‘If you pay, we’ll operate immediately’

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Abstract

Objectives—To study the attitudes of health care staff in four postcommunist countries towards taking gifts from their clients—and their confessed experience of actually taking such gifts.

Design—Survey questionnaire administered to officials including health care staff, supplemented by focus-group discussions with the general public.

Setting—Ukraine, Bulgaria, Slovakia and the Czech Republic.

Participants—A quota sample of 1,307 officials including 292 health care staff, supplemented by stratified national random samples of 4,778 ordinary members of the public and in-depth interviews or focus-group discussions involving another 323.

Main measurements—Explicit justifications and willingness to accept offers, reported frequency of offers, and personal confessions to accepting “money and expensive presents” as well as smaller gifts.

Results—Health care staff were far more inclined than the average officer or public servant to accept “money or an expensive present” if offered, far more inclined to justify asking clients for “extra payments”, and far more inclined to confess that they had actually taken gifts from clients recently. Judged by their own confessions, hospital doctors were only rivaled by traffic police and customs officials for taking money or expensive gifts from their clients.

Conclusions—Poor pay does not explain why doctors so often took large gifts from their clients. Moral self justification, opportunity, and bargaining power are much more effective explanations.

(Keywords: Gifts; justification; gratitude; extortion; confession)

Introduction

Health care was in theory free in communist Europe but in practice contributions towards hospital costs were already widespread under communism. On the basis of anecdotes, