Changing Perceptions of Informal Payments under Privatization of Health Care: The Case of Kazakhstan

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Abstract

Previous studies on informal exchanges in the health care sector in post-socialist states have extensively discussed their complex and diverse nature, in particular the difficulty in distinguishing between gratuities and bribes given to health care providers. In examining this in Kazakhstan, I argue that the ongoing privatization of health care has blurred the boundary between official user fees and informal payments given as a reward for quality care. This has, in turn, sharpened the contrast between informal payments given in the expectation of proper treatment and money extorted by health practitioners. This paper also demonstrates that ordinary people often circumvent formal procedures by using money to obtain services to which they are not officially entitled or to gain access to public medical funding.

Keywords

informal payments – privatization of health care – fee-for-service – extortion – Kazakhstan

Over the past two decades, the phenomenon of informal payments in the health care sector in Eastern Europe and former Soviet states has attracted considerable scholarly attention. Studies from different disciplines have investigated the extent, nature, and causes of informal payments, as well as their effects on equity and access to health services. While research purposes and methods vary, the topics examined in these studies can generally be grouped into three categories. First, scholars have tried to elucidate structural factors that have contributed to the prevalence of informal payments; they

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have also evaluated possible policy options to reduce such payments. Lack of transparency and accountability, the tradition of giving a reward for services rendered, and other factors have been mentioned as causes for the embedded practice of making informal payments for health care. Among other factors, there appears to be a consensus that severe economic decline, significant welfare retrenchment, and deep cuts in public spending following the end of planned economies in addition to subsequent market reforms had the greatest impact on the proliferation of informal payments.[1] Socialist regimes considered the health care sector to be "unproductive" in the economy and as a result did not make it a high priority. Limited budgets and over-centralized, ineffective management led to the under-supply of health services, and people commonly used personal connections and informal payments to get access to quality medical treatment.[2] The collapse of the socialist welfare system result- ed in an unprecedented decline in the quantity and quality of state-provided health care, which fueled severe competition over resources. In addition, the inadequate incomes of medical workers, which were very low not only in absolute terms but also relative to other industries in many post-socialist countries, created a strong incentive to accept or demand informal monetary payments from patients. Given budget constraints and the inability of governments in many countries to provide free universal health care, scholars have examined what policies would serve to eliminate informal payments, including their legalization in the form of official user charges and the introduction of health insurance systems.[3]

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1 D. Sharipova, "State Retrenchment and Informal Institutions in Kazakhstan: People's Perceptions of Informal Reciprocity in the Healthcare Sector," *Central Asian Survey*, 34, no. 3 (2015): 310–20.

2 M. G. Field, "Postcommunist Medicine: Morbidity, Morality and the Deteriorating Health Situation," in J.R. Millar and S.L. Wolchik (eds.), *The Social Legacy of Communism* (New York: Cambridge University Press, 1994), 178–95.

3 T. Ensor, "Informal Payments for Health Care in Transition Economies," *Social Science and Medicine*, 58, no. 2 (2004): 237–46; M. Fotaki, "Informal Payments: A Side Effect of Transition or a Mechanism for Sustaining the Illusion of 'Free' Health Care? The Experience of Four Regions in the Russian Federation," *Journal of Social Policy*, 38, no. 4 (2009): 649–70; M. Lewis, "Informal Health Payments in Central and Eastern Europe and the Former Soviet Union: Issues, Trends and Policy Implications," in E. Mossialos, A. Dixon, J. Figueras and J. Kutzin (eds.), *Funding Health Care: Options for Europe* (Buckingham: Open University Press, 2002), 184–205; M. Lewis, *Who Is Paying for Health Care in Eastern Europe and Central Asia?* (Washington D.C.: World Bank, 2000); R. Thompson and S. Witter, "Informal Payments in Transitional Economies: Implications for Health Sector Reform," *International Journal of Health Planning and Management*, 15, no. 3 (2000): 169–87.

In the second category, studies on health care in former socialist states have aimed to measure the extent of informal payments and provided evidence on who was paying or receiving them. Despite differences among countries, the reported frequency and estimated amount of informal payments have generally indicated that they have a significant impact on individual households and the health system as a whole. Data have been accumulated on the relationships between the use of informal payments and patients' demographic, socioeconomic, and health backgrounds (e.g. gender, age, education level, occupation, income level, place of residence, and morbidity) in various countries. These analyses have revealed that informal payments have become a serious impediment to health care access, especially among the poorest segments of the pop- ulation.4 Studies have also investigated how the type of treatment (inpatient or outpatient care, provider specialization) and location of care (e.g. clinic or hospital, urban or rural, public or private) affects the frequency with which patients make informal payments. Surgery and obstetrics have been named as the areas where the use of informal payments is the most widespread.5 The relationship between informal payments and physicians' behavior has also been explored, specifically whether and to what extent prior payment influences the quality of care they provide.6

In the third category, scholars have sought to shed light on people's perceptions of, and attitudes toward, informal exchanges, and the circumstances under which such practices occur. Studies on various countries have focused on the following questions: why do patients or their families make informal payments to individual providers or health care institutions; why do physicians and nurses accept or even demand cash from patients; and what are the types

4 D. Balabanova and M. McKee, "Understanding Informal Payments for Health Care: The Example of Bulgaria," *Health Policy*, 62, no. 3 (2002): 243–73; J. Falkingham, "Poverty, Out-of-Pocket Payments and Access to Health Care: Evidence from Tajikistan," *Social Science and Medicine*, 58, no. 2 (2004): 247–58; N.N. Habibov, "The Inequity in Out-of-Pocket Expenditures for Healthcare in Tajikistan: Evidence and Implications from a Nationally Representative Survey," *International Journal of Public Health*, 56, no. 4 (2011): 397–406; N. Sari and J.C. Langenbrunner, "Consumer Out-Of-Pocket Spending for Pharmaceuticals in Kazakhstan: Implications for Sectoral Reform," *Health Policy and Planning*, 16, no. 4 (2001): 428–34.

