Towards a stakeholders' consensus on patient payment policy: the views of health-care consumers, providers, insurers and policy makers in six Central and Eastern European countries

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Abstract

Background Although patient charges for health-care services may contribute to a more sustainable health-care financing, they often raise public opposition, which impedes their introduction. Thus, a consensus among the main stakeholders on the presence and role of patient charges should be worked out to assure their successful implementation.

Aim To analyse the acceptability of formal patient charges for health-care services in a basic package among different health-care system stakeholders in six Central and Eastern European countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine).

Methods Qualitative data were collected in 2009 via focus group discussions and in-depth interviews with health-care consumers, providers, policy makers and insurers. The same participants were asked to fill in a self-administrative questionnaire. Qualitative and quantitative data are analysed separately to outline similarities and differences in the opinions between the stakeholder groups and across countries.

Results There is a rather weak consensus on patient charges in the countries. Health policy makers and insurers strongly advocate patient charges. Health-care providers overall support charges but their financial profits from the system strongly affects their approval. Consumers are against paying for services, mostly due to poor quality and access to health-care services and inability to pay.

Conclusions To build consensus on patient charges, the payment policy should be responsive to consumers' needs with regard to quality and equity. Transparency and accountability in the health-care system should be improved to enhance public trust and acceptance of patient payments.

Introduction

The increased financial imbalance of health-care systems as well as the demographic challenges have focused policies in Central and Eastern European (CEE) countries on measures to improve the sustainability of health-care financing.¹ One of these measures is the system of mandatory patient charges. These charges are often implemented with the objective to provide incentives for a more efficient service use but also to raise additional revenues for health-care provision.^{2,3} Their designs are related to health-care system characteristics, such as type of health-care system funding and provider payment mechanisms, as well as to the general socio-political context in the country.^{4,5}

Although patient charges are broadly applied in CEE countries for dental care and pharmaceuticals,⁶ their implementation for other services in the basic service package (such as visits to GPs and specialists, hospitalization) was successful only in few CEE countries (e.g. Bulgaria, Slovenia, Latvia).⁵ Elsewhere in CEE, the lack of public support has impeded policy attempts to introduce such charges (e.g. Poland) or has led to their abolition (e.g. in Hungary, Slovakia).^{7–9} Public opposition may be driven by the fact that patient charges impose a financial barrier to the use of health-care services, and thus, they may have an adverse effect on both patients' health and patients' wealth.³ The reason for the non-acceptance of patient charges in CEE can also be the perception of free-of-charge health care as a basic right for all citizens (inherited from the Semashko system).¹⁰ This could be questioned however, because patients in CEE, even if not obliged by law to co-pay for health-care services, are accustomed to payments (informal

or quasi-formal for better quality or quicker access).^{11,12}

Thus, an increased reliance on patient charges in CEE countries can be successful only if there is a consensus among the health-care system stakeholders (incl. health-care consumers) on the presence and role of these charges. Data on stakeholders' opinions and factors underlying these opinions could facilitate the development and implementation of an adequate patient payment policy acceptable to all stakeholder groups.

In this paper, our aim is to explore the acceptability of patient charges across CEE countries (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine) and across stakeholder groups (health-care consumers, providers, insurers and policy makers). We focus on formal and obligatory patient charges for health-care services included in a basic package as they present a highly sensitive policy issue. We specifically include the group of health-care consumers and compare their opinions to that of other stakeholder groups because consumers directly bear the consequence of patient charges, also the negative ones, for example impoverishment and health deterioration. We use a combination of qualitative and quantitative data to examine differences in opinion on formal patient charges between the stakeholder groups and across countries.

The next section provides background information on the six countries included in the study. This is followed by the description of study methodology and the main results – qualitative and quantitative. We present qualitative results applying the WHO framework on health financing policy objectives (i.e. equity and financial protection, efficiency, quality,

transparency and accountability).¹³ At the end of the paper, discussion and conclusions are presented.

