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Meanings and consequences of informal payments in the Romanian health care sector

Marius Wamsiedel

"If you don't move the table, you don't get anything," an elderly Roma tells me bitterly during an interview about access to health care services.[1] The local idiom doesn't make much sense to me, but from the context of our talk I could tell that it was a veiled reference to the need to make informal payments in order to receive adequate care. Many other participants echo this view, bemoaning the venality and callousness of some doctors or, more rarely, praising a "good-hearted" practitioner who has refused the money offered.

Informal payments to doctors and nurses are one of the open secrets of the health care sector in Romania, a significant source of concern for people in need of medical care, and a topic of interest for scholars of informality. This paper provides a historical overview of informal payments in Romania and discusses the ambivalent morality of the practice. I begin by introducing the economy of favors in Romanian society before and after socialism to show that informal payments in the health care sector took on different forms and acquired new meanings during the passage to a market economy). Then, I discuss the reasons why many people make informal payments even when practitioners do not request them. I conclude by showing that, despite some undeniably positive aspects (such as keeping the health care system afloat in conditions of chronic underfinancing), informal payments impact access to and the quality of health care services, and this impact is uneven across class and ethnic lines.

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The economy of favors during socialism

The few studies documenting informal practices in socialist Romania emphasize their ubiquity and ordinariness. At that time, an intricate economy of favors bearing a family resemblance to the Soviet *blat* (Fitzpatrick 2000) and the Chinese *guanxi* (Yang 1994) emerged as a practical response to the shortcomings of society's formal organization. By mobilizing the personal network of *pile, cunoștințe și relații* ("props," acquaintances, and connections), exchanging gifts, and making under-the-table payments, ordinary people could muddle through the vicissitudes of life (Sampson 1981). The economy of favors that was intermeshed with and exploitive of the formal economy helped them to obtain goods in scarce supply, access (quality) services, navigate a cumbersome and unpredictable bureaucracy, get coveted jobs, or avoid being dispatched to rural areas.

Health care was one field in which personal relations were essential. Steven Sampson, an American anthropologist who conducted extensive fieldwork in Romania during the socialist period (Sampson 2018), noted that connections with doctors and gift-giving were a prerequisite for good diagnosis and treatment: "quality medical care exists only if one has a personal doctor who can be cultivated with periodic gifts, visits, and offers of godparenthood" (Sampson 1983, 76). It should be noted that Sampson's data was collected in a village undergoing urbanization. The doctor–patient relationships he describes are characteristic of rural areas and general practice.

To my knowledge, there are no studies examining how doctors made sense of informal transactions during the socialist period. However, the diary of Viorel Pătrașcu (2010) provides ample evidence on how rural patients used gifts and connections in the early 1970s. A general practitioner who spent his first

three years of medical practice in a remote and underdeveloped village in the northeastern part of the country, in his notes Pătrașcu describes the objects that changed hands and the context of such transactions. Aware of his inability to procure food and alcohol through formal channels due to limited supply, the locals started to provide the young doctor with eggs, meat, loaves of freshly baked bread, milk, and homemade wine and liquor. While the doctor refrains from theorizing these exchanges, they appear to be consistent with the ethos of socialist medicine and the traditional systems of reciprocity described by Mauss (2002). By offering the doctor items with both utilitarian and symbolic value, the locals paid him back for the "gift of health [care]" (Andaya 2009). The food and alcohol acted as a counter-gift, creating a social obligation to reciprocate and thus cementing personal relationships.