5 N. Danilovich and E. Yessaliyeva, "Effects of Out-of-Pocket Payments on Access to Maternal Health Services in Almaty, Kazakhstan: A Qualitative Study," *Europe-Asia Studies*, 66, no. 4 (2014): 578–89; S. V. Shishkin, T. V. Bogatova, Y. G. Potapchik, V. A. Chernets, A. Y. Chirikova and L. S. Shilova, *Informal Out-Of-Pocket Payments for Health Care in Russia* (Moscow: Inde- pendent Institute for Social Policy, 2003).

6 R. Thompson and A. Xavier, "Unofficial Payments for Acute State Hospital Care in Kazakhstan. A Model of Physician Behaviour with Price Discrimination and Vertical Service Differentiation," *licos Discussion Paper* 124, Licos Centre for Transition Economics (2002).

of payments (monetary or non-monetary) and the specific circumstances (e.g. voluntary or forced, before or after services)? From these studies, it has been revealed that both in-kind and cash payments are made, but that the latter have become more common since the transition to a market economy. Researchers also agree that the boundary between gifts and bribes is not necessarily clear, as it is often difficult to precisely determine whether payments are made voluntarily or whether patients are being forced to make them. Neither the timing nor the legality of the exchange can serve as criteria for distinguishing between gratuities and other forms of informal payments. One may argue that a contribution made after services should be understood as a genuine gratuity, as it does not influence the content or the quality of care. If a patient receives continuous care by the same doctor, however, it is not possible to draw a clear line between "before" and "after." The legality of monetary or other transactions depends on the local legal context, which may change over time even within the same state. In addition, similar exchanges may be perceived differently depending on the context, as the characteristics of informal transactions are influenced by actors' behaviors and interactions with each other.7

In all three categories of studies—and in the third one in particular—the definition of informal payments has been one of the most debated issues. In a systematic review of 61 papers using a definition of informal payments in the

7 P. Belli, G. Gotsadze and H. Shahriari, "Out-of-Pocket and Informal Payments in Health Sector: Evidence from Georgia," *Health Policy*, 70, no. 1 (2004): 109–23; J. Morris and A. Polese, "Informal Health and Education Sector Payments in Russian and Ukrainian Cities: Structuring Welfare From Below," *European Urban and Regional Studies*, 23, no. 3 (2016): 481–96; A. Polese, "Informal Payments in Ukrainian Hospitals: On the Boundary between Informal Payments, Gifts, and Bribes," *Anthropological Forum*, 24, no. 4 (2014): 381–95; S. Stan, "Neither Commodities nor Gifts: Post-Socialist Informal Exchanges in the Romanian Healthcare System," *Journal of the Royal Anthropological Institute*, 18, no. 1 (2012): 65–82; T. Stepurko, M. Pavlova, I. Gryga and W. Groot, "Informal Payments for Health Care Services—Corruption or Gratitude? A Study on Public Attitudes, Perceptions and Opinions in Six Central and Eastern European Countries," *Communist and Post-Communist Studies*, 46, no. 4 (2013): 419–31; M. Rivkin-Fish, "Bribes, Gifts and Unofficial Payments: Rethinking Corruption in Post-Soviet Russian Health Care," in D. Haller and C. Shore (eds.), *Corruption: Anthropological Perspectives* (London: Pluto Press, 2005), 47–64; M. Rivkin-Fish, *Women's Health in Post-Soviet Russia: The Politics of Intervention* (Bloomington and Indianapolis: Indiana University Press, 2005); T. Vian, K. Gryboski, Z. Sinoimeri, and R. Hall, "Informal Payments in Government Health Facilities in Albania: Results of a Qualitative Study," *Social Science and Medicine*, 62, no. 4 (2006): 877–87; P. Gaal and M. McKee, "Fee-for-Service or Donation? Hungarian Perspectives on Informal Payments for Health Care," *Social Science and Medicine*, 60, no. 7 (2005): 1445–57.

health care sector, Chereches, et al.8 found three definitions that they described as original: Lewis,9 Belli et al.,10 and Gaal et al.11 Chereches and co-authors concluded that the definition by Gaal et al. ("a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others acting on their behalf, to health care providers for services that the patients are entitled to") is "the best available starting point." The advantage of this definition, according to Chereches, et al., is its comprehensiveness and neutrality, which avoids the potentially problematic classification of informal payments as either legal or illegal, voluntary or forced, ethical or unethical. Gaal and his co-authors described informal payments as being distinctive due to the "*superfluous* [emphasis original] characteristic of the contribution, regardless of whether utilization is free or entails a direct contribution (copayment) set out in the terms of health care entitlements."12 Many authors have cited the clear and concise definition by Lewis ("payments to individual and institutional providers in kind or in cash that are outside official payment channels or for purchases meant to be covered by the health care system"). This may be limited, however, as Lewis explicitly excludes discretionary gratuities from the category of informal payments, while recognizing the difficulty in distinguishing them from one another.13

As typically seen in the literature on the definition of informal payments, previous studies have extensively discussed the complex and diverse nature of informal exchanges in the health care sector. This paper aims to illuminate two aspects that have largely remained outside of the discussion. The first concerns the ways in which ongoing marketization of health care has changed people's perceptions of and attitudes toward informal payments. Due to the introduction of user charges, the practice of choosing and purchasing quality care has become commonplace. As explained below, Kazakhstan's laws allow health care providers (both private and public) to charge certain fees for services be- yond the minimum standard. These market-oriented health care reforms have

8 R.M. Chereches, M.I. Ungureanu, P. Sandu and I.A. Rus, "Defining Informal Payments in Healthcare: A Systematic Review," *Health Policy*, 110, nos. 2–3 (2013): 105–14.