Background

During the communist period, all six countries included in the study (Bulgaria, Hungary, Lithuania, Poland, Romania and Ukraine), although at different pace, adopted the Semashko health-care model.¹⁴ Even though the system was based on the principle of free-of-charge universal health-care provision, the limited resources devoted to health care as a non-productive sector led to chronic shortages in specialized personnel and equipment, and as a consequence to quality and equity problems.¹⁵ After the collapse of communism, the countries experienced a sharp economic decline, which further limited the available health-care resources and provoked major health-care system reforms aimed at the establishment of social health insurance (except for Ukraine).^{16–18} Nevertheless, the design of the new insurance system was not aligned with economic conditions and could not assure adequate levels of resources to finance the generous benefit package inherited from the communism time.^{19,20} At the same time, the significant and explicit reduction of this package has been difficult to achieve, which often leaves the boundaries between covered and non-covered services blurred.^{21,22} The countries tried to react to this problem by shifting part of health-care funding to patients, that is, by applying charges for pharmaceuticals and dental care, but also for other services in the basic service package.⁶

In Bulgaria, obligatory visit fees for all levels of medical services (with the exception of emergency care) were introduced in 2000 along with the implementation of a social health insurance system.²³ The fee size is equal to 1 per cent of the minimum wage of the country for each visit to a GP and outpatient medical specialist after a referral from a GP, and 2 per cent of the minimum wage for the first 10 days of the first hospitalization in a year (at present about 1 and 2 euro, respectively). The charges are

collected and used by the service provider. There is a wide range of exemptions and fee reductions for certain population groups.

In other countries, constitutional, political and above all social obstacles impeded the implementation of obligatory patient charges. In Hungary, co-payments for basic health-care services (approximately 1 euro for each visit to GP and medical specialist after a referral and for each day of hospitalization) were introduced in 2007 with the objective to decrease unnecessary use of health-care services and to eliminate informal patient payments.⁸ These fees were collected and retained by the health-care institutions. The payment system was also accompanied by various exemptions and fee reductions. Nevertheless, in April 2008, fees were abolished as a result of a public referendum initiated by the government's opposition. Similarly, in Ukraine, the government made some attempts in 1996 to introduce official charges for health-care services. However, constitutional provisions proclaiming free-of-charge medical care in state and community health facilities prohibited the introduction of the fee.²¹ In Poland, Lithuania and Romania, uniform obligatory charges for services included in the basic package have been under policy discussion but are not (yet) implemented.^{5,7,24}

Notwithstanding the absence of obligatory charges for health-care services in the basic package, poor quality and access to public health care often force patients in CEE countries to seek care in the private sector. Moreover, in the face of the underfunding of services under the public health-care system, implicit rationing regulated by providers and outside the control of the government takes place and results in quasi-formal charges for health-care services in the basic package.^{21,25–27} This refers to payments for health-care services with higher hospitality standards (better room in the hospital, for example in Hungary, Poland, Romania, Lithuania, Ukraine), more diagnostic tests (e.g. Ukraine, Lithuania), services with quicker access (bypassing waiting list, visits to a specialist without referral, e.g. Lithuania, Romania) and free choice of a

physician (surgeon or obstetrician, e.g. Lithuania, Bulgaria, Hungary). Patients are also asked to purchase pharmaceuticals and/or surgical materials for their hospitalizations (e.g. Lithuania, Romania, Ukraine, Bulgaria). Additionally, in Ukraine, there are also voluntary charitable donations for public hospitals, which in practice are almost compulsory.²⁸

In all countries included in the study, informal (under-the-table) patient payments to personnel continue to exist to a greater or lesser extent.^{12,22,26,29} Recent studies suggest that these payments are widespread in Ukraine and Romania but also in Lithuania and Hungary, while they are comparatively rare in Bulgaria and Poland.³⁰ Some of these payments are considered as gratitude payments, yet patients often pay to get better service quality, more attention from medical staff or quicker access.

Data collection and analysis

Qualitative and quantitative data were collected in 2009 in six CEE countries: Bulgaria, Lithuania, Romania, Ukraine, Hungary and Poland among the following stakeholder groups: health-care policy makers and health insurance representatives, health-care providers and health-care consumers. Qualitative data were obtained using focus group discussions and in-depth interviews. Due to the different characteristics of the groups (e.g. size, diversity), policy makers and insurers were approached via face-to-face semi-structured interviews, while health-care providers and consumers were approached via focus group discussions. After a discussion or interview, participants were asked to fill in a self-administrative questionnaire to collect quantitative data. Appendix S1 presents further details about the groups.

