



EUROPEAN POLICY BRIEF



THE PRICE OF A CHILDBIRTH

OUT-OF-POCKET PAYMENTS FOR MATERNITY CARE IN CENTRAL AND EASTERN EUROPE

Findings of ASSPRO CEE 2007, an EU-funded research project assessing efficiency and impact of patient payments policies in Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine, as well as in Albania, Serbia and the Russian Federation

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INTRODUCTION

Although the maternal mortality ratio in Central and Eastern European (CEE) region has shown a downward trend for more than 30 years, it remains relatively high. In some countries like Hungary, Romania and Ukraine, this ratio exceeds 20 maternal deaths per 100,000 live births, which is more than three times the EU average (6-7 maternal deaths per 100,000 live births). Notably however, this high maternal mortality is reported against the background of favorable official statistics in CEE, which indicate widespread coverage of prenatal care (95% of the cases), presence of a skilled attendant at birth (nearly always), adequate availability of emergency obstetric care (ca. 4 facilities per 500,000 inhabitants) and moderate total health expenditure rates.

The contradiction between the relatively high mortality ratios in CEE and the favorable official statistics is not surprising since the above macro-indicators only quantify capacity, funding and utilization of care but provide no information on the actual allocation of financial and human resources, and on quality of the care process, which is the genuine problem in the region. It is now evident from empirical research that despite the motivation declared by the CEE governments to improve maternity care, and despite the adjustments in medical guidelines during the transition period, maternity care in this region suffers major drawbacks. This includes inequality in access, inefficient distribution of funds, no account for women's preferences, slow diffusion of innovations, and financial barriers to access due to formal and informal charges. This policy brief provides evidence on the types and magnitudes of such charges.

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BARRIERS TO ACCESS

A major concern in CEE is the inequality in access to maternity care. Despite the official statistics mentioned above, empirical evidence suggests that around 12%-29% of women in this region give birth without the assistance of a skilled professional. Although some countries make efforts in implementing programs focused on the most disadvantaged social groups (e.g. the Roma women), access to care remains problematic especially in rural areas, as well as for poor and women with lower education level. This is attributed to physical barriers (such as the lack of professionals and transportation in rural areas). However, cultural barriers (low public awareness about the need of care, as well as gender inequalities, perceptions and religion) are also reported to be essential. There are also financial hurdles due to formal fees (in some countries) and widespread informal (under-the-table) payments. Informal payments in CEE countries are found to be higher and more frequent for services of obstetricians, gynecologists and surgeons (incl. the case of childbirth) compared to other health care services. The multiple barriers to care are well recognized but the lack of systematic research precludes the use of evidence in policy-making.

INEFFICIENT RESOURCE ALLOCATION

Maternity care in CEE also suffers from funding problems. Health expenditures in this region are moderate. However, the allocation of available resources is inefficient and inequitable, which creates the perception of underfunding. The inefficient and inequitable use of resources is evident from the poor quality telephone lines, lack of medicines and consumables, absence of fuel (especially in rural areas) as well as outdated equipment and a deteriorated infrastructure (urban areas included) in contrast to luxury-equipped facilities in the capital cities. Clearly, the abilities of the CEE governments to allocate more public resources to maternity care are limited. However, governments can play an important role in rationing the funding of this sector with the aim to ensure that basic maternity care is provided with an adequate quality to all women in need.

QUALITY-RELATED DRAWBACKS

The quality of care delivery appears especially challenging. Despite the updated medical guidelines in most CEE countries, the care delivered to childbearing women runs counter to internationally standards. Women often lack a reliable formal channel of information related to pregnancy and birth. The communication skills of medical personnel do not always meet the requirements of contemporary patient-oriented care. Over-medicalization, inappropriate use of technology, unnecessary hospitalizations, high rates of caesarean sections and episiotomies, ineffective (even harmful) interventions and non-user-friendly services are acknowledged in country reports. Care after birth is basically lacking in the region despite the increasing incidents of post-partum depression. Needless to say that diffusion of care innovations (such as the presence of the partner during birth, free choice of birthing positions, rooming-in and early breastfeeding) are rather slow and fragmented. In view of this, strengthening the role of the midwife (in particular in providing reliable information and care before, during and after birth) and setting up a care process centered on women's needs and preferences appear important in improving quality of care.

