating a legal framework of exit within the boundaries of the public system, but implementation experiences are mixed. Uptake of this option is considered slow, but volume is high and the measure may have made some small reductions in IPs (I11). Some implementation difficulties have arisen from hospital staff finding the boundary between the public and private sector unclear (I11). Given that the tariff within the scheme is regulated, there should be an emphasis on setting an economically fair fee schedule that

2 The afternoon clinic initiative offers public doctors the possibility to use public facilities for private consultations.

allows gains comparable to those that can be realized from IPs so that the financial incentives do not work against the formal system. An economically fair tariff is higher than at least the variable cost of the service so that the physician does not incur losses. Further, it should approximate the opportunity cost of the time of the physician, in this case the revenue lost from IPs. Given that the formal tariffs are not based on proper cost assessment it is possible that the current arrangements are not economically fair and it is not realistic to expect individuals to run a scheme, or observe rules, under which they incur financial losses or continuous personal sacrifices. This is also relevant for the social health insurance scheme, in the frame of which it is perfectly possible for a monopsonistic single payer to use its market power to set reimbursement tariffs too low (below economically reasonable), making providers feel it legitimate to circumvent the rules and game the system. This has been the experience in the case of free consultations by EOPYY-contracted private providers, some of whom may have justified gaming the system by exhausting the full quota of 200 consultations in the first three to four days of the month, because they considered the €10 consultation fee unfairly low (14).³ Without adequate information on the actual costs of services, it is very difficult to set correct financial incentives. Also, it is not wise to try to counter the impact of badly set financial incentives through regulations and enforcement, albeit this is the approach often taken by decision-makers in the public sector (e.g. limiting the number of cases per day, as in the aforementioned case) (14) (Economou, 2010, 2015). International experiences with schemes which open up the possibility of exit within the boundaries of the public system (e.g. private wards in Ireland) are also mixed as there are always risks that the private option works against the public-service provision, for example by decreasing the available public capacities or by reversed cross-subsidization (Vian, Feeley & Domete, 2014).

5. Policy options for Greece

IPs for health care can be addressed successfully only if reforms aim at eliminating the root causes of the phenomenon, as presented in Table 1. Ignorance-, fee- and bribe-type informal payments coexist in Greece and therefore each has to be addressed in order to eliminate the phenomenon. From the policy-making perspective the most important of these is the fee-type IP which is the product of (real or perceived) shortages in the health system. Gift-type IPs also exist but should not be a reason to justify non-action, because the blurred boundaries with fee-type IPs can easily paralyse policy-making and implementation.

Some root causes of IPs – such as (lack of) trust in the health system – are impossible to change in the short term and so any viable plan must be considered over a longer time horizon. Structural inefficiencies are key performance problems for longer-term systemic reforms to address shortages and rebuild lost social capital.

The complex and multifaceted nature of the root causes of informal payments requires interventions that are comprehensive and well-sequenced, backed by adequate and stable funding. Some of this funding can and should come from reinvestment of efficiency gains resulting from any reform of the health system. This can create a desirable positive feedback loop that greatly enhances the sustainability of

3 It is important to note that the quota will be abolished as of 1 January 2018.

the implemented changes. These are likely to be critical success factors (Gaál, Jakab & Shishkin, 2010). Fortunately, the government appears to show a commitment to support such a transformation of the health system (I1) with both the reinvestment of efficiency gains and increases in public expenditures on health from additional revenues from health taxes such as those on tobacco and alcohol (Ministry of Health Greece, internal document, 2015, actions 84 and 95).

Nevertheless, a long-term health-system transformation plan alone is unlikely to eliminate IPs, or even reduce them significantly, because the long implementation period allows key players in such transactions to adapt gradually to step-by-step changes. Consequently, some form of quick fix is an indispensable component of a comprehensive plan for the elimination of IPs. Such solutions address them directly by taking account of the type of IP to determine the motivation and underlying cause.