9 Lewis's paper mentioned in Chereches et al. was first presented at a workshop held in 1999 and published in 2002. I quote Lewis 2002 here as the original unpublished paper is not available.

10 Belli et al., "Out-of-Pocket and Informal Payments in Health Sector."

11 P. Gaal, P.C. Belli, M. McKee and M. Szócska, "Informal Payments for Health Care: Definitions, Distinctions and Dilemmas," *Journal of Health Politics, Policy and Law*, 31, no. 2 (2006): 251–93.

12 Gaal et al., "Informal Payments for Health Care," 276.

13 Lewis, *Who Is Paying for Health Care in Eastern Europe and Central Asia?*

blurred the boundary between official and unofficial payments for desired services, further sharpening the contrast between informal payments given in the expectation of adequate care and extortion by physicians who abuse their professional authority. My interviews in Kazakhstan have revealed that patients and their families generally distinguish informal payments based on pre-negotiation with health care providers from extortion by physicians, and their attitudes toward the two types of payments are often contrasting. Many are ready to make a monetary payment to a physician who has agreed to make frequent visits to a patient during his or her stay in the hospital. Yet an emergency surgeon who extorts cash from a seriously injured car accident victim isharshly criticized.

Second, although informal health care payments definitely constitute a serious burden on many households, people are not one-sided victims of the rampant use of informal payments in the health care sector. Contributions to health care providers (and health officials) are not limited to those made for "services that the patients are entitled to," as defined by Gaal and his co- authors. Ordinary citizens often find such payments convenient if they allow them to procure services to which they are not officially entitled or circumvent formal procedures to gain access to public medical funding. In Kazakhstan, the most widespread examples of this are purchasing false health-related certificates and authorization for expensive state-funded treatment. Such practices are commonly observed in almost all spheres of Kazakhstani society—in the avoidance of traffic citations, tax evasion, reduced terms of imprisonment, and the procurement of good grades at university, to name a few.14 In this sense, informal exchanges in the health care sector have similar characteristics to thosein other sectors.

This paper is based on empirical data collected during seven months of fieldwork in Almaty in 2011, as well as separate, two-week visits to Kazakh- stan in 2012, 2014, 2015, and 2016. These interviews were carried out as part of a larger project on informality in a variety of spheres in Kazakhstan. My interviews involved 147 respondents (out of them, four individuals were interviewed twice, in different years), including men and women of varying ages, professions, and ethnic backgrounds. Of these respondents, 62 referred to their experiences in the sphere of health care, a commonly raised topic. Generally, people were eager to share their stories with me, which indicates, on the one

14 N. Oka, "Informal Payments and Connections in Post-Soviet Kazakhstan," *Central Asian Survey*, 34, no. 3 (2015): 330–40; N. Oka, "Grades and Degrees for Sale: Understanding Informal Exchanges in Kazakhstan's Education Sector," *Problems of Post-Communism*, published online on May 30, 2018, doi.org/10.1080/10758216.2018.1468269.

hand, how acute the problem of health care access is for them, and, on the other, the extent to which obtaining favors for money has become common in daily life. I asked respondents about their personal use of informal payments as well as that of their family members, friends, and acquaintances. I also asked how and in what situations informal exchanges occur, and how they evaluated their experiences.15 Most of the interviews took place in Almaty, the financial center of Kazakhstan, with some interviews also being carried out in the sub- urbs of Almaty and in the capital, Astana. Respondents were selected through a combination of snowball sampling and introductions from local social sur- vey organizations. In what follows, the currencies provided are as reported by the respondents, with payments made using Kazakhstani tenge and U.S. dollars on different occasions. For payments in tenge, the equivalent value in U.S. dollars was calculated using the exchange rate at the time when the payment was made. The payment amounts quoted in this paper are the values reported by respondents and may not be completely accurate for a variety of reasons (incorrect recollection, shading of truth during interviews, etc.).

This paper is structured as follows. After a brief explanation of Kazakhstan's health care system and its market-oriented reforms, I present contrasting perceptions of patients and their families who gave informal payments as a reward for quality care or from whom money was extorted by physicians. I then describe how various services are exchanged for money, including the use of fabricated medical documents and the right to expensive medical treatment within the state funding quota. Finally, I conclude the paper with some remarks on the consequences of the increase in out-of-pocket—both formal and informal—payments for people's attitudes toward the health care system.

Kazakhstan's Health Care System

During the early 1990s, Kazakhstan's population experienced a deterioration in the delivery of health services due to severe economic recession and concomitant state welfare retrenchment. The government of Kazakhstan implemented one of the most drastic welfare reforms in the former Soviet states, with deep cuts in public spending and radical liberalization.16 Government expenditures

15 As in other sectors in Kazakhstan, the use of personal connections is widespread in the health care sector and serves as an important means of gaining access to medical resources. This paper, however, limits itself to examining monetary exchanges.