QUESTIONABLE OFFICIAL STATISTICS

Another issue is the trustworthiness of the official statistics in CEE countries. Across the region, there is a problem of documentation. Underreported maternal deaths, unattended home births and induced abortions are suspected to bias statistics in some of these countries. In rare cases, facilities may even exist only on paper. Also, there are no uniform standards for recording emergency obstetric care, caesarean sections, as well as other aspects of care. This questions the use of official statistics in assessments against international standards. Micro-level data are necessary to understand women's needs and preferences, and to set up policies for the adequate care provision.

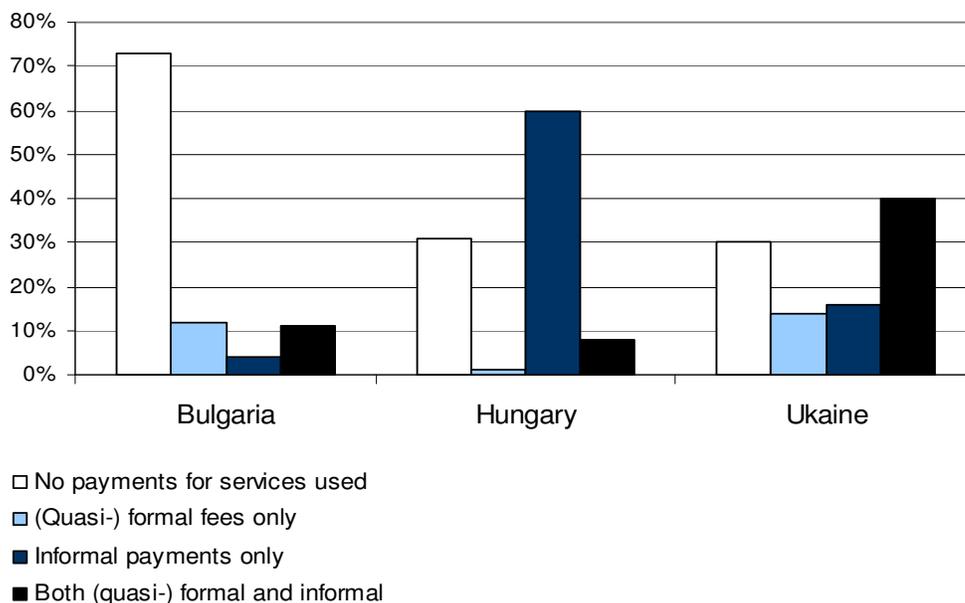
DATA POOL

This policy brief reports results on formal and informal payments for maternity care in CEE countries based on micro-level data collected in the project. In particular, the nature and size of out-of-pocket payments for childbirth in three Central and Eastern European countries - Bulgaria, Hungary and Ukraine, are outlined. These findings are based on representative surveys among health care consumers carried out in the targeted countries in July 2011. In addition, qualitative data on women’s experience with maternity care in Serbia and Ukraine are used to describe two country cases.

TYPES OF OUT-OF-POCKET PAYMENTS FOR MATERNITY CARE

Our data suggest a variety of out-of-pocket payments for maternity care in Bulgaria, Hungary and Ukraine. While in Bulgaria only about 30% of pregnant women pay for services received during childbirth or due to complications during pregnancy (i.e. hospital services), this share is about two times higher in Hungary and Ukraine (see Figure 1). In Bulgaria, these are mostly formal fees (only 14% of pregnant women report informal payments in case of childbirth). In Hungary and Ukraine, informal payments prevail in case of both childbirth and complications during pregnancy. Informal payments are usually the only charges in Hungary, while in Ukraine they are combined with formal fees (in fact, quasi-formal fees since the fees charged by the providers are not officially regulated). Informal payments include both cash payments and in-kind gifts.