The strategy to address IPs should mix two components: (i) long-term and large-scale health-system reforms focused on potential efficiency improvements; and (ii) short-term measures that address the phenomenon directly. It is very important to ensure that these two are compatible within a comprehensive plan based on a common explanatory framework that ensures the necessary seamless fit of the various interventions. According to the theoretical foundations of this report already discussed, the cognitive-behavioural model of IPs in the inxit framework has been selected for this purpose.

5.1 Approaches for reducing and eliminating IPs

Despite the obvious failures of the justice system, the legal-ethical approach appears to be dominating current policy thinking on IPs in Greece. This is also reflected in the government's 100 actions plan – action 83 includes peer pressure, sanction mechanisms, complaint mechanisms and communication campaigns, among others (Ministry of Health Greece, internal document, 2015). Yet this approach is unlikely to deliver significant tangible results in either the short or the long term, since the corruption interpretation of IPs applies only to a small proportion of extreme cases located at the margin of the phenomenon (bribe-type IPs). Patients and doctors have widely differing judgements on what is acceptable and fair, blurring the border between IPs that are corrupt and unacceptable and legitimate IPs that both groups consider necessary to correct the failures of the public system. This makes it very difficult to define any but the most extreme cases that all, or at least a definitive majority, agree to be corrupt – and it would not be surprising to see involved parties offering a rationalization or justification for even these cases.

Analysis of the data of the 2013 special Eurobarometer survey on corruption (European Commission, 2014a) shows that 70% of those in southern Europe who reported giving IPs for health care considered it unacceptable to give money or a gift, or perform a favour, in order to obtain higher quality public services. The corresponding figure in Greece was only 49%, with large regional variations from 36% in Crete to 57% in northern Greece (Horodnic et al., 2017). This implies that the bulk of IPs can be attributed to failures of the health system (fee-type IPs) and understood as the reaction of patients and doctors to these structural and functional failures, manifested as real or perceived shortages (this reaction is the informal/internal exit, the so-called inxit). While the classic approach of detect, punish and deter is, therefore, both ineffective and inefficient for addressing these mainstream fee-type IPs, it is very useful for addressing bribe-type IPs if and when there are clear boundaries between the two types of payment, and the fee-type IPs are also addressed with appropriate policies.

Consequently, it is recommended that the policy focus on addressing IPs should be shifted from the legal-ethical approach to reform of those health-system characteristics that induce and maintain (fee- and ignorance-type) IPs. Nevertheless, changing priorities should not mean that efforts to increase the effectiveness and efficiency of the legal-regulatory system should be abandoned. They can and should continue, provided that this tool is not misused to discriminate, blame and punish participants in all IP transactions. It is interesting to consider the other marginal type of IP: gratitude payments or gratuities. Gift-type IPs lie at the other margin of this phenomenon and, given their allegedly benign nature, are often misused by the medical society to make the practice of IPs acceptable and justify inaction (Gaál & McKee, 2005). While this is in sharp contrast to the approach that blames it all on doctors and patients, both approaches make the mistake of treating different types of IPs alike. The evidence discussed before has confirmed that fee-type IPs are the mainstream in Greece. Both bribe- and gift-type IPs are outliers, representing only a small part of the phenomenon.

The inxist theory of IPs suggests that any reform measure that improves the efficiency of the health system, frees up resources and makes it possible to reallocate resulting efficiency savings to shortage areas (in particular, remuneration of health workers) will contribute to reduction of the problem. In terms of health policy-making, the only other requirement for putting together a meaningful plan is that the various reform measures should be compatible and fit within a comprehensive whole. Although it is beyond the scope of this report to consider all potential health-system interventions, the following paragraphs highlight some key measures, distinguishing between long-term measures to enhance efficiency and quick fixes to address IPs directly.