16 L.J. Cook, "Negotiating Welfare in Postcommunist States," *Comparative Politics*, 40, no. 1 (2007): 41–62.

devoted to health care significantly decreased in real terms and as a percentage of gdp. The closure of a number of medical facilities and the shortage of qualified medical personnel resulted in the population having limited access to necessary services, particularly in rural areas.17 In January 1996, following the legalization of private health care services and user fees, a mandatory national health insurance system was set up. Employers were required to deduct 3% from employee salaries for health insurance, while the self-employed were required to pay by themselves. Local governments were responsible for paying the contributions for socially vulnerable groups. This scheme, however, did not pan out due to large revenue shortfalls, and the national government had to reintroduce funding for health care as part of the central budget in 1999.18

The consequences of underfunding the health care sector were reflected in statistical figures. The deterioration in the quantity and quality of health services, together with other factors such as an increase in suicides and a greater rate of alcohol dependence, undoubtedly contributed to the country's sharp decrease in life expectancy, which dropped from 62.6 years for men and 72.4 years for women in 1991 to 58.0 and 69.4 years, respectively, in 1995. These figures returned to the 1991 levels only in 2009.19

From 2000, rapid economic growth and abundant oil income allowed the government to increase public health care expenditures. At the same time, Astana began seeking to diversify sources of revenue for health care financing, as well as limiting the percentage of the national budget allocated for medical services (see Table 1). The Constitution of Kazakhstan (Article 29.2) stipulates that citizens are entitled to free-of-charge medical services that are regulated by law. In November 2004, a Health Ministry decree specified the rules for the provision of the State Guaranteed Benefits Package (*Garantirovannyi ob'em besplatnoi meditsinskoi pomoshchi [gobmp]* in Russian) and established limits for the volumes of these free-of-charge services. This package is to be revised every two years, and currently includes emergency care, outpatient and inpatient care for "socially significant diseases" (e.g., malignant tumors, diabetes, myocardial infarction, rheumatism, tuberculosis, viral hepatitis B and C, and diseases caused by HIV), diseases that pose a danger to others, and prophylactic

17 Sharipova, "State Retrenchment and Informal Institutions in Kazakhstan."

18 A. Katsaga, M. Kulzhanov, M. Karanikolos and B. Rechel, "Kazakhstan: Health System Review," *Health Systems in Transition*, 14, no. 4 (2012): 1–154; M. Borowitz and R. Atun, "The Unfinished Journey from Semashko to Bismarck: Health Reform in Central Asia from 1991 to 2006," *Central Asian Survey*, 25, no. 4 (2006): 419–39.

19 "Osnovnye sotsial'no-ekonomicheskie pokazateli Respubliki Kazakhstan," Committee on Statistics, Ministry of National Economy of the Republic of Kazakhstan, http://stat.gov.kz (accessed March 12, 2018).

Table 1 *Trends in health expenditure, 1995–2014 (selected years)*

Expenditure	**1995**	**2000**	**2005**	**2010**	**2014**
Health expenditure per capita, PPP*	270.1	318.5	554.8	849.5	1068.1
Health expenditure, public (% of total health expenditure)	64.0	51.0	62.0	57.2	54.4
Health expenditure, public (% of government expenditure)	11.5	9.2	9.3	11.4	10.9
Health expenditure, public (% of GDP)	3.0	2.1	2.5	2.5	2.4
Health expenditure, private (% of GDP)	1.7	2.0	1.5	1.9	2.0
Out-of-pocket health expenditure (% of total expenditure on health)	35.5	48.5	37.5	42.3	45.1
Out-of-pocket health expenditure (% of private expenditure on health)	98.6	98.9	98.6	98.9	98.9

* In international dollars using 2011 purchasing power parity.
Source: World Development Indicators online, https://data.worldbank.org/indicator.

vaccinations.20 Pharmaceutical drugs are also provided within the benefits package, either free of charge or at a discounted price, depending on the disease and population group. For example, children, adolescents, and women of reproductive age are entitled to free outpatient pharmaceuticals. User fees for services or pharmaceuticals included in the benefits package are illegal, but all too often patients bear expenses for them. In particular, ordinary citizens are not necessarily well informed as to which services or medicines are included in the benefits package. Pharmaceuticals for inpatient care should be covered

20 Decree of the Ministry of Health and Social Development of the Republic of Kazakhstan, No. 344, May 13, 2015 (revised by the Health Ministry Decree No. 589, August 4, 2017); "Kakie bolezni budut lechit' v Kazakhstane besplatno bez medstrakhovki," *Sputnik*, August 21, 2017, https://ru.sputniknews.kz/society/20170821/3048712/kakie-bolezni-budut-lechit-v- kazahstane-besplatno-bez-medstrahovki.html (accessed March 12, 2018).

by the hospital, but if not provided, patients have little choice but to purchase drugs at their own expense. They end up buying them at pharmacies or giving money to medical personnel to obtain them.

In January 2010, the government introduced the Unified National Health Care System (*Edinaia natsional'naia sistema zdravookhraneniia [ENSZ]* in Russian) to encourage competition among health care providers by allowing patients to choose medical facilities. Since 2010, private hospitals and clinics have also been able to provide services included in the State Guaranteed Benefits Package.21 As a result, the share of services within the benefits package provided by private facilities increased from 0% in 2009 to 27.4% in 2014.22

Health insurance reforms are still in progress.23 In March 2016, the Mandatory Social Health Insurance System was re-introduced for all citizens and residents of the Republic of Kazakhstan.24 Under the new system, most medical services (outpatient and inpatient care, surgery, prescription drugs, etc.) are covered by health insurance, while certain services (emergency care, vaccinations, etc.) continue to be financed by the national government. Employers and employees are required to contribute 3% and 2% of an employee's pay, respectively, to a newly established health insurance fund. For self-employed workers, the insurance premium is set at 5% of their income. No contribution

21 Katsaga et al., "Kazakhstan: Health System Review".

22 "Iu. Iakupbaeva: 'V Kazakhstane chastnye meditsinskie organizatsii imeiut ogranichennvi dostup k gosudarstvennomu zakazu'," Association of International Pharmaceutical Manufacturers in Kazakhstan, https://www.aipm.kz/ru/novosti-i-sobytiya/717-yu-yak- upbaeva-chastnye-meditsinskie-organizatsii-imeyut-ogranichennyj-dostup-k-gosudarst- vennomu-zakazu.html (accessed March 12, 2018).