The informal exchanges took a different form in the cities, especially when the relevant medical care was specialized. In his memoir "The Hooligan's Return," émigré writer Norman Manea recounts the grim experience of his elderly mother's eye surgery in the early 1980s in a Bucharest hospital. To set an appointment with the ophthalmologist, one had to either find a connection, no matter how loose – "So-and-so knows so-and-so, a friend of one's wife, or sister, or mistress" (Manea 2013, 115) – or wait for six months until an appointment became available. To smooth things out and ensure that the patient got adequate medical treatment and a private room, the family took several days off work to procure gifts for the staff. The gifts were chosen based on the recipient's status. Thus "cartons of cigarettes, soap, deodorant, nail polish, and chocolate, all with Western labels, […] were the currency of securing the goodwill of the nurses, cleaning ladies, and assorted functionaries whose assistance would be needed" (Manea 2013, 116). The most expensive gift was for the eye surgeon and consisted of a painting worth an engineer's monthly salary. The gift was used instead of a monetary payment, even though "sealed envelopes with greasy, crumpled banknotes [were] the normal transaction under socialism's free medical insurance" (Manea 2013, 116). Despite using personal connections and relatively expensive gifts, however, the patient didn't receive the coveted private room. Instead, during the four days of convalescence, she had to share a bed with her daughter-in-law caregiver and the room with five other patients.

This personal account may not be generalizable to the entire urban health care sector in the late socialist period. However, the experience it describes is by no means exceptional. Passing gifts or money to health care workers was a common strategy to shorten the waiting time, ensure standard treatment, and avoid microaggressions of different sorts, such as being ignored or treated with contempt.

Post-socialist informality

The economy of favors did not disappear from the health care sector after the demise of socialism. Instead, it experienced substantial changes, the most significant being the monetization of informal exchanges[2] (Weber 2009, 232). Money gradually replaced gifts or started to be used alongside them. Several factors contributed to this process. First, the post-socialist transition was a period of severe and protracted economic crisis, with rampant inflation eroding the earning power of public service workers. Informal payments became a way for doctors and nurses to supplement meager formal incomes and cope with the increased cost of living (Rechel and McKee 2009). Second, during socialism, goods in short supply, such as imported coffee, cigarettes, chocolate, or spirits, were imbued with a symbolic value that they lacked in a market economy. The rarity turned these goods into objects of prestige to be consumed on important occasions (Chelcea 2002) or used as an alternative currency in the secondary economy (Verdery 1996, 51). That symbolic value vanished once these goods could be easily procured, and these "luxury" products became mere commodities. Third, during socialism, the vigilance of the Securitate (secret police) increased the risks associated with participating in illicit monetary transactions (Weber 2009, 232). This barrier was removed after 1989, as the authorities tended to turn a blind eye to informal payments that did not involve exorbitant amounts of money. Fourth, patients had additional incentives to give money to doctors and nurses, as their goodwill could translate into receiving free tests, subsidized medicines, paid medical leave, admission to low-cost spa facilities, and other benefits carrying a monetary value (Stan 2012, 70). In other words, the transformation of the economy and the reorganization of the health care system created the conditions in which informal payments could flourish.

In this context, it is not surprising that most studies of the economy of favors in the post-socialist health care sector focused on the nature and consequences of *șpaga*, the colloquial name for informal monetary payments in Romania.[3] As scholars of informality have noted, informal practices occupy a complex moral space ranging from legal to illegal, and from licit to illicit (Polese 2014a, 86). The illegal status of *șpaga* is unambiguous: regarded as a form of bribery, it constitutes a criminal offence carrying up to ten years' imprisonment for the receiver and seven years for the giver.[4] Its social acceptability in the health care

sector varies considerably, depending on the context of the transaction, the existence or absence of a request, the participants' socio-economic status, the amount of money changing hands, and the timing of the transaction.