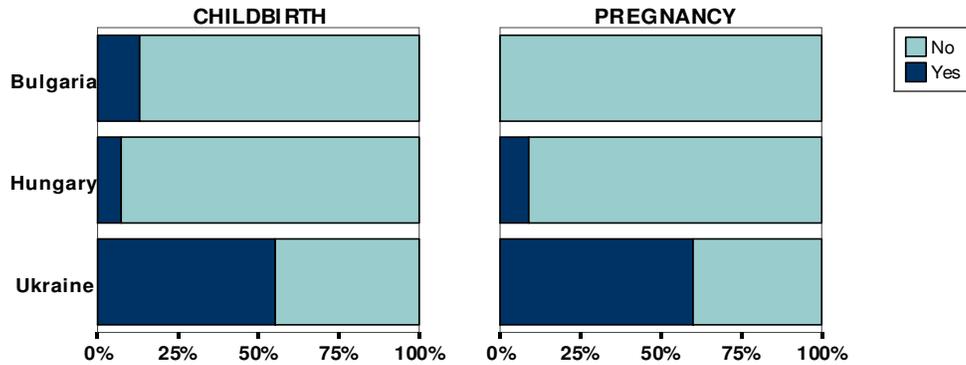
Figure 1. Types of payments for hospitalization due to childbirth or complications during pregnancy - bars represent the share of women (service users) per country



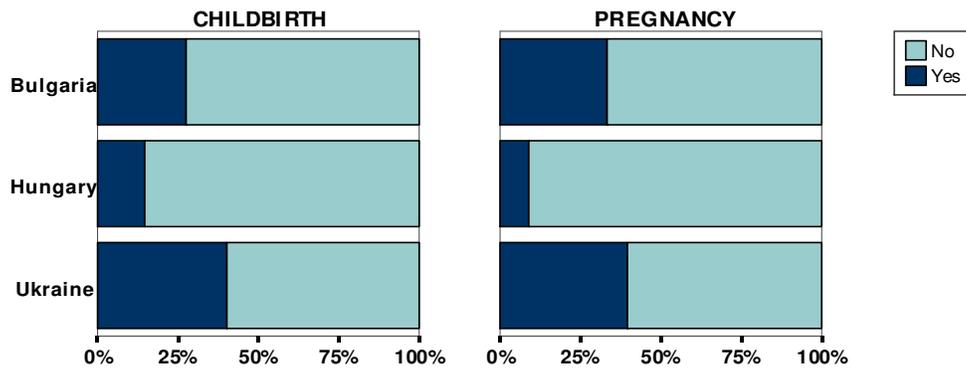
In addition to formal, informal and quasi-formal charges, in all three countries, pregnant women are also often asked by the health care staff to bring various types of goods for their hospitalization. This includes pharmaceutical, medical supplies, appliances, and even bed linen and food, which in principle should be provided free of charge to the patients. In Hungary, such practice is reported in about 20% of the cases, while in Bulgaria and Ukraine it reaches 60% - 80% respectively. Figure 2 provides more information on this issue.

Figure 2. Goods brought by the women for their hospitalization due to childbirth or complications during pregnancy

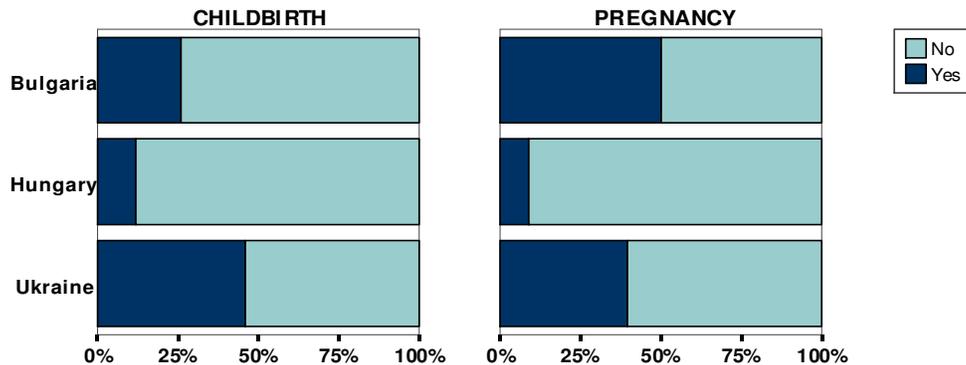
Were you asked to bring pharmaceuticals (medicines) for this hospitalization?