23 In Kyrgyzstan, the introduction of the mandatory health insurance system in 1997 and copayment along with the state benefits package in 2002 had certain positive results in terms of reducing informal payments. See A. Baschieri and J. Falkingham, "Formalizing Informal Payments: The Progress of Health Reform in Kyrgyzstan," *Central Asian Survey*, 25, no. 4 (2006): 441–60; J. Falkingham, B. Akkazieva, and A. Baschieri, "Trends in Out-of- Pocket Payments for Health Care in Kyrgyzstan, 2001–2007," *Health Policy and Planning*, 25, no. 5 (2010): 427–36; M. Jakab and J. Kutzin, "Improving Financial Protection in Kyrgyzstan through Reducing Informal Payments: Evidence from 2001–06," *Policy Research Paper* 57, Health Policy Analysis Center, http://hpac.kg/wp-content/uploads/2016/02/ PRP57.eng.pdf (accessed March 12, 2018).

24 The Law No. 405-V on Compulsory Social Health Insurance, November 16, 2015 (revised by Law No. 29-vi, December 22, 2016; Law No. 80-vi, June 30, 2017; and Law No. 122-vi, December 25, 2017); "World Bank to Support the Improvement of Health Service De- livery in Kazakhstan," World Bank, April 27, 2016, http://www.worldbank.org/en/news/ press-release/2016/04/27/world-bank-to-support-the-improvement-of-health-service -delivery-in-kazakhstan (accessed March 12, 2018).

is required for socially vulnerable populations, including children under 18 years of age, students, disabled persons, pensioners, the unemployed, and individuals on parental leave. In addition, members of the military and employees of law enforcement agencies are exempted from paying insurance fees. Under the law, the collection of insurance premiums started in 2017 and will be fully phased in by 2022 following a gradual increase in the contribution amount to the aforementioned levels. It remains to be seen, however, whether this goal will be achieved as anticipated. The newly introduced system increases the financial burden on employers and their employees. Among the various concerns about the program, one is that self-employed individuals with unstable or low income may find it difficult to make regular contributions of 5% of their income to the health insurance fund. Another is that there exists a general distrust of the state welfare system, which may lead to negative attitudes toward the health insurance fund and low health insurance coverage of the population.

As voluntary health insurance is still underdeveloped in Kazakhstan, 99% of private health expenditures are direct payments by households. According to the World Health Organization, in the last two decades, out-of-pocket payments fluctuated between 35 and 49 percent of total health care expenditures (see Table 1).25 This figure includes both formal and informal out-of-pocket payments, but the formal-informal ratio is unknown as the latter is difficult to measure. Moreover, the actual amount of such payments may not be fully reflected in the database. In addition to possible non-reporting or under-reporting, respondents may not be aware of whether they are paying formally or informally, as they often lack accurate information about which services or medicines are to be provided from the budget.

Despite the recent increase in public health expenditures, the inadequate in- come of health care personnel remains an unresolved issue. Monthly nominal

25 The who defines out-of-pocket health expenditure as "any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups." For other estimates of out-of-pocket (formal and informal) payments in Kazakhstan, see T. Ensor and L. Savelyeva, "Informal Payments for Health Care in the Former Soviet Union: Some Evidence from Kazakstan," *Health Policy and Planning*, 13, no. 1 (1998): 41–49; N. Sari, J.C. Langenbrunner and M.A. Lewis, "Affording Out-of-Pocket Payments for Health Services: Evidence from Kazakhstan," *EuroHealth*, 16, no.2 (2000): 37–39; D. Balabanova, B. Roberts, E. Richardson, C. Haerpfer and M. McKee, "Health Care Reform in the Former Soviet Union: Beyond the Transition," *Health Services Research*, 47, no. 2 (2012): 840–64.

wages in 2016 were significantly lower in the health care and social services sector (106,049 tenge, US$318) than in industries as a whole (142,898 tenge, US$428).26 The average monthly wage for physicians (148,823 tenge, US$446) was slightly higher than that for all workers, but was considerably lower than the wages for other highly skilled professionals, such as engineers *(inzhener*) in the oil and gas sector (300,000–1 million tenge).27 As this figure includes those working in both public and private medical facilities, the average salaries of the former are presumably even lower. Indeed, health care professionals working in public facilities tend to switch jobs and move to private clinics in order to earn higher wages.28 While dentists and pharmacies have mostly been privatized and the number of private providers is increasing, a majority of hospitals and large polyclinics remain state-owned.29 In 2017, 72.8% of all medical facilities were public.30 One physician explained the reason why young novice physicians are tempted to take bribes: not only are their salaries low, but they find it difficult to get legal supplementary income by working part-time in private clinics.31 Yet the situation appears to be different for medical facilities associated with law enforcement and the military, which themselves are generally perceived as being highly corrupt. A former military hospital nurse recalled that she and her colleagues definitely declined the offer of symbolic gifts from patients, not to mention cash payments. They were afraid of being fired as they enjoyed higher salaries than nurses working at public civilian hospitals and were entitled to a better benefits package that included housing and a pension.32

26 "Srednemesiachnaia zarabotnaia plata po osnovnym vidam ekonomicheskoi deiatel'nosti za 2010–2017gg.," Committee on Statistics, Ministry of National Economy of the Republic of Kazakhstan, http://stat.gov.kz (accessed March 12, 2018).

27 "Zarabotnaia plata rabotnikov po professiiam (dolzhnostiam) v otdel'nykh vidakh ekonomicheskoi deiatel'nosti Respubliki Kazakhstan za 2016 god," Committee on Statistics, Ministry of National Economy of the Republic of Kazakhstan, http://stat.gov.kz (accessed March 12, 2018).

28 D. Chukmaitova, "Sector-Switching in Transition Economies: A Case Study of Kazakhstan's Health Care Sector," *CGU Theses and Dissertations* 20 (2011), doi: 10.5642/cguetd/20.