Drawing upon extensive ethnographic fieldwork and over eighty interviews, Sabina Stan (2012) distinguishes between two extreme types of *șpaga*: ethical and predatory. An exchange is regarded as ethical if it is embedded in personal relations or is guided by "the moral economy of the just price" (Stan 2012, 77), which means that the amount of money changing hands is proportionate to the service provided and the giver's economic circumstances. Thus, without being an egalitarian relationship, the exchange provides benefits to both parties to the transaction: the doctor receives compensation for their expertise and effort, whereas the patient gains personalized care and sometimes free tests and subsidized medicines.[5] Ethical *șpaga* is a form of mutual help and a local solution to structural problems affecting health care practitioners and patients alike. Even low-income patients tend to feel sympathetic or ambivalent towards these forms of monetary exchange, considering that the doctors' low salaries are not commensurate with their education level and social status (Weber 2009, 247). At the other end of the spectrum of informal payments lies "predatory" *șpaga*, which happens when doctors use their professional position to extort money from people in need of care without any consideration for their ability to pay (Stan 2012). Predatory practices limit not only the access to, but also the quality of health care services: some patients who are unable to cover the informal fees allegedly receive sub-standard interventions.[6] Certainly, the distinction between "ethical" and "predatory" *șpaga* is analytical; most transactions fall in-between these two extremes.

The apparent paradox of *șpaga*

The monetization of informal transactions and the social acceptability of giving money to practitioners in exchange for (better) care are not particular to Romania. Similar phenomena have been documented in other former socialist countries, including Russia (Listrovaya 2021; Rivkin-Fish 2005), Ukraine (Polese 2014b), and Kazakhstan (Oka 2019). However, the informal payments in Romania stand out through their pervasiveness and seemingly voluntary character.

The 2013 Eurobarometer data revealed that the reported prevalence of informal payments in health care is much higher in Romania than in the other ten former socialist countries that are now part of the European Union (28 percent vs. 9 percent, the average for all countries), and so is the likelihood of giving the money before the service (Williams, Horodnic, and Horodnic 2016). At the same time, only 6 percent of the participants in Romania reported being asked to make the payment, which is slightly lower than the average for the other post-socialist countries included in the study. Based on these intriguing findings, the authors conclude that "in Romania, informal payments in [the] healthcare system are rather related to patient behavior" (Williams et al. 2016, 54).

While this interpretation is certainly plausible, the ethnographic data suggest a more nuanced explanation. Because soliciting informal payments is illegal and socially unacceptable, health care practitioners usually refrain from making explicit demands. Nevertheless, there is a vast repertoire of maneuvers through which doctors and nurses can convey the expectation of *șpaga*, including the invitation addressed to family members to discuss the patient's situation, treating the patient coldly, or ignoring them for extended periods, performing medical acts rather roughly, delaying the administration of treatment, or alluding to the cost of the intervention in a private clinic. Moreover, the doctors and nurses do not need to engage in any of these tactical moves. The rumors of misdiagnosis or operations going wrong in the case of patients who didn't give anything (see Weber, 2009) are strong enough arguments for many to play on the safe side. Thus, patient behavior may drive informal payments, but this behavior is shaped by the stock of knowledge patients have acquired through personal or vicarious experiences of the health care system.

Unintended consequences of *șpaga*

Qualitative studies of informal payments in Romania and other post-socialist countries unravel the complex and often contradictory meanings assigned to them by participants in health care exchanges. They convincingly demonstrate that, notwithstanding some degree of overlap, informal payments are not bribes and the economy of favors is not subtly camouflaged corruption. Some monetary exchanges are mutually beneficial, helping doctors and patients achieve their goals and turning the therapeutic relationship into a personal one. Others are fundamentally exploitive. They impact patients financially and emotionally and compromise the doctor–patient relationship by breaking the expectation that doctors will act in the interest of patients rather than their own interest (Parsons 1951).

Predatory informal exchanges disproportionately affect vulnerable groups. Gerard Weber's (2009,

2015) ethnography of working-class urban pensioners shows that even ordinary payments can disrupt the lives of those who have a hard time making ends meet. When the amount of *șpaga* grossly exceeds their means, the disruption to their livelihood is significant. Pensioners cope with it by contracting loans or borrowing money from relatives and friends, postponing the payment of house maintenance costs, performing physically demanding temporary jobs on the black market, or drastically curtailing food expenditures. The financial reliance on children, some of whom are already in dire economic straits despite holding a regular job, undermines their sense of self-worth. To avoid such disruptions, many decide to self-medicate instead of seeing a doctor, even when the symptoms experienced are disquieting enough to warrant a medical check. Thus, informal payments constitute an important yet often neglected contributor to inequity of access to health care.