*Were you asked to bring **medical supplies (consumables) and/or appliances** (for example prosthetics, blood-sugar meters) for this hospitalization? Please also include less expensive items such as bandages, catheters, syringes, thermometer, etc.*



*Did you bring with you **bed linen, blankets and/or food** for this hospitalization (excluding additional food items such as fruits, chocolate, juices etc.)?*



SIZE OF OUT-OF-POCKET PAYMENTS FOR CHILDBIRTH

We find that the total size of out-of-pocket payments related to childbirth is lower in Bulgaria (on average 63 EUR up to 265 EUR) compared to that in Hungary (on average 97 EUR up to 678 EUR), and considerably lower compared to that in Ukraine (on average 246 EUR up to 1027 EUR). These amounts include formal fees (incl. quasi-formal charges), informal payments (cash and in-kind), as well as payments for goods brought by the women for their hospitalization (see Table 1).

Although the amounts do not include all relevant payments (such as transportation and other indirect costs for the patient and her family), they are already quite substantial when compared to the wage rates in the countries. In Bulgaria and Hungary, the mean value of the total out-of-pocket payments for childbirth measured in our study, is equal to nearly the half of the minimum monthly wage in the countries, and in Ukraine, the mean value of these payments is nearly 3 minimum monthly wages. This confirms the problem of financial barriers to access in maternity care in CEE.

Table 1. Out-of-pocket payments related to hospitalization due to childbirth
- amount per hospitalization among those who paid

	BULGARIA	HUNGARY	UKRAINE
	[in EUR]	[in EUR]	[in EUR]
(Quasi-) formal fees:			
<i>mean (standard deviation)</i>	21.29 (29.24)	59.08 (48.09)	170.27 (166.86)
<i>minimum – maximum</i>	1.00 – 120.00	16.95 – 159.32	9.09 – 727.27
Informal payments:			
<i>mean (standard deviation)</i>	58.25 (66.44)	92.10 (99.96)	79.40 (94.45)
<i>minimum – maximum</i>	20.00 – 225.00	0.17 – 677.97	1.82 – 363.64
Pharmaceuticals brought to the hospital:			
<i>mean (standard deviation)</i>	26.64 (22.61)	32.20 (25.74)	86.32 (82.60)
<i>minimum – maximum</i>	9.00 – 75.00	10.17 – 67.80	13.64 – 290.91
Supplies/appliances brought to the hospital:			
<i>mean (standard deviation)</i>	22.00 (27.32)	25.42 (36.50)	19.96 (22.15)
<i>minimum – maximum</i>	0.50 – 100.00	1.69 – 118.64	0.36 – 90.91
Total:			
<i>mean (standard deviation)</i>	62.50 (60.80)	96.67 (99.74)	245.77 (258.63)
<i>minimum – maximum</i>	0.50 – 265.00	0.17 – 677.97	0.36 – 1027.27

We also find that in all three countries, informal payments for childbirth are mostly made by the pregnant women or her family in order to secure more appropriate attention from the health care staff. Quality of care appears as the second most important reason for paying informally, followed by the skills of the obstetrician. Access to care is rarely a reason for informal payments.

The informal payment is sometime requested by the staff but most often it is initiated by the women or her family due to the belief that an extra payment is appropriate. This is not surprising as many patients in CEE countries accept the poor remuneration of health care staff as an excuse for the existence of informal payments, even though their attitude towards these payments is not always positive especially in case of ex-ante, requested and monetary informal payments.

CHILDBIRTH IN UKRAINE – “CONTRACTING” PERSONAL OBSTETRICIAN

The discussion of a childbirth plan between expecting parents and obstetric care provider is a well-known health care practice to reduce fear and pain in child delivery. However, in Ukraine, it is applied in a perverted form. Indeed, our qualitative data collected in 2009 among mothers and gynecologist-obstetricians suggest that in Ukraine, expecting parents discuss with their “personal obstetrician” not only the childbirth process but they also openly negotiate the informal payments related to it (even though maternity care is officially free of charge in Ukraine).

The bargaining process, guided by mentality and culture, is an important part of the pre-delivery arrangements. It can be regarded as a bargaining process before signing a contract where the price (i.e. the informal payment) is formed after all service details are discussed. Although, sometimes patients characterize such payment as gratitude, informal payments resulting from this bargaining process are neither gratitude payments per se, nor requested payments. Such payments can be best described as payment for “extra work” following the “contract model”. In this case, the “extra work” refers to the provision of “services with higher quality” as agreed in advance. The “price” of such a contract according to our qualitative study ranges from 300-500 Euro (similar to our quantitative data for Ukraine reported above).