29 Katsaga et al., "Kazakhstan: Health System Review."

30 "Iu. Iakupbaeva: 'V Kazakhstane chastnye meditsinskie organizatsii imeiut ogranichennyi dostup k gosudarstvennomu zakazu'."

31 Interview with a Kazakh man in his thirties, Almaty, July 20, 2011.

32 Interview with a Kazakh woman in her forties, Almaty, November 8, 2011.

Blurred Boundary between Formal and Informal Fees

Unlike in Soviet times, today those who can bear the necessary expenses are able to choose the type of care they wish to receive. Currently, both private and public medical providers are allowed to charge a fee for services outside the state-supported health benefits package. The introduction of the copayment system has made the boundary between official charges and informal payments unclear, at least as far as the latter is based on an agreement for services of a desired quality. From a patient's perspective, paying informally and directly to a physician—a practice that existed during socialist times and has become more conspicuous since the 1990s—and paying an official charge to an institutional provider are similar practices in that they have to give money for the health services that they wish to receive. Patients generally consider informal monetary payments a necessary or even proper reward for professional medical care if they are given with prior mutual consent. Even if made outside of official channels, such payments are not viewed as improper or embarrassing.

With privatization of the health care system under way, patients navigate between public care and private care by seeking adequate services in line with their financial (and geographical) situation.33 There are ways to obtain quicker and better care in both the public and private sectors, as well as formally and informally. Patients may visit private clinics and pay the consultation fee; choose the "paid department" (*platnoe otdelenie*) of public hospitals, where higher-quality services are available for a fee; or make a direct informal payment to a physician who guarantees better treatment. For example, a freelance social researcher always turned to paid services at a public hospital and booked a well-equipped room with a television and refrigerator for her 70-year-old mother, who often needed hospitalization. Most importantly, her mother did not need to call physicians and nurses, as they frequently visited her themselves. For herself, this social researcher also reserved a room with adequate care when she gave birth to her son in a provincial city in the south of Kazakhstan in 2008. She handed us$100 to an obstetrician during negotiations, a payment that she believed was necessary for the safe delivery of her baby. While public hospitals are supposed to provide maternity care for free, it is standard practice to put several pregnant women into one large room without sufficient care or attention. In the social researcher's case, the room was only

33 S. Stan and V.-V. Toma, "Accumulation by Dispossession and Public-Private Biomedical Pluralism in Romanian Health Care," *Medical Anthropology*, published online on August 6, 2018, doi.org/10.1080/01459740.2018.1492572.

for two, and the obstetrician with whom she had "arranged the deal" made frequent visits throughout her hospital stay.34 We should note here that what she paid for was not only rooms with good facilities, but also the care necessary to ensure the safety of her mother, her child, and herself.

In a similar way, a woman working for an international NGO in Almaty gave a doctor us$500 when she gave birth to her first baby in the late 2000s and us$700 for the delivery of her second baby several years later. Having admitted that the money could be construed as bribes, as both children were born at a public hospital, she justified herself by stressing that paying higher prices for better services was also "common in the West."35 While in these cases only the lead obstetrician was paid, in other cases monetary payments were made to the supervising physician or nurses as well. The monetary amount of informal fees at obstetric facilities can vary greatly, and the amount depends on various factors, including the career and social status of the physician, the type of the room at the hospital, and the location of the medical facility. Yet the general tendency is that the better the services, the more a patient is expected to pay.

Likewise, many patients and their families are willing to bear additional costs to ensure a safe surgical operation. One explanation for this is perhaps that, like delivery, surgery may result in severe complications or even the patient's death, and in both cases the results of care are rather visible. In one case, a social worker made desperate efforts to find a skilled physician when her mother needed surgery. Because of her job, she had frequently met elderly people living alone who suffered from the serious aftereffects of improper surgery or who had to have a second surgery. When she finally found a suitable surgeon, he at first declined her request due to his busy schedule, but later she managed to persuade him to operate on her mother. Although the expenses for the surgery were covered by public funding within the quota system (see below), she gave the doctor us$500 as a reward for the satisfactory results.36

If forced, however, payments are not considered to be a reward for services. Some in-depth qualitative research on informal patient payments in post-socialist countries has concluded that the practice of extortion is not endemic. A study on informal payments in the Polish health care sector found that informal payments are almost nonexistent in severe and urgent cases, and that patients admitted on an emergency basis are not denied access to necessary care

34 Interview with a Kazakh woman in her thirties, Almaty, May 28, 2014.

35 Interview with a Russian woman in her thirties, Almaty, July 30, 2011.

36 Interview with a Kazakh woman in her fifties, Almaty, October 3, 2016.

regardless of ability to pay.37 Similarly, interviews with health care practitioners in Russia revealed that doctors and nurses believed that no form of extortion or racketeering should be tolerated. They have a norm that prohibits taking money from patients whose condition is serious or those who cannot afford to pay.38 My research, however, suggests that the situation in Kazakhstan is rather different; many respondents had faced such a situation themselves or heard of extortion at health facilities, and expressed their deep indignation about it. Patients are particularly vulnerable to extortion in circumstances where there is little room for negotiation on their part.

