

The Self-Provision of Public Healthcare Services: A Threat to Democracy

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Abstract

How and why could the self-provision of public healthcare services pose a threat to democratic values? We define the informal self-provision of healthcare, identify the factors that promote its appearance, and discuss its destructive implications for society. In addition to substantiating the existence of these strategies around the world, we also maintain that in the long run, such strategies may crush traditional political participation and weaken democratic values.

Keywords: self-provision, public healthcare services, informal payments, political participation

1. Introduction

How and why could the self-provision of public healthcare services pose a threat to democratic values? While the literature stresses various negative implications of strategies for the self-provision of healthcare services, the implications and influence of these strategies with regard to democratic values are less discussed. Defining self-provision strategies as informal methods and actions used by individuals and groups to satisfy their immediate interests and need for services, we point to informal payments for healthcare as emblematic of the self-provision of public healthcare goods and services.

The literature reveals that there are both socio-economic benefits and disadvantages when citizens in any given society adopt such strategies. In many cases, these strategies negatively affect the quality of services received (Ensor 2004), increase inequality (Balabanova & McKee, 2002; Lewis, 2000) and hurt both lower and middle class (Cohen 2011). In addition to their negative effects, these strategies are often illegal, as they involve for-profit exchanges for illegal goods and services (Mendoza, 2010).

Given that the informal self-provision of healthcare services is in many cases illegal, and problems with efficiency and equity arise from them, we would expect decision makers to fight the phenomenon. Yet, that does not always happen. Decision makers often ignore the phenomenon, especially given financial difficulties and crises. Hence, in the eyes of many decision makers around the world, the implications of these strategies are limited to the local healthcare system.

In this article we argue that the main disadvantage of the phenomenon is not limited to the healthcare policy or system. Instead, we maintain that such strategies have a destructive effect on democratic values. In the long run, the self-provision of healthcare services not only threatens the values of efficiency and equity, but also challenges the values of participatory democracy. We suggest that over time, this strategy may slowly and silently pervade all of the players, sectors and areas of public policy and become an integral part of the patterns of a society's political behavior. This behavior bypasses formal institutions in favor of illegal or semi-legal means of acquiring desired public goods and services. Citizens who are dissatisfied with the quality and/or quantity of public goods and services, and believe that the political structure is so paralyzed that they are powerless to effectively change the situation engage in such behavior. Thus, citizens internalize illegal and extra-legal behaviors or attitudes that in essence bypass the existing mechanisms of social participation and social norms.

2. Public Goods, Public Dissatisfaction and Political Participation

One of the main rationales for public policy is market failures. Thus, as the economic reality shows, the desire of individuals and profit-oriented firms to maximize their utility through the Pareto-efficient allocation of goods in such a way that no one will be better off without making someone else worse off does not always work. Hence, in

situations in which decentralized behavior does not lead to Pareto efficiency, public policy is needed (Weimer & Vining, 2005). Market failure is an equilibrium allocation of resources that is not Pareto optimal. In such a situation, the surplus of a social good would be greater using an alternative allocation, one that would lead to market equilibrium. Traditionally, this situation occurs due to natural monopolies, externalities, information asymmetries and public goods. To varying degrees, public goods are non-rivalrous in consumption and non-excludable in use. Most, if not all, citizens benefit from them without reducing the benefits of those already using them. Public policy is a tool for designing solutions to "collective action" problems (Olson, 1965).

However, public intervention in the market is often limited. Just as individual choice sometimes fails to promote social values in predictable and desirable ways, so too, does collective choice. Government failures are caused by problems inherent in direct democracy and representative government, problems inherent in bureaucratic supply (Weimer & Vining, 2005; Winston, 2006) and the intervention of various interest groups that usually attempt to promote narrow interests (Mitchell & Munger, 1991). These factors may entail significant social costs for government intervention and often lead to a decline in social welfare as well as distributional inequalities.

The healthcare market has very unique characteristics that often exacerbate these challenges. As Arrow (1963) demonstrates, healthcare markets are characterized by a uncertainty about disease and its financial consequences, socially unacceptable market outcomes, and distributional inefficiencies due to market imperfections and failures. Nevertheless, state involvement in medical care to deal with health-related externalities, economies of scale in the creation of healthcare, regulation of monopolies, and the value of good health to the national good may create failures similar to those that exist in other social and economic endeavors. Moreover, healthcare is a crucial yet sensitive policy domain, as it affect one's life and the lives of his /her family or loved ones.

Inefficiency in the provision of public services may intensify citizen dissatisfaction significantly, leading them to find new sources of supply. Hence, given both market and government failures – especially when healthcare is on the table – we can expect people to look for alternative solutions to their immediate problems. Furthermore, when market and government failures occur at the same time, citizens may also be very pessimistic about the chances of improving their outcomes through the established institutional framework. This pessimism will gradually increase their dissatisfaction and spur them to take action.