Two push-factors can lead to a search for a “personal obstetrician” in Ukraine and negotiation of informal payments: the need for twenty-four-hour access to reliable information and the need for psychological comfort during the childbirth. Obstetricians in Ukraine usually make decisions about possible interventions without consulting with the patient or her relatives, and without mentioning the benefits and risks of the interventions. The lack of information among patients leads to a perception of maternity care as a high-risk care. The desire to receive better “service wrapping” (reliable information, better attention, responsiveness) against the background of feelings of anxiety can be also seen as a strategy to avoid “substandard care”. Though, when clear standards in health care provision are lacking, as it is in Ukraine, service quality can be artificially lowered by physicians. Hence, “substandard care” appears in the context of providers misusing their market position as well as government’s failure to ensure the necessary financial and regulatory framework in health care provision.

Gynecologist-obstetricians are quite open about the redistribution of the informal payments among medical staff as well as the use of the informal payments to buy pharmaceuticals and to maintain physicians’ wards. As a result, informal payments not only add to the salary of the obstetricians but also to the salary of other staff and to the budget of the hospital facility. In fact, the low salary of medical staff is indicated by both obstetricians and mothers in our study as the main cause for the existence of informal payments. Thus, informal payments remain an unregulated tool that ensures extra payments to health care providers when adequate reimbursement policies are lacking.

We observe however, that the informal payments are not well accepted by mothers and obstetricians, especially when it comes to payments requested before childbirth. Nevertheless, the fact that obstetricians bargain over informal payments suggest that medical ethics of obstetricians (and physicians in general) requires the attention of Ukrainian policy-makers.

Notably however, not all expecting parents search for a “personal obstetrician”. In fact, we find that there are two groups of patients in the Ukrainian maternity care ward: “individual patients” who have agreed with the obstetrician about the childbirth services and related payments, and “emergency room patients” who do not have a “personal obstetrician” though they may still pay a variety of charges (such as charitable contributions, which are supposed to be voluntary but are expected by providers). It is necessary to add to this classification, a third type of patients whose friend works at the hospital, i.e. “individual friend-patient”. These patients do not bargain and do not pay informally but receive attention and comfort during the hospital stay. Probably, the lack of any capital (social or monetary capital as well as information) will result in being an “emergency-room patient” in Ukraine and having less chances of receiving adequate treatment during childbirth.

IF YOU PAY, WE WILL TAKE CARE – EXPERIENCE WITH CHILDBIRTH IN SERBIA

Although, official users' charges have been introduced in Serbian public hospitals since 2002, users of maternity care are officially exempted from such charges. However, our qualitative data collected among Serbian women, who recently delivered a child, suggest a very different situation. Women in our sample report both quasi-official payments (set up by the hospital in the absence of government regulations) and informal (under-the-table) payments for maternity services.

Women report that they are charged officially by the hospital (i.e. quasi-formal payments) for so called standard services (e.g. presence of skilled persons, delivery assistance, analgesia), which should be provided to them free of charge. Hospital charges are most often reported for epidural analgesia. The amount varies from hospital to hospital and is about 100-200 Euro. This amount has to be paid in advance by the pregnant women or her family. In case the epidural is not used (e.g. in case of a Caesarean section), the patient does not get any money back.

The informal patient payments are given in order to secure adequate quality of care. About a quarter of the women in our sample report informal patient payments. The majority of them report informal payments to the obstetrician, but some also report informal payments to the anesthesiologist for epidural analgesia (thus, in addition to the quasi-formal charge mentioned above). The average amount of total informal payments per childbirth reported in our study, is approximately one minimum monthly salary in Serbia.

The informal payment can in principle guarantee that the obstetrician is present during the entire course of childbirth and all necessary procedures are applied. Although, women who “bribe” an obstetrician usually do not approve of informal payments, they opt for such payments for the safety of their child. Some women report that a planned Caesarean section is only possible if it is paid informally in advance.

“There is no necessary Caesarean, there is only paid one.”

Women emphasize that informal patient payments can be avoided if they can make use of so called “personal connection”, e.g. friends, colleagues or relatives, who work in hospitals. This helps to secure adequate care without extra payments. “Personal connection” is seen as a special way to establish a trustworthy relation between the pregnant women and the obstetrician. Women with “personal connections” report fewer inconveniences (even less than those who pay informally). Overall, “personal connections” represent a more secure way of receiving the nature and quality of care desired than informal payments – bribing with trust.