The objective was to study the acceptability of patient charges for basic health-care services and the opinion about the adequate role and design of these charges. A list with key questions was developed based on a preliminary literature review. The key questions were used to develop guides (including questions) for focus group dis-

cussions and in-depth interviews as well as a questionnaire (covering the same questions) to collect quantitative data. The guides and questionnaire were standardized (i.e. the questions and explanations were the same for all countries). They were developed in English and then translated into national languages by professional translators or bilingual experts in the field of the research. The accuracy of translation was verified by 1–2 other bilingual experts. The guides for focus group discussions and interviews, as well as the questionnaire, were discussed with researchers from the six countries to assure that the country specificities were well reflected. The data collection instruments were also pre-tested after translation to assure that the translation is understandable for the potential respondents.

The qualitative data from the focus group discussions and in-depth interviews were tape-recorded, then transcribed and translated into English by professional translators or bilingual experts and then verified by other experts. The transcripts in the original languages were also available for the researchers, and if necessary, the translation was again verified during the process of analysis. Data analysis focused on respondents' opinions on whether patient charges for health-care services in a basic package should exist in their country. An inductive approach to develop a set of codes was applied. Transcripts were reviewed, and codes were assigned to emerging concepts. Ultimately, data were classified into three main categories (respondents' arguments in support of patient fees, condition for patient fees existence, arguments against patient fees) and specific subcategories related to the main objectives of health financing systems defined by the WHO, that is, equity and financial protection, efficiency, quality, transparency and accountability.¹³

Quantitative data analysis was targeted on general acceptability of patient fees and policy objective of their introduction. Respondents' opinions on selected elements of patient fees design were also analysed (charges for emergency services, fee beneficiaries, exemption or reduction mechanisms) (see Appendix S2 for the wording of questions). All original data were

re-coded into binary variables, and Pearson's Chi-squared test or Fisher's exact test (if more than once cell has expected number of observations fewer than five) was performed to determine whether the above-mentioned issues got equal support in all countries and among all stakeholders groups.

Results

This section separately presents the results of the qualitative and quantitative data analysis. The conformity of the results from the two types of analysis is also indicated.

Qualitative results

The results of the qualitative data analysis are presented in Table 1. Below, the main findings are summarized. Relevant quotes from the transcripts are presented in boxes.

Arguments in support of patient payments

In all countries, two arguments supporting patient charges, namely improving efficiency and generating additional resources, prevail among those in favour of charges, that is, policy makers and insurers and majority of health-care providers (Box 1). According to these respondents, patient charges could reduce unhealthy behaviour as well as unnecessary use of health-care services, which improves the efficiency of health-care provision. With regard to the fiscal argument, respondents from all countries more often refer to patient payments as a necessary measure to fill the gap between an inadequate reimbursement from insurance/state funds and the actual cost of services (in Bulgaria also a lack of cost reimbursement for services provided to the uninsured), and less often to incentives for quality-improving competition.

In Lithuania and Ukraine, where informal and quasi-formal payments are common, the legalization of these fees and improving transparency are perceived as an important issue among all stakeholders groups, including also health-care consumers. The presence of formal patient

charges in other European countries is also an argument in favour of fees introduction.

Conditions for patient payments implementation

Service exemption is commonly viewed as a complementing condition for patient payments implementation (Box 2). Respondents in all countries agree that payments could be applied but only for selected services (services that are not essential/life-saving). In Lithuania, Romania and Ukraine, there is a common opinion (expressed also by policy makers/insurers and health-care providers) that a basic service package financed from public resources should be clearly defined and mandatory patient payments should not be applied to these services. Nevertheless, physicians in Poland express negative attitudes towards service exemption, arguing that the unfavourable situation of all health-care providers justifies applying universal fees.

Respondents, who do not oppose patient charges, also make the fees' implementation conditional upon setting payments at an affordable level and protecting vulnerable population groups. However, this opinion is less common among providers (physicians but not nurses) in different countries, who often are against any exemptions or fee reductions. They argue that the protection of vulnerable individuals is not the role of the health-care system, and such mechanisms result in additional administrative work. Consumers, who do not express firm opposition towards patient payments, would accept fees if quality and access to health-care services were better. In Bulgaria and Hungary, the opinion on a general improvement in quality is more common, while in other countries patients would also agree to pay voluntarily to get higher quality, higher standard of services or extra services.