5.2 Long-term measures

International experiences have been distilled into several dos and don'ts in efficiency enhancing reforms, most of which are directly or indirectly related to addressing fragmentation in both financing and service delivery functions (Gaál, Rekassy & Healy, 1999; Gaál, Evetovits & Sinkó, 2006; Kutzin et al., 2010; Gaál & Sinkó, 2014). A non-exhaustive list includes reduction of the fragmentation of pooling, introduction of selective contracting, pay for performance, efficiency enhancing provider-payment methods coupled with increased provider autonomy, territorial supply obligation with a progressivity-based referral system, primary-care reforms, and health-care provider based care coordination with disease and case management. It is important to note that several major reforms have already been implemented, are under implementation or are being considered in the Greek health system. A few notable examples are establishment of the ESY; merging the social health insurance funds into one main purchaser (EOPYY); introduction of diagnosis-related groups for greater transparency in hospital payment; reforms of primary health care; and introduction of the system of territorial supply obligation. Unfortunately, the complex politics surrounding the various interventions have led comprehensive health policies to encounter frequent setbacks, abandonment and failed or partial implementation (Kyriopoulos, Economou & Dolgeras, 2001; Economou, 2010).

Despite recent significant progress the Greek health system still has much potential to improve through greater efficiency in pooling (merging central government health budget with that of the EOPYY). Also, by developing EOPYY's ability to engage in strategic purchasing, and by introducing provider-payment reforms with increased provider (hospital) autonomy, territorial supply obligation with a progressivity-based referral system, and primary-care based care coordination, among others. If properly implemented, these can all improve the efficiency of resource use and work against IPs, provided that efficiency savings are reinvested in the health system and not taken out for fiscal stabilization. Further, implementation of some of these policy suggestions has already begun – for instance, the new law on primary health care which also aims to establish a system of territorial supply obligation.

The government's 100 actions plan is a comprehensive and ambitious programme to improve the performance of the Greek health system that targets most of the potential reform areas suggested here (Ministry of Health Greece, internal document, 2015). For IPs, the key actions of the plan include establishment of a countrywide network of family health units (successful implementation of this could be a game changer) with responsibility for care coordination (first axis, area 2); pooling reforms (third axis, area 5, actions 92 and 96); purchasing and provider payment reforms (actions 94 and 98, but also second axis, area 4, action 74, and first axis, area 4, actions 20 and 32); and improved governance and transparency through monitoring and evaluation (second axis, areas 1 and 2, as well as first axis, area 8, actions 47, 48 and 50). Care coordination is a common theme across many actions, and there are several promising initiatives (e.g. action 15 – patient pathway guidelines, action 51 – peer reviews between ambulatory and hospital specialists) but it is not fully clear who will be responsible for what part of the process and how case and disease management will be implemented (action 52 only talks about the need for establishing mechanisms and responsibilities for care coordination). Further, it is not clear how much provider autonomy will be given to hospital managers. The level of discretion over resource-allocation decisions should be large enough to enable hospital managers to react to the financial incentives conveyed by the new provider-payment methods.

The publicly financed benefit package is also important from the IP perspective but is not recommended as a first-choice reform as the priority-setting process is complicated and usually fraught with high politics. Nonetheless, the government's 100 actions plan aims at the reassessment of entitlements (actions 9, 16, 46), which can be useful if the process focuses on prioritization rather than reduction of the benefit package. This is coupled with the provision of information (e.g. action 4), but these will work only if the promised coverage is in line with effective coverage of the population.

Inxit theory suggests that opening up the channels of voice could help to reduce the prevalence of IPs. The government has included voice-related policies in the 100 actions plan (Ministry of Health Greece, internal document, 2015, actions 47, 49, 73) but rather than working in the short term – by playing a significant role in the elimination of IPs – these will work in the longer term by preventing their reappearance. As already discussed, international examples have successfully improved resource allocation through increased transparency, especially when such measures have been coupled with the establishment of effective channels/mechanisms of voice. Nevertheless, such interventions are more suitable for addressing ignorance-type (rather than fee-type) IPs and will have limited impact if the underlying shortages persist.

5.3 Quick-fix options

Among the few options for direct quick-fix solutions, experiences are mixed at best. Five options are considered here: (i) prohibition and enforcement; (ii) pay rises for health workers; (iii) provision of information, awareness, transparency and voice; (iv) creation of conditions for exit; and (v) formalization of IPs.

5.3.1 Prohibition and enforcement

Prohibition and enforcement is an option to address bribe-type IPs through the justice system, but both the theoretical framework and implementation experiences suggest that this is not an effective intervention unless fee- and ignorance-type IPs are addressed at the same time. As already discussed, the success of any regulatory measure is dependent on the majority of society accepting it as fair and reasonable. Consequently, the few violators face a high risk of being caught and a reasonable level of enforcement capacities. In contrast, the majority of Greek society considers IPs legitimate, with blurred boundaries between fee- and bribe-type IPs. It is vital to address fee-type IPs through reform of the health system to make this border clearer if the regulatory approach is to work. Without this, no improvement in the legal system (e.g. whistle-blowing legislation) or in the legal framework to punish those who accept IPs through social health insurance contracts (as in the Republic of Moldova) or the mystery patient programme (Vian, Feeley & Domete, 2014) could reduce IPs significantly.

An alternative to the legal approach uses the mechanisms of a sense of duty (i.e. train medical doctors in medical ethics) (I2). This is not part of the current medical curriculum in Greece (I2). Use of the sense of duty can potentially be useful to decrease the cost of enforcement but it cannot substitute measures needed to address fee-type IPs. Further, regulation via ethical norms is usually run by professional self-regulation institutions such as medical chambers.

5.3.2 Pay rises for health workers

International examples show consistently that, on its own, even a relatively high pay rise for medical doctors is doomed to fail, most probably because it does not address the patient side of the transaction. Pay rises for medical doctors are an option for addressing fee-type IPs by addressing provider-side shortages. International and domestic evidence shows that a pay rise alone is ineffective because it does not address the motivation of the user side. Greece experienced this failure when the ESY was introduced – despite a relatively high pay rise the practice of fakelaki has persisted.

5.3.3 Provision of information, awareness, transparency and voice

The provision of information, raised awareness and increased transparency, and establishment of channels of voice (complaint systems) are a means to address ignorance-type IPs in the short term and can also be useful in preventing re-emergence of the phenomenon in the long term. Increased transparency requires information in the short term, together with effective methods and channels of communication. The several options range from information posters on the walls of health-care providers to printed and electronic media campaigns, or the involvement of issue champions (e.g. VIP campaign faces). It is debated whether some of these methods can be counterproductive (e.g. information posters in service providers raise the attention of patients who might misinterpret them and assume that the contrary is true). In the organizational setting there is evidence that management of service providers plays a key role and personal examples can change organizational culture for the better (e.g. the case of the Albanian hospital director, described in section 4.1). Further, there is evidence that increased transparency is

successful only if complemented by effective channels of voice. Involvement of civil society has great potential and opens the door to new, innovative approaches such as the introduction of social audit in the Republic of Moldova (Vian, Feeley & Domete, 2014). Nevertheless, such measures may contribute to the persistence of the phenomenon unless they are complemented by reforms to address shortages in the system. The government's 100 actions plan covers several of these options.

5.3.4 Creation of conditions for exit

Another option is to create the conditions for exit, but these work only if both parties find the formal alternative almost as desirable as the informal. Experiences with the afternoon clinic show that it is very difficult, if not impossible, to put together such a scheme. Further, there is a danger that public doctors concentrate their efforts on those patients who use the private option while patients in the public system can be neglected.