The impact of *șpaga* on access to health care is severe in the case of Roma as well. The second-largest ethnic minority in the country, accounting for over 3 percent of the total population (National Institute of Statistics [Romania] 2013), the Roma are more affected than the general population by poverty and poor health (Wamsiedel 2013) and less likely to be covered by national health insurance (Kühlbrandt et al. 2014). A survey conducted in one of the most developed parts of Romania, the Northwest Development Region, found that fewer of them make informal payments when using health care services compared with ethnic Romanians and Hungarians (18 vs. 42 percent and 53 percent, respectively) (Rat 2008). Interviews with Roma revealed that explicit requests to give *șpaga* in order to get admitted are common (Szeman 2018; Wamsiedel, Vincze, and Ionescu 2012) and constitute a deterrent to seeking medical care.

Concluding remarks

The economy of favors experienced continuities and changes in the passage from socialism to a market economy. The gradual increase in preferences for money instead of gifts as objects of informal exchanges and the tacit tolerance of the practice by the authorities opened the way for predatory practices in the health care sector. These practices predominantly affected vulnerable groups, disrupting their livelihoods and contributing inconspicuously to the inequities of access to medical care.

Certainly, not every practitioner demands or expects informal payments. Nevertheless, the spread of the practice and the potential repercussions for failing to give *șpaga* delineate a horizon of expectation, which is the backdrop against which people in need of medical care decide whether to seek it or not. Thus, it can be argued that while some informal monetary exchanges are benign, the monetization of informal transactions has been largely detrimental to disadvantaged members of society. In the case of Roma, there is insufficient evidence to conclude whether informal payments act as a protective mechanism, reducing discrimination or, on the contrary, racism exacerbates predatory exchanges. However, the normativity of *șpaga* prevents many of them from accessing health care services.

Further studies are needed to explore the connection between doctors' changing work conditions and informal monetary transactions. As low wages provided some degree of moral justification to receiving *șpaga*, it is reasonable to expect that higher salaries in the health care sector should make the practice less common. The substantial increase in wages for doctors and nurses in 2018 as part of efforts to curtail the emigration of health care practitioners provides an excellent opportunity to test this hypothesis.

Endnotes

1 The research was conducted in 2010 in six counties in Romania (Wamsiedel et al. 2012).

2 Another notworthy transformation is the decline of *blat*-like networks. However, among the participants in a statistically representative nationwide survey, more people reported mobilizing personal connections in 2010 than in 1989 (Stoica 2012). Intermediation of access is also widespread in emergency departments (Wamsiedel 2016).

3 The word lacks a proper equivalent in English. Roughly similar in meaning to "petty bribe," *șpaga* doesn't have any legal connotations, and its moral interpretation is flexible and context-dependent. The etymology is not entirely clear: some linguists (e.g., Zafiu 2002) trace it back to a Russian or Serbian word for "pocket," while others (e.g., Boerescu 2013) argue that it most likely originates in an Albanian word for "compensation" or "fine." The formerly argotic word entered the language during the First World War and became widespread during the socialist time, possibly as an ambiguous alternative to words implying criminal activity (Zafiu 2002).

4 However, ordinary *șpaga* cases are rarely prosecuted and, even then, the punishment of doctors is usually lenient, taking the form of suspended sentences (Benea 2021).

5 In the psychiatric hospital studied by Jack Friedman (2009, 388), doctors and nurses use the informal payments and gifts to morally categorize patients in terms of deservingness. The "wealthy" ones, that is the patients whose families make informal payments at the moment of admission and during hospitalization, receive the best possible care and tend to get discharged earlier than the others.

6 There is ample anecdotal evidence of things going wrong when

patients are unable or unwilling to pay, most of them involving surgery. For instance, before performing an appendectomy, a surgeon tells the patient that it could be "a $100, a $200, or a $300 operation", with the implication that it was up to them (Weber 2009, 245).

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