Arguments against patient payments

Opponents of patient payments express concern about patients' inability to pay and the financial barrier to use health-care services (especially for the poor and chronically sick) (Box 3). This argument is often used by

Table 1 Summary of qualitative results

	Arguments supporting patient charges	Conditions for patient charges	Arguments against patient charges
Equity and financial protection		If no obligatory payments for basic services/life-saving services (Services exemptions): H (1,2), LT (1,2,3), PL (1), RO (1,2,3), UA (1,2,3) If payments are adequate to ability to pay (population exemptions): BG (1), H (1,3), PL (2,3), UA (1,2,3)	Inability to pay for health-care services: BG (1,2,3), H (1,2), LT (1), PL (1), RO (1,2), UA (1,2) Social health insurance contribution/taxes paid by working individuals: BG (1,2,3), H (1,2), LT (1,2), PL (1), RO (1,2), UA (1)
Efficiency	Reducing moral hazard ex ante (increase people responsibility for own health and compliance with physicians recommendations): BG (2,3), H (2,3), LT (2,3), RO (2,3), UA (2,3) Reducing moral hazard ex post (increase cost consciousness, reduce unnecessary consumption): BG (2,3), H (1,2,3), LT (2,3), PL (2,3), RO (2,3)	If payments system is administratively efficient/resources are not wasted: BG (1), H (2) If payments system does not result in extra administrative work for physicians: H (2), LT (2), RO (2)	Inefficiency in health-care system (in using public money): LT (1), PL (1)
Quality	Generating additional resources by institutions (for investment), increasing competitions: H (1,2,3), PL (2,3) Filling the gap between service cost and inadequate reimbursement: BG (2), H (3), LT (2,3), PL (2,3), RO (1,2,3), UA (1,2,3)	If overall quality (access) is improved/physician attention/better equipment: BG (1), H (1,2), LT (1), PL (1), RO (1), UA (1) If payments are for better quality/standard services (at patient choice): LT (1,2,3), PL (1), RO (1,2,3), UA (1,2,3)	Poor quality and access to health-care services: BG (1), H (1,2), LT (1), PL (1), UA (1) Lack of benefits for physicians and administrative burden: BG (2), H (2), LT (2)
Transparency and accountability	Legalization and formalizations of existing patient payments (quasi-formal, informal): LT (2,3), UA (1,2,3) Increasing accountability of physicians: UA (1,2,3)	If payments system is transparent (price list, exemptions, use of generated resources): BG (1), UA (1) If patients do not have to pay informally: RO (1), UA (1)	Lack of transparency and control over patient payments: BG (1,2), H (1,2) Existence of informal patient payments: LT (1), UA (1)
Other	Presence of patient charges in other European countries: BG (2,3), H (3), LT (3), PL (2,3), UA (2,3) Presence payments for other services (e.g. public transport): UA (1,2)		Legislations obstacles/constitutional provision: UA (1)

BG, Bulgaria; H, Hungary; LT, Lithuania; PL, Poland; RO, Romania; UA, Ukraine; 1, Health-care consumers; 2, Health-care providers; 3, Policy makers & insurers.

consumers but also by providers, especially in Bulgaria, Romania and Ukraine. Respondents in these countries underline that public

health-care services are often used by the poorest, while those who can afford to pay use the private system. Another argument commonly

Box 1 Statements that advocate patient payments

- 'Patients would take the health care service more seriously, take our advices more carefully, and also feel that it has its price. Because although they pay the health insurance that is distracted from the salary, then everyone use the services as they were for free. And if something is free of charge, it doesn't have value' (GP, city, Hungary).
- 'Patient payments should exist. And why? This is an universal problem, but I think that such goods financed with public resources, if they are available in an unlimited manner, free of charge, then naturally they will be abused' (Policy maker, regional level, Poland).
- 'One more reason why official patient payments should exist in hospitals is that current state funding is not enough to provide high quality and sufficient services (...) It should be clearly declared what is covered by the state and what – by a patient' (Physician, district hospital, Lithuania).
- 'Our healthcare institutions have to raise additional funds and earn money in a civilized way' (Policy maker, regional level, Ukraine).

discussed by consumers in all countries who object to patient fees, is poor access and quality of health-care services. This is contrasted with the high health insurance contributions paid by health-care consumers. Consumers question whether the funds accumulated through these contributions are used appropriately. They also do not trust that the additional resources generated through patient charges are used to improve quality, but they see them as a double payment. The same opinion among Bulgarian and Hungarian consumers is based on their experiences with patient charges in their own country. As stated by respondents, charges have not resulted in access or quality improvements, and the system lacks transparency and control over the revenue collected (e.g. patients do not get a receipt). Most consumers also believe that formal patient payments cannot eliminate paying informally. Health-care providers who have experienced charges (i.e. Hungary, Bulgaria) but have not been direct beneficiaries of the revenues (i.e. physicians who do not work in