5.3.5 Formalization of IPs

The most promising option is formalization of IPs, but the Hungarian example shows that the introduction of user charges (co-payments) is generally not a good means of doing so. This is because user charges that are not based on understanding of the motivation for IPs add to, rather than replace, the burden of IPs. Inxit theory suggests that any formalization attempts should be based on analysis of what is perceived to be lacking in terms of access to publicly financed health care for which doctors expect a payment and patients are willing to pay informally.⁴ The key informant interviews are surprisingly consistent in identifying this as choice of physician in the Greek health system (similar to Hungary) (I02, I04, I08, I09, I11, I13). Greece can learn from the failure of the Hungarian experience of formalizing IPs – the policy of charging patients for choice of doctor was workable in theory but implementation failed because it did not take account of some key characteristics of IP transactions. First, initial charges must be very moderate so that a large proportion of the population can afford to participate. Second, purchasers should pay the fee in addition to (not instead of) the provider payment otherwise hospitals have no interest in collecting the fees. Third, a substantial part of the revenue should go directly to the medical doctor treating the patient in order to encourage the doctor's participation in the formal scheme, rather than the informal one. Fourth, the payment should be subject to no (or at least little) taxation. Fifth, medical doctors who treat non-paying patients should receive some additional payment (i.e. from the purchaser) in order to avoid any negative consequences on access to care. This latter, however, requires some additional public money.

⁴ As discussed before, inxit theory suggests that the gap between rhetoric (what is promised to the population in the benefit package) and reality (what is actually delivered) can be addressed by patients and doctors reassessing official entitlements and excluding certain services from the official benefit package for which doctors expect a payment and for which patients are willing to pay out of pocket. Where the majority of patients and doctors agree, a new unwritten set of entitlements emerges as a new informal benefit package which is closer to the reality. The key to a quick fix for IPs is formalization of those transactions which lie outside the official benefit package, but this requires the transactions to be identified first – the service(s) excluded from the publicly funded benefit package in line with majority decision of patients and doctors as a result of the individual reassessment of entitlements.

This scheme has three key ingredients: (i) clearly defined patient pathway for each health problem free of user charges; (ii) two main sources of remuneration for medical doctors: fixed monthly salary and performance-related bonus payment; and (iii) same (or at least similar) bonus payment after each patient to ensure that non-paying patients are not discriminated against. All of these are important to make this scheme work in practice and to mitigate any potential adverse effects related to the characteristics of fee-for-service payment systems.

5.3.6 Technical details of the formalization of IPs

The feasibility of the formalization of fakelaki has a technical and a political aspect. Formal user charges are a highly political issue and it might well be that the government finds that implementation of the proposal involves too much political risk to be acceptable (I1). These political risks have to be weighed against the detrimental impact of letting IPs persist. It is important to understand that poor people suffer at least as much (and likely even more) under the current system as under any formal alternative, because it is not possible to grant exemption from an informal practice.

Under the proposed system the remuneration of hospital doctors has two components: (i) fixed monthly salary; and (ii) bonus payment related to the number (and complexity) of patients attended. It is possible to set and adjust the proportions of these two components freely and they can be different for different groups of medical doctors (e.g. by specialization, levels of care, regions, academic level). Detailed calculations are needed to put together an initial model which could then be refined on the basis of actual implementation experiences.

Two benchmarks can be used to set an acceptable (fair) level of salary. First, in many respects Greece is aiming to achieve the EU average, hence the EU average can be used as a target salary level. Second, many areas of the Greek health system have an extensive private sector. The level of pay in this sector is an appropriate and realistic benchmark given that it is the public sector's most immediate competitor for human resources for health.

5.3.7 Preconditions of implementation

Some partly technical, partly political issues of implementation must also be considered, including additional public revenues, establishment of a referral system and setting of the user-charge schedule. Establishment of a single national pool is not a prerequisite for this scheme to succeed but unified cost reimbursement helps to convey the right financial incentives to improve production efficiency. Most of these are addressed in the government's 100 actions plan (Ministry of Health Greece, internal document, 2015, actions 84 and 95) and the introduction of a new referral system has already been passed by the parliament.