Women, who do not have “personal connections” and do not pay informally, usually state that they regret this and they would do so next time. They are often left alone during the course of childbirth and without adequate therapy. These women more often experience problems with breastfeeding, but also problems with derogative communication by the staff.

“I did not give money to anyone, that was the main problem.”

The existence of informal payments in the highly centralized and hierarchical system of maternity care in Serbia makes the position of pregnant women very vulnerable. The use of so called “personal connections” (the same as the informal payments) brings the issue of equity but also of equality. In particular, women without “personal connections” and those unable to pay informally are practically left without adequate care.

Future policy in Serbia should re-consider the monopole position of the public maternity wards (childbirth is only allowed in public hospitals), as well as the professional code of conduct of health care staff. They should also promote the equal access to medical procedures and services that cater to individual preferences, as a norm in every maternity ward.

EUROPEAN LEVEL

- Encourage Central and Eastern European countries to review the adequacy of their legislation and quality standards related to maternity care. They should regulate not only the quality of medical procedure but also the attention and attitude of the staff toward the patient (the pregnant women). The legislation should bring the patient-physician relationships into a legal realm, providing a place for physicians and patients to defend their rights.
- Stimulate Central and Eastern European countries to improve the governance and accountability in their maternity care sectors and to create a transparent monitoring system for a direct control of both provision and out-of-pocket payments for maternity care services. In particular, there is a need of clear regulations on formal charges. There is also a need of banning staff's requests to patients to bring goods for their hospitalization.
- Develop professional code of conduct at an European level related to non-medical activities of maternity care providers, where the request or acceptance of any informal payments (either in cash or in kind), including gratitude payments and gifts, is banned.
- Establish instruments to increase the awareness of European patients, physicians and policy-makers about the negative effects of informal patient payments, and promote patients' rights to maternity care services with an adequate quality and access with no informal charges or gratitude payments.
- Stimulate comparative research on maternity care provision and funding in Europe, especially in Central and Eastern Europe, as well as research on the use of micro-level policy indicators in maternity care in general, that combines quantitative and qualitative research methods from a broad range of fields related to Socio-economic Sciences and Humanities.

NATIONAL LEVEL

- Continue to invest in the improvement of quality and access to maternity care, and assure an adequate allocation of funding for the normal functioning of maternity care services.
- Review the adequacy of quality standards related to maternity care, and incorporate in these standards not only the quality of medical procedure but also the staff's attitude toward the patient, as well as the existence of reliable information channels for the patients.
- Implement a provider payment mechanism that allows for an adequate and fairer compensation for maternity care provision (depending on professional skills and patient satisfaction) than a uniform central payment scale for maternity care staff.
- Strengthen the control and accountability in the maternity care sector and regulate the official/formal patient charges for maternity care. Assure the availability of information about official charges and free-of-charge services that is easily accessible by patients prior to the service use. Implement an adequate exemption and fee reduction mechanism for those who cannot pay.
- Carry out information campaigns among consumers, providers and policy-makers with the objective to create a social opposition against informal patient payments. Ban staff's requests to patients to bring goods for their hospitalization, and work on the elimination of informal payments (both cash payments and in-kind gifts) in maternity care, as well as in other sectors.

REGIONAL FOCUS

Project ASSPRO CEE 2007 studies the systems of patient payments for health care services in Europe, but the project specifically focuses on Central and Eastern European countries:

- Hungary and Poland
(economically advanced Central European countries)
- Lithuania
(economically advanced former Soviet republic)
- Bulgaria and Romania
(less advanced countries from Eastern Europe)
- Ukraine
(less advanced former Soviet republic)
- Other Central and Eastern European countries
e.g. Albania, Serbia and the Russian Federation.

OBJECTIVES OF THE RESEARCH

Project ASSPRO CEE 2007 specifically aims to assess patient payment policies in Central and Eastern European countries and to evaluate their efficiency, equity and quality effects.

The project addresses the need for improved indicators for evaluating patient payment policy at European level. It also addresses the need of micro-level data from Central and Eastern Europe on health care payments and consumption.