Box 2 Statements that specify conditions for patient payments

- 'I think that general rules should apply, i.e. the patient should have a sense of security and this sense of security should come from the guarantee of free access to those services that save lives, which is related to emergency situations' (Policy maker, national level, Poland).
- 'In order to be able to provide medical care of good quality there should be co-payment, but a guaranteed level of healthcare should be defined on the state level (...) It should be "a sacred law" and within this level the healthcare should be provided free of charge' (Policy maker, national level, Ukraine).
- 'The system operates as a whole, all services are elements of the health care system. If there are patient payments, they should apply to every area.' (Physician, city hospital Poland).
- 'I'm not against paying, if we will be able to afford paying the price' (Consumer, disabled, Ukraine).
- 'There should be no exceptions! If a person cannot afford to pay, belongs to some kind of special social group, his expenses for health care services should be covered by some social institution. Health-care specialist should not care about it!' (Physician, district hospital, Lithuania).
- 'It is not my problem if people cannot pay; it is the problem of those who brought them into this status' (GP, city, Romania).
- 'If there are fees, greater attention should be paid to the patients, proper examinations should be made and not only writing a prescription' (Consumer, pensioner, Bulgaria).
- 'I am in favour of those patient payments – optional or compulsory, but in exchange for this we must get something!' (Consumer, rural area, Poland).

individual practises), are against them due to the administrative burden of collecting charges.

Quantitative results

To statistically test the differences in the opinion on patient charges between stakeholder groups as well between countries, quantitative analysis of data collected through the standardized questionnaire was performed. The results presented in Table 2 indicate that there are significant differences in the acceptability of formal patient charges among different

Box 3 Statements that oppose patient payments

- 'Those fees stop many people from visiting the doctor because of the sum (Consumer, working individual, city, Bulgaria).
- 'If I have nothing to pay, am I supposed to die?' (Consumer, pensioner, Ukraine)
- 'A lot of money was collected as patient payment, but we, patients didn't see any change' (Consumer, pensioner, Hungary).
- 'We should not be paying extra because we pay insurance contributions. We don't know what happens to them. The worst thing is that, in general, we don't take advantage of our contributions' (Consumer, family with children, city, Poland).
- 'The only thing we could see was that there was lots of administration with patient fees, consulting was much slower and I don't know where that money has gone' (Physician, outpatient specialist, city, Hungary).
- 'It is much easier for me to negotiate personally and to pay not at the desk but straight to a doctor' (Consumer, student, Ukraine).

stakeholder groups included in the study. The lowest support for patient payments is among health-care consumers, (mostly disapproval) while the majority of policy makers, insurers and health-care providers advocate formal patient fees. There are no significant differences across countries in the consumers' perceptions of fees. Yet, Lithuanian and Polish health-care consumers in our study are least in favour of fees. Similarly, the groups of policy makers and insurers present a rather homogeneous attitude towards fees. However, health-care providers are less uniform in their opinion. In particular, Hungarian health-care providers express considerably less approval for patient fees than providers in other countries. These results are in line with our findings from the qualitative data, which shows that health-care providers who have not been direct beneficiaries of fees are against their reintroduction.

The views on the main policy objective of patient fees differ across stakeholders groups as well as across countries (see Table 3). Overall, the efficiency improvement's goal gets the greatest support among policy makers and

Table 2 Approval of patient charges

	Bulgaria N = 102		Hungary N = 46		Lithuania N = 104		Poland N = 92		Romania N = 99		Ukraine N = 103		Total N = 546		P value (between-country comparison)*
	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	
Health-care consumers N = 266	21/44	48	14/26	54	16/54	30	17/47	36	18/43	42	26/52	50	112/266	42	0.19
Health-care providers N = 227	41/48	85	7/15	47	33/40	83	35/36	97	41/47	87	28/41	68	185/227	81	<0.001
Policy makers and insurers N = 53	8/10	80	5/5	100	9/10	90	8/9	89	8/9	89	8/10	80	46/53	87	0.97
Total N = 546	70/102	69	26/46	57	58/104	56	60/92	65	67/99	68	62/103	60	343/546	63	0.31
P value (between-stakeholders comparison)*	<0.001		0.12		<0.001		<0.001		<0.001		0.08		<0.001		

*P value based on Pearson's Chi-squared test or Fisher's exact test (used when more than one cell has expected count < 5) applied for binary outcome agree that official patient payments should exist (strongly agree or agree) vs. do not agree (neutral or disagree or strongly disagree).