Additional financial resources are needed to cover the performance-based bonus payment for doctors treating regular, non-paying patients. These can come either from reinvestment of efficiency gains or from additional public investment in the health system.

Implementation of a referral system is needed to designate the free patient pathways in the system, deviation from which must be paid out of pocket. Patient pathways are designated on the basis of catchment areas (the territorial supply obligation) of each health service provider for each health service. The system of territorial supply obligation is further complicated by so-called progressivity levels that

are defined in relation to the complexity of cases requiring treatment for the same condition. These levels rise in tandem with the complexity of the cases treated – the higher the level, the greater the complexity of the cases that the service provider is capable to attend. In order to achieve a seamless functioning the system has to be complete (i.e. without gaps) in terms of both the scope of services and levels of care.

5.3.8 Potential side effects

The bonus payment is a fee for service and therefore can have negative effects such as supplier induced demand and cost explosion. Such important problems have to be monitored and addressed where necessary.

There are several options to tackle these problems within and outside the payment scheme. Within the payment scheme the bonus payment can be decreased in parallel with an increase in the fixed salary in the remuneration package. Outside the payment scheme, any reforms aiming to establish care coordination through referral could mitigate this side effect by avoiding unnecessary hospitalizations.

5.4 Politics and management of change

Successful implementation of the comprehensive plan recommended here is much more dependent on the political than the technical aspects of feasibility. The history of health-sector reforms in Greece shows many technically well-designed and meaningful reform programmes which failed mostly due to the opposition of powerful stakeholder groups (such as medical doctors) or to battles between political parties and political instability. The latter is a major obstacle to much-needed continuity of implementation.

It seems that expertise in change management and experience of large-scale system transformations are much more necessary than technical assistance on what to do to make things happen in the Greek health system. Nevertheless, a few pertinent technical points include the sequence of reforms; whether a regulation is made compulsory upfront or based initially on voluntary compliance; or how much certain interventions change the power and composition of stakeholder groups, which in turn can influence how a coalition for change can be built up.

The quick-fix policy has inherent political risks. Formalization of IPs may be seen as the creation of a barrier to access care, but in fact it aims to eliminate the access barrier and financial hardship that they create. Political risks have to be weighed against the well-known problems caused by the persistence of IPs.

Political risks can be decreased by techniques such as focusing on implementation of preconditions and ensuring that they are fully functional before the quick fix is brought to the forefront. This could be achieved by starting with a pilot in a few hospitals or building stakeholder support by inviting relevant stakeholders into the planning process. In order to start implementation a number of preconditions must be met by other reforms. These include full-scale implementation of the progressivity based referral system, and provision of additional public revenues which can be generated from the implementation of cost-saving reforms, if no other source is available.

An important prerequisite for achieving complex (so-called high-hanging fruit) reforms is knowledge of what is happening in the system. This requires the development of an information system which identifies patients with a unique (national) identification number for all episodes of health-care utilization. Further, the collection of proper cost information is a prerequisite for setting the economically fair tariffs necessary to set the correct financial incentives. In general, a modern health information system is key for exploiting the efficiency gains brought about by the digital revolution. All of these are part of the government's 100 actions plan and are being implemented (Ministry of Health Greece, internal document, 2015, actions 11, 66, 86, 87 and 99).

If it is impossible for political parties to achieve consensus on a long-term health-system transformation strategy, the change coalition should be established with the involvement of relevant stakeholders in the health system and civil society. Health-care managers could be an important stakeholder group and allies in health-system transformation, but they are currently relatively weak because of restricted managerial autonomy in hospitals. With the implementation of hospital payment reforms, hospital directors can be strengthened and further efficiency gains could be realized, which in turn could be used to finance the quick-fix policy.

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Annex

List of participants at workshop in Athens, 7 November 2017.

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