One illustrative example involves an employee of a dairy products company who had a traffic accident after she went for a drive with friends. Leaving the wrecked car on the road, the woman and her friends were taken to a hospital by ambulance with nothing but the clothes on their backs. Instead of prompt and appropriate emergency care, which is supposed to be provided for free, the hospital demanded that she and her friends obtain necessary medicine at a pharmacy by themselves. Despite her strong objection, this accident victim was refused treatment until her parents arrived and handed cash to the physician in charge. Worse still, the treatment at the hospital was so inadequate that she later had to have a cast redone at a private clinic. She expressed deep resentment over the way she had been treated: "Free-of-charge treatment is not medical treatment. What we can get for free is an insult."39

Unfortunately, this sort of story is fairly common in Kazakhstan today. A nurse-turned-housekeeper called an ambulance for her daughter who complained of a stomachache in the middle of the night. A young surgeon on duty that night demanded 15,000 tenge (us$100 in 2002) for an appendectomy. Having promised the physician to have the money ready by 7:00 am, she desperately pleaded with the physician to start the operation while she went home to retrieve the money. The surgeon refused this request, however, insisting on receiving half of the amount immediately. In the meantime, her daughter's appendix ruptured. Recalling her terrible experience, she expressed strong resentment: "How dare he negotiate the price, as if we were at the bazaar, in front of a suffering child!"40 Another young woman I interviewed almost lost her leg after she broke it. A surgeon at a public hospital demanded as much as

37 H. Shahriari, P. Belli and M. Lewis, *Institutional Issues in Informal Health Payments in Poland: Report on the Qualitative Part of the Study*, Health, Nutrition and Population Discussion Paper Series (Washington, dc.: World Bank, 2001).

38 Shishkin et al., *Informal Out-Of-Pocket Payments for Health Care in Russia*.

39 Interview with a Russian woman in her twenties, Almaty, September 26, 2011.

40 Interview with a Kazakh woman in her forties, Almaty, July 7, 2011.

us$8,000 for an operation that was supposed to be done without any payment. While her parents were making every effort to raise the money, an infection in her leg worsened to such a serious extent that she was urgently transferred to the infectious diseases department. Luckily, she got a proper operation there without having to pay a huge sum of money.41 In another instance, a physician demanded that a former oil company employee pay several hundred U.S. dollars when his wife gave birth to their baby. When I asked whether he agreed to pay the money or not, he replied by asking me a question: "What could I do? She had already gone into labor."42 My interviews revealed that even patients with authorization and available funding under state quotas are not necessarily exempted from needing to make monetary payments at the hospital.

In demonstrating the contrasting types of informal payments, I do not con- tend that all instances of informal payments observed in Kazakhstan's health care sector can be categorized into "fee-for-service" or extortion. As discussed in the literature on informal payments, the phenomenon is indeed diverse. Symbolic gifts such as a box of sweets or a small sum of money are often exchanged. I argue that people generally distinguish money extorted by physicians from money given as a reward for medical services, but such a reward cannot be entirely distinguished from a gift. After all, patients appreciate the physician's agreement to provide necessary care, as well as the quality of care provided. Conversely, physicians and other medical workers sometimes indirectly coerce patients to "thank" them for care that is supposed to be provided for free. Acknowledging this diversity, I argue that informal health payments need to be understood not only as encounters between providers and patients. We need to place such payments in the context of health care privatization and introduction of copayments, which have increasingly blurred the line between formal and informal payments. I will return to this point in my conclusion.

Obtaining Illicit Services

In Kazakhstan, market principles have infiltrated almost every aspect of ev- eryday life, to the point that ordinary people can procure various benefits that they are not eligible to receive. "Poorly performing students get sick," a university professor told me with an ironic tone. It is an open secret that certificates of illness are available in exchange for money at some clinics. Students simply visit these clinics and buy a certificate to justify their absence from class. Those with a poor academic record can avoid dismissal from university on the

41 Interview with a Russian woman in her twenties, Almaty, October 24, 2011.

42 Interview with a Kazakh man in his forties, Almaty, October 31, 2011.

grounds of serious illness if they can present documents indicating that their illness requires long-term medical treatment.43 Working adults also purchase certificates of illness to take holidays, especially when it is difficult to take leave at work. A pharmaceutical company employee made it a habit to obtain a certificate of illness for 1,000 tenge (us$5.4). "It pays," she said, because she gets 7,000 tenge per day from her private health insurance when ill.44 The certificate of illness or disability may also be used to claim an exemption from mandatory military service.

At other times, people buy medical certificates indicating the absence of an illness. For example, users of public swimming pools need to certify that they have no infectious diseases. A young mother told me that many parents whose children take swimming lessons prefer to give money to physicians in exchange for certificates, thereby saving the time and effort of a medical checkup.45 Health examinations in the workplace are also problematic, as clinics have long lines. A woman working for a casino in the suburbs of Almaty complained that her employer does not allow employees to take days off but that checkups take more than one day to complete. This is why she and her colleagues turn to a mediator who helps them obtain fabricated medical certificates in exchange for 5,000 tenge (us$27). All they need to do is to leave their identification card and a photo with the mediator, and the document will be ready quickly without having to go to a clinic.46

To send a child to a nursery, parents must demonstrate that the child is in good health and that his or her immunizations are current. A mother of a toddler boy contacted a polyclinic physician through an acquaintance who had previously worked as a nurse, hoping to quickly obtain a children's health certificate (*pasport zdorov'ia rebenka*) for her son. Getting the certificate, as a rule, requires various tests at a children's polyclinic, and the results are available only after several days. Instead of going through this process, the mother provided some health information about the child (birthdate, height and weight at birth, and a handwritten list of previous vaccinations and inoculations) and handed a box of sweets and an envelope with 1,500 tenge (us$10) to the physician. The physician quickly examined the boy and ordered an additional vaccination, which he immediately received at the polyclinic. On the next day, the mother successfully got the certificate, without having to have a blood, urine, and stool test conducted for her child. Following the advice of her former nurse acquaintance, she also gave 500 tenge to a nurse at the same polyclinic as a sort

43 Interview with a Kazakh man in his forties, Almaty, August 2, 2011.

44 Interview with a Russian woman in her thirties, Almaty, May 26, 2015.

45 Interview with a Russian woman in her twenties, Almaty, August 3, 2011.

46 Interview with a Kazakh woman in her forties, Almaty, May 23, 2015.

of advance payment for a possible favor in the future. If a child is absent from the nursery for several days in a row, parents must obtain a physician's per- mission for the child to return. This document is available through that nurse, who, according to the acquaintance, charges 200 tenge for each certificate.47

People also make informal monetary payments to "speed up" (*uskorit'*) the time-consuming process of issuing health-related certificates, not necessarily to obtain false documents. In the case of certificates indicating the absence of illness, most people buy them simply to avoid standing in long lines at clinics or hospitals, not necessarily to hide an illness or morbidity. From the local perspective, there is little difference between purchasing illicit certificates and speeding up the process for issuing genuine documents by paying money. Some people consider both practices an essential part of life, whereas others feel uncomfortable about them. Many respondents felt that a special tariff should officially be introduced for those who agree to pay more for the quicker issuance of documents.