Table 3 Approval of efficiency improvement as the primary policy objective of patient charges

	Bulgaria N = 102		Hungary N = 46		Lithuania N = 104		Poland N = 92		Romania N = 99		Ukraine N = 103		Total N = 546		P value (between-country comparison)*
	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	
Health-care consumers N = 266	18/44	41	5/26	19	5/54	9	7/47	15	8/43	19	14/52	27	57/266	21	0.004
Health-care providers N = 227	26/48	54	9/15	60	14/40	35	20/36	56	15/47	32	6/41	15	90/227	40	<0.001
Policy makers and insurers N = 53	10/10	100	5/5	100	3/10	30	5/9	56	4/9	44	3/10	30	30/53	57	0.001
Total N = 546	54/102	53	19/46	41	22/104	21	32/92	35	27/99	27	23/103	22	177/546	32	<0.001
P value (between-stakeholders comparison)*	0.003		0.001		0.008		<0.001		0.18		0.31		<0.001		

*P value based on Pearson's Chi-squared test or Fisher's exact test (used when more than one cell has expected count < 5) applied for binary outcome approve of efficiency goal (discouraging unnecessary use of health care services or controlling the overall health care expenditure) vs. disapprove of efficiency goal (approving other goals, that is, generation of resources or elimination of informal patient payments).

insurers, while the majority of health-care consumers and health-care providers support the generation of resources as the main objective. The elimination of informal patient payments as a main policy objective of patient fees gets marginal support. Nevertheless, significant differences in stakeholders' views can be observed between countries. The results indicate that efficiency improvement is more important for respondents in Hungary, Poland and especially in Bulgaria where this objective finds substantial approval also among health-care consumers. Respondents in Lithuania, Romania and Ukraine perceive patient fees rather as an additional source of funding than a measure to improve efficiency. It is noteworthy that Ukrainian health-care consumers express relatively strong support for efficiency improvement (stronger than Ukrainian health-care providers).

Table 4 presents respondents' views on three main elements of the patient fee design, that is, services that are the subject of fees (emergency services is given as an example), the beneficiary of patient fees (approval for health-care providers) and the need of a protection policy (general approval for applying reduction or exemption mechanisms). The majority of respondents are against fees for emergency services. It is especially noticeable among policy makers/insurers and among health-care consumers, though to a lesser extent. Nevertheless, in total, more than 30 per cent of health-care providers (with significant differences across countries) are of the opinion that fees should be also applied to emergency services. This support is particularly high among Polish health-care providers, which is in line with findings from the focus group discussions.

Significant differences in opinions on patient payments' beneficiary are observed among stakeholder groups. Policy makers/insurers and health-care providers commonly agree that the beneficiary of patient payments revenue should be the health-care providers. However, this opinion is less common among health-care consumers who often opt for other beneficiaries (health insurance fund/state/municipality). The opinion of health-care consumers across