By providing information on formal and informal patient payments - as well as on the willingness and ability of consumers to pay for health care services - ASSPRO CEE 2007 is expected to enable a rational policy choice regarding the design of patient payment policies, specifically in Central and Eastern European countries.

The project also aims to create a research network focused on the analysis of the Central and Eastern European health care systems, and to train young researchers from these countries.

SCIENTIFIC APPROACH/METHODOLOGY

ASSPRO CEE 2007 relies on research methods from a broad range of fields related to Socio-economic Sciences and Humanities. In particular, the project applies quantitative techniques (such as modeling, trend analysis, revealed and stated preference methods) combined with qualitative data to study micro and macro outcomes of patient payment policies.

The research within the project follows a uniform fashion: conceptualization of the problem, qualitative data collection, preparation of quantitative data collection, data collection, data analysis, and exploration of the analytical results for the purpose of policy assessment and policy analysis.

Currently the project activities are related to the analysis of the quantitative data collected within the project. Although the EU funding of the project ends in February 2013, the project activities related to data analysis will continue.

PROJECT IDENTITY

PROJECT NAME	Assessment of patient payment policies and projection of their efficiency, equity and quality effects: The case of Central and Eastern Europe [ASSPRO CEE 2007]
COORDINATOR	MAASTRICHT UNIVERSITY; Maastricht, the Netherlands Project coordinator: Dr. Milena Pavlova; E-mail: m.pavlova@maastrichtuniversity.nl Scientific coordinators: Prof.Dr. Wim Groot; E-mail: w.groot@maastrichtuniversity.nl Prof.Dr. Frits van Merode; E-mail: f.vanmerode@maastrichtuniversity.nl
CONSORTIUM	CENTER FOR PUBLIC AFFAIRS STUDIES FOUNDATION; Budapest, Hungary Prof.Dr. László Gulácsi; E-mail: laszlo.gulacsi@uni-corvinus.hu MEDICAL UNIVERSITY OF VARNA; Varna, Bulgaria Dr. Emanuela Moutafova; E-mail: dep_hcm@abv.bg PUBLIC ENTERPRISE "MTVC"; Vilnius, Lithuania Dr. Liubove Murauskiene; E-mail: murauskiene@mtvc.lt SHKOLA OHORONY ZDOROVIA; Kiev, Ukraine Dr. Irena Griga; E-mail: griga@ukma.kiev.ua SCOALA NATIONALA DE SANATATE PUBLICA, MANAGEMENT SI PERFECTIONARE IN DOMENIUL SANITAR; Bucharest, Romania Dr. Constanta Mihaescu Pintia; E-mail: cmpintia@snspsms.ro UNIWERSYTET JAGIELLONSKI COLLEGIUM MEDICUM; Krakow, Poland Prof.Dr. Stanisława Golinowska; E-mail: stellag@onet.pl
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WEBSITE	www.assprocee2007.com
FOR MORE INFORMATION	Contact: Dr. Milena Pavlova (project coordinator) Department of Health Services Research (HSR - CAPHRI) Faculty of Health, Medicine and Life Sciences; Maastricht University P.O. Box 616, 6200 MD Maastricht; The Netherlands Tel.: +31-43-3881705; Fax: +31-43-3670960 E-mail: m.pavlova@maastrichtuniversity.nl
FURTHER READING	<ul style="list-style-type: none">• Tetiana Stepurko, Milena Pavlova, Olena Levenets, Irena Gryga, Wim Groot. Informal patient payments in maternity hospitals in Kiev, Ukraine. <i>International Journal of Health Planning and Management</i>, forthcoming.• Vladimir Gordeev, Milena Pavlova, Wim Groot Informal payments for health care services in Russia: old issue in new realities. <i>Health Economics, Policy and Law</i>, forthcoming.• Jelena Arsenijevic, Milena Pavlova, Wim Groot. Out-of-pocket payments for public health care services by exempted groups in Serbia during the period of post-war health care reforms. <i>International Journal of Health Planning and Management</i>, forthcoming.• Petra Bajj, Milena Pavlova, László Gulácsi, Wim Groot. Exploring consumers' attitudes towards informal patient payments using the combined method of cluster and multinomial regression analysis - the case of Hungary. <i>BMC Health Service Research</i>, 2013, 13:62.