The use of informal payments for the purpose of circumventing official channels is not limited to health-related certificates. Before the introduction of the Unified National Care System in 2010, patients had to first see a physician at a polyclinic located in the area in which they were registered as residents. If specialized medical care was required, one had to ask a polyclinic physician to issue a medical referral letter to a specialized hospital. It is not uncommon, however, for people to live in one place but register elsewhere. For example, a young person might rent an apartment but remain registered at his or her parents' house. Some people might prefer a different polyclinic that offers better services or a polyclinic that has a physician whom they trust. In such cases, patients used informal payments to see physicians at polyclinics that they were not entitled to visit as residents. Another common way of solving this problem was to register at the address of a stranger in exchange for compensation.48

In terms of the seriousness of illness or injury involved, a more acute problem is the illicit trading of expensive medical treatment within the state funding quota. For certain high-cost procedures, including those provided abroad, Kazakhstan uses a quota system.49 To have an expensive medical treatment paid for by the state, a patient must receive authorization that funding is available within the quota. As a rule, the availability of funding within the quota is limited and the demand is greater than the supply. Instead of waiting in long lines, patients in urgent need of surgery or other high-cost medical

47 Interview with a woman in her forties, Almaty, June 1, 2011.

48 Interview with a Korean woman in her fifties, Almaty, May 26, 2015.

49 "Kvoty na lechenie v Kazakhstane i zarubezhom," E-Gov, egov.kz/cms/ru/articles/2Fkvota (accessed March 12, 2018).

care often seek authorization through other means. They use personal connections and/or they make informal payments to physicians who can grant permission to apply for the quota or to the health officials in charge of distributing the quota slots.50 Purchasing authorization is economically reasonable for patients, as it costs less than paying entirely out-of-pocket for an expensive surgery at a medical facility.

These illicit practices occur against a backdrop of time-consuming, troublesome, and non-transparent bureaucratic procedures. Therefore, if health-related services were to become available without having to wait too long and public medical funding were provided for every patient in real need of treatment, the need to resort to informal payments would be greatly reduced. At the same time, however, using cash to achieve objectives by skipping formal procedures is incredibly common and widely accepted in today's Kazakhstan, and the health care sector is no exception. It is no easy task to change such perceptions among ordinary people and physicians, not to mention health officials.

Conclusion

Based on fieldwork in urban settings in Kazakhstan, this paper demonstrated that the boundary between formal and informal health care payments has be- come increasingly blurred. In the perception of patients who navigate between public and private care, making a direct payment to a physician as a reward for professional medical treatment resembles formal payments for private care, which is delivered at private as well as public facilities today. This does not mean, however, that informal "fee-for-service" is completely voluntary or free of any coercion. As Gaal and co-authors rightly suggest, patients' anxiety over failing to receive proper treatment without payment in itself serves as internal pressure for payment, even if providers neither openly demand nor subtly imply that patients make a payment.51 Meanwhile, it is this distrust toward and lack of confidence in the public health system that makes people choose private care in Kazakhstan. In that sense, formal payments are also being made under indirect pressure caused by the state's failure to deliver adequate care. It should be stressed here that what most patients seek is not luxurious hotel- style room service. Rather, they simply wish to receive safe and effective carethat will enable them to recover from illness or injury.

Both official and informal medical expenses pose a serious financial burden for many families. Those who can afford to bear the required expenses might

50 Sharipova, "State Retrenchment and Informal Institutions in Kazakhstan."

51 Gaal et al., "Informal Payments for Health Care," 271–72.

welcome the option to choose better care of higher quality, either formally or informally. Others, especially in the poorer segments of society, are, in practice, denied full access to necessary care. In light of the ongoing official and unofficial marketization of the health care sector, the good old socialist welfare state is remembered with a sense of nostalgia. To be sure, the use of personal connections and informal payments flourished under the Soviet health care system. However, everyone had, as people recall now, access to a minimum level of health care for free. Today, despite the officially declared guaranteed benefits package, patients often have to pay even for standard medical services. In particular, blatant extortion by health practitioners who abuse their authority over patients needing urgent care is a source of resentment and anger among patients and their families. In my interviews about informal practices in various spheres of society in Kazakhstan, those who remember the Soviet times often asserted that society in that period was more humane and more just than it is now. Without a doubt, growing inequality in access to health services and the serious problem of extortion in the health care sector have contributed toproducing such nostalgia for the Soviet past.

The case of Kazakhstan also demonstrates that people commonly procure health care services to which they are not entitled. Doing so allows people to save time and effort, or to secure financial or other benefits. For a majority of ordinary citizens, what matters most is gaining access to the medical care they need or obtaining necessary health documents in the context of an un- friendly environment. The legality of such practices, and whether they are officially sanctioned, is of secondary importance. As many post-Soviet states have much in common in terms of the proliferation of informal exchanges in education, law enforcement, business, and other spheres, it can be assumed that payment for illicit health-related services is also a reality beyond the borders of Kazakhstan. Further empirical research is needed on this topic in other post-socialist states.

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