Table 4 Opinion on the main elements of patient charges design

	Bulgaria N = 102		Hungary N = 46		Lithuania N = 104		Poland N = 92		Romania N = 99		Ukraine N = 103		Total N = 546		P value (between-country comparison)*****
	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	n/N	%	
Approval of fees for emergency services															
Health-care consumers N = 266	5/44	11	3/26	12	14/54	26	6/47	13	11/43	26	10/52	19	49/266	18	0.24
Health-care providers N = 227	10/48	21	3/15	20	14/40	35	30/36	83	13/47	28	7/41	17	77/227	34	<0.001
Policy makers and insurers N = 53	0/10	0	0/5	0	2/10	20	1/9	11	3/9	33	1/10	10	7/53	13	0.34
Total N = 546	15/102	15	6/46	13	30/104	29	37/92	40	27/99	27	18/103	17	133/546	24	<0.001
P value (between-stakeholders comparison)*	0.17		0.69		0.51		<0.001		0.89		0.78		<0.001		
Approval of beneficiary – health care providers															
Health-care consumers N = 266	20/44	45	24/26	92	43/54	80	28/47	60	26/43	60	23/52	44	164/266	62	<0.001
Health-care providers N = 227	46/48	96	14/15	93	37/40	93	33/36	92	42/47	89	31/41	76	203/227	89	0.08
Policy makers and insurers N = 53	9/10	90	5/5	100	8/10	80	7/9	78	8/9	89	9/10	90	46/53	87	0.91
Total N = 546	75/102	74	43/46	93	88/104	85	68/92	74	76/99	77	63/103	61	413/546	76	<0.001
P value (between-stakeholders comparison)**	<0.001		1.00		0.21		0.004		0.003		0.001		<0.001		
Approval of exemption/reduction															
Health-care consumers N = 266	43/44	98	21/26	81	53/54	98	45/47	96	41/43	95	49/52	94	252/266	95	0.07
Health-care providers N = 227	28/48	58	12/15	80	31/40	78	24/36	67	28/47	60	38/41	93	161/227	71	0.003
Policy makers and insurers N = 53	10/10	100	3/5	60	8/10	80	8/9	89	9/9	100	10/10	100	48/53	91	0.05
Total N = 546	81/102	79	36/46	78	92/104	88	77/92	84	78/99	79	97/103	94	461/546	84	0.013
P value (between-stakeholders comparison)***	<0.001		0.60		0.003		0.002		<0.001		1.00		<0.001		

*P value based on Pearson's Chi-squared test or Fisher's exact test (used when more than one cell has expected count < 5) applied for binary outcome - approve of fees for emergency services vs. disapprove of fees for emergency services.

**P value based on Pearson's Chi-squared test or Fisher's exact test (used when more than one cell has expected count < 5) applied for binary outcome - approve health-care providers (institution or physician) for beneficiary of fee revenues vs. disapprove health-care providers for beneficiary (approving health insurance fund or state or municipality for beneficiary).

***P value based on Pearson's Chi-squared test or Fisher's exact test (used when more than one cell has expected count < 5) applied for binary outcome approve of exemption/reduction mechanism vs. disapprove of exemption/reduction mechanisms.

countries differ significantly. Approximately 45 per cent of Ukrainian and Bulgarian respondents support health-care providers as a beneficiary, while this percentage is much higher in Hungary and Lithuania.

Overall, respondents have a positive attitude towards protection mechanisms for vulnerable population groups. Yet, health-care providers express the least support for this, which confirms our finding from the qualitative data analysis. Significant variation between countries is found. In Bulgaria and Romania, approximately 60 per cent of health-care providers approve fee reductions or exemption policy, while in Ukraine, this share is more than 90 per cent.

Discussion

This paper presents the results of a study on the acceptability of patient payments by health-care stakeholders in six CEE countries. Although we combine two types of analysis (qualitative and quantitative) to strengthen validity and reliability (we have found no conflicting results), the limitations of the study should be acknowledged. Most importantly, the study groups are small, and the degree of their representativeness of the wider population is unknown. However, the primary research objective was to collect in-depth information on the views of different stakeholders rather than achieving representatives for a country. Furthermore, the quality of our qualitative data is highly influenced by the knowledge and skills of the moderator or interviewer. We mitigated this limitation by choosing experienced moderators and interviewers and by applying a standardized guide to assist them during the data collection process. Also, our findings can be subject of biases arising from the translation of the research tools and of the transcripts (the qualitative data). By involving professional translators and research experts in the translation process, we diminished such biases to a certain extent. Notwithstanding the study limitations, our results suggest some patterns that apply to all six countries, which will be the focus of our discussion.

Patient charges are strongly advocated by policy makers and insurers' representatives in our study. This finding is in line with our expectations based on previous research^{5,6} as well as with the fiscal pressure in the CEE health-care systems.¹ Both fiscal goals (generation of additional resources) and efficiency goals (reduction in moral hazard) of patient charges implementation are acknowledged by policy makers and insurers in all countries included in the study. Yet, their importance differs in accordance with the expectation that in health-care system with relatively better funding, efficiency goals gain in relevance.¹⁹ The exemption is Bulgaria where although public health spending is relatively low, patient charges are perceived as a means to improve efficient use of health resources. This can result from the fact that reducing unnecessary use was the initial goal of patient payments when they were implemented along with the health insurance system in 2000.²⁹ Moreover, the long experience with patient payments has proved that these charges hardly increase resources or improve quality of services, as was stated by Bulgarian respondents.