In a normative democratic world, when one is not satisfied with policy outcomes, he/she should be motivated and able to influence policy outcomes by participating in the political process. Such participation includes voting in elections, taking part in demonstrations, and signing petitions (Almond & Verba, 1989; Pateman, 1970). In addition to being functional, political participation is considered normative behavior. It strengthens political and civic life, encourages people to become more active in and informed about their community and nation, and strengthens the value of participation. In essence, democratic values are participation values.

But what happens when the option of participating via the political system is not effective?

3. The Self-Provision of Public Healthcare Services as a Quasi-Exit Strategy

In his influential work, *Exit, Voice and Loyalty*, Hirschman (1970) explain that when individuals are dissatisfied, they may choose either the voice option and demand better outcomes, or the exit option and simply leave the product or their place of work. The choice between the two alternatives depends on the level of loyalty to the place of work or brand name. As the level of loyalty increases, the greater the chance of the voice option being chosen, and vice versa.

While focusing on the phenomenon of informal payments for healthcare, Gaal and McKee (2004) made an interesting and significant effort to develop a behavioral, cognitive model that extends Hirschman's model. They argue that when the internal and external channels of influence are blocked, the individual will not work through the formal channels, for instance, by lodging a complaint, but will use informal channels, such as payments or personal connections. Nevertheless, this activity cannot be considered an exit strategy because it is performed within the organization itself. Indeed, Gaal and McKee's rationale provides a very good framework for the analysis of informal payments for services (Cohen, 2012). And yet, they applied this model rather narrowly to healthcare only, so it is very difficult to determine the long-term influences on society and its democratic character from it.

As Lehman-Wilzig (1991, 1992) explained earlier, Hirschman's seminal economic model may apply in the political arena. Hence, dissatisfaction with policy outcomes may lead people to protest or exit – depending on the level of their loyalty. Dissatisfied people with low levels of loyalty may leave the country, while others may take part in various forms of democratic participation such as elections and protest movements. When political participation does not succeed in bringing about fundamental changes in political performance, people will attempt

to change the institutional structure itself through the use of democratic forms of influence such as protest activities (North, 1990).

Still, there are situations in which people are dissatisfied with policy outcomes but cannot or will not either protest or exit. Therefore, they will use illegal or semi-legal channels in order to create an alternative supply of public goods or services. Lehman-Wilzig (1991) developed the concept of quasi-exit to describe this unique situation. In these cases, the public solves the immediate problem of a shortage and threatens the politicians' monopolistic hold on public goods and services. When citizens provide their own services, the mechanisms of voice are completely marginalized. Thus, citizens exit by creating their own alternatives – without actually leaving the country. The literature describes such activities in various policy domains as alternative politics (Mizrahi & Meydani, 2003).

Alternative politics (henceforth: AP) refers to specific strategies citizens and interest groups adopt in response to their dissatisfaction with the declining availability of governmental services (Ben-Porat & Mizrahi, 2005; Cohen, 2012; Mizrahi, 2012). More specifically, AP is based on a "do-it-yourself" approach where citizens on their own adopt extra-legal, and often illegal, strategies to improve the services the government provides. In many cases, individuals adopt such strategies to solve their immediate problems, such as obtaining more responsive and better quality services, rather than having organizations resolve these issues. AP is also characterized by a sophisticated amalgamation of public resources and private financing. Under certain conditions, such modes of behavior diffuse throughout all sectors and levels of society through a process of collective learning. Given such diffusion, players on the policy scene are guided by short-term considerations and tend to apply unilateral strategies that bypass formal rules, either through illegal activity or by marginalizing formal rules.

AP is generally embedded as an integral part of a given culture. Therefore, we expect it to diffuse to most of the layers and actors in the society. Hence, the broad definition of the term AP also refers to the manner in which the public goods are supplied, which includes the activities of the suppliers of public goods and services, namely, the politicians and the bureaucrats. Thus, the decision makers themselves use informal institutions during the process in which they supply public goods. When structural conditions prove difficult, we should expect to see the phenomenon emerge in many areas, not confined to just specific areas of policy or particular public groups.

4. The Self-Provision of Public Healthcare Services: Evidence from Around the World

We have evidence about the existence of the self-provision of healthcare strategies that citizens have adopted in tens of countries throughout the world. In most cases, this strategy takes the form of informal payments for healthcare, and occurs in the former Soviet Union, Eastern and Central Europe, Northern and Central Asia, South America and Africa, as well as in Greece, Turkey, Mexico and Israel (Cohen, 2012).

In many cases, informal payments for healthcare exist because the options of exit or voice do not exist. Hence, citizens have no choice but to use quasi-exit strategies. For example, a comparative study conducted in Bangladesh, India, Nepal, Pakistan and Sri Lanka confirmed that in all of these countries, citizens had to pay informally in order to get a hospital bed, and receive subsidized medicines and healthcare services from the hospital. With the exception of Sri Lanka, informal payments for healthcare were a precondition for the receipt of healthcare services from the suppliers of healthcare services (Thampi, 2002). Gopakumar (1998) describes a more disturbing phenomenon in which mothers in India are forced to make informal payments to nurses in order to see their new-born babies.