Health-care providers, although they overall support payments, are the least homogeneous group in our study, and their opinion differs depending on the country. In Bulgaria and especially in Hungary, health-care providers, who have experienced formal patient payments but have not been direct beneficiaries of fees revenues, express negative attitudes towards patient charges, perceiving them mostly as an administrative burden. By the same token, some health-care providers oppose excluding services or population groups from payments obligations. Thus, it can be concluded that acceptability of patient payments by health-care providers to a large extent depends on the financial benefit from these payments.

The majority of health-care consumers in our study (irrespective of the country) are against obligatory charges for services in the basic service package. Our results indicate that the low acceptability of fees among consumers follows from poor quality and access to health-care services offered in the public health-care

system in these countries, combined with the low transparency and accountability, for example in patients' entitlements. Although patients in CEE countries are entitled to a broad range of services, the quality and accessibility of these services are rarely specified.¹⁷ Consequently, due to the shortage of public resources, patients are often denied free-of-charge high-quality and timely health care. This contributes to the common characteristics in CEE countries: lack of trust in public institutions and in the adequate use of health resources.³¹ As our results indicate, this attitude also finds an explanation in the failure of patient payment policies, that is, lack of quality improvement, poor transparency, coexistence of informal payments. The low effectiveness of patient payment policy might result from the fact that health policy making in CEE countries is rarely rooted in evidence.³² The reforms are usually ad hoc measures implemented when a political window of opportunity opens.

Despite the opposition against obligatory fees, some consumers in our study agree to voluntary payments for additional value, that is, in exchange for additional service, better quality, standard or better access (except for life-saving/essential services). The relatively high acceptability of such fees (especially in Lithuania, Romania and Ukraine) may be explained by widespread informal and quasi-formal charges in these countries, which serve the same goals.^{11,21,25,26,33} Yet, it should be noted that payments for additional value (e.g. payments for quicker access) may raise equity concerns or even efficiency concerns (e.g. co-payments for additional tests without medical indication).

Our results indicate that consumer attitudes towards obligatory charges are also a reflection of their concern about the inability to pay for health-care services. Financial barriers to health care are a common problem in CEE countries due to already high out-of-pocket health expenditure (including payments for pharmaceuticals) and lack or failure of protection mechanisms for vulnerable population groups.^{20,34–36} The development of an effective exemption mechanism that accompa-

nies patient payments is a challenging task due to considerable informational, administrative, resource and socio-political constraints.^{37,38} The broad exemption policies, often applied by governments due to the pressure of different social groups, do not effectively target the most vulnerable but increase administration of the system and reduce its fiscal efficiency.

Conclusion

Our study shows that there is a rather weak consensus among the main stakeholder groups on the presence and role of patient charges in CEE. Health policy makers and insurers strongly advocate patient charges, in countries with better funding, mostly as a measure to improve efficiency in health-care utilization. Health-care providers acknowledge the importance of reducing unnecessary use of health-care services, but their approval of charges is driven by the perspective of financial profit from the payment system and a low administrative burden. However, the majority of health-care consumers are against charges. This is largely due to distrust that the implementation of obligatory formal patient payments would benefit patients, that is, improve the poor access and quality of health-care services and thus reduce other payment obligations. Although in CEE countries with relatively poor public funding all stakeholders groups see the implementation of universal formal patient charges as the way to regulate the quasi-formal payments, patient inability to pay for health services and inequity are major concerns in these countries.

Our findings indicate that enhancing public trust and acceptance of patient payments in CEE countries require improving transparency and accountability in the health-care system, for example a clear formulation of a feasible (considering limited resources) basic package, well-defined quality and access standards, eradication of informal payments. The introduction of obligatory patient payments should be accompanied by investments to assure high-quality health-care services, through reinvesting the fee revenues in health-care facilities. Further, deci-

sion makers should protect the most vulnerable groups against adverse equity effects, for example applying transparent exemption or reduction mechanisms. Administrative costs and fiscal efficiency should be closely considered when developing a patient payment system. Relying on evidence (e.g. preliminary analyses of the impacts of patient charges) should facilitate building an effective and more equitable patient payment policy in CEE countries.

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Appendix S1. An overview of focus group discussions and in-depth interviews.

Appendix S2. Wording of questions used in the quantitative analysis

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