The literature suggests that the main variables that explain the phenomenon are the perception that the medical staff is underpaid, the belief that good health is worth any price, the fear of being denied treatment, the tradition of giving a gift to express gratitude, the desire to obtain better service, the perception that little attention is paid to patients' dissatisfaction, the lack of definition or concrete information about the services to which the patients are entitled, the lack of accountability, and structural conditions of basic corruption in the public administration (Belli, Shahriari & Gotzadze, 2004; Ensor, 2004; Gray-Molina et al., 2001; Vian et al., 2006).

It is clear that the lack of government involvement is a very important structural factor that promotes the informal payments for healthcare (Belli, Shahriari & Lewis, 2001; Kutzin et al., 2003). Findings indicate that unless the formal rules are enforced, suppliers are allowed to provide healthcare services while violating the existing rules, but when laws are enforced, the phenomenon decreases (Jaen & Paravisini, 2001). It has been argued that unless decision makers address these issues in all sectors of society, the phenomenon will not disappear (Ensor, 2004). And yet, for various reasons, decision makers tend to ignore this phenomenon. Indeed, Lewis (2000: 27-30) concluded that not only do they ignore the situation, but also in some cases they actually help perpetuate the offense. Moreover, this phenomenon indirectly becomes part of the official political process. In some countries, decision makers even take these payments into account when setting doctors' salaries. Hence, more and more citizens around the world find themselves limited to the option of quasi-exit strategies.

5. The Normative Implications of the Self-Provision of Healthcare Services

The advantages and disadvantages of the self-provision mechanisms in healthcare are the core of continual debate. On one hand, one significant advantage of this strategy is the distinct contribution of the phenomenon to the funding of various healthcare systems throughout the world – especially in times of economic crisis. On the other hand, there are many socio-economic disadvantages, particularly with regard to efficiency and equity.

In many cases, these strategies negatively affect the quality of clinical care and the treatment received. Such strategies can prompt family members to resort to performing some clinical services themselves, in an effort to defray healthcare costs, or result in doctors recommending procedures in order to increase their income (DiTella & Savedoff, 2001; Falkingham, 2004). In public facilities, they can also create distortions in healthcare financing systems, draining revenue needed to support public sector goals and activities (Ensor, 2004).

Another significant disadvantage is inequality. Poorer people usually cannot use this strategy (Lewis, 2000). If they do, they may delay seeking medical care or go into debt to pay for the care they need, and are likely to pay a higher share of their income than the rich (Balabanova & McKee, 2002; Falkingham, 2004). Moreover, given the depth of the phenomenon in the healthcare system, even those who are not necessarily having financial difficulties at a given point in time will be under great pressure to make informal payments when they do need medical services (Cohen, 2012).

In addition to their negative effects, these strategies are often illegal, as they involve profitable exchanges for illegal goods and services. As Mendoza (2010: 256) explains, the buying and selling of these goods and services are deemed illegal because of outright legal prohibitions, because they were stolen or produced through unlawful means, and/or because they may have been produced or obtained legally, but are sold illicitly to avoid government interference through taxation and regulation. A combination of strong demand and stiff government restrictions on their provision (legality, financing, pricing) and/or production (service delivery, operations and management) encourages the growth of black markets.

Given that the informal self-provision of healthcare is often illegal, and problems with efficiency and equity arise from them, we would expect decision makers to fight the phenomenon. However, such is not always the case. Decision makers often ignore the phenomenon, especially given financial difficulties and crises that threaten to collapse the healthcare system. Decision makers may also help institutionalize the phenomenon in an attempt to control and even improve the healthcare situation (Balabanova & McKee, 2002). In some cases, decision makers themselves are benefiting from those payments (Di Tella & Savedoff, 2001).

Some may argue that normatively, the informal self-provision of healthcare services is not necessarily negative; it may strengthen political participation, increase citizen involvement in public policy and the civil society, and serve as a safety valve in a complex world. Yet, this argument raises an interesting question – is it possible for such a phenomenon to persist in so many places throughout the world merely in the field of healthcare without expanding and diffusing to other areas of policy?

The self-provision of healthcare services may not only threaten the values of efficiency and equity. It can also challenge democratic values. We suggest that over time, this strategy may slowly and silently pervade all of the actors, sectors and areas of public policy and become an integral part of the patterns of political behavior of a given society. This behavior bypasses formal institutions in favor of illegal or semi-legal means of acquiring desired public goods and services. Citizens who are dissatisfied with the quality and/or quantity of public goods and services engage in such behavior because they believe that the political structure is so paralyzed that they are powerless to effectively change the situation (Cohen, 2012). We may point at such a behavior as a quasi-exit strategy. Thus, citizens internalize illegal and extra-legal behaviors or attitudes that in essence bypass the existing mechanisms of social participation and social norms. In the long run, these attitudes and behaviors may have destructive economic and political outcomes for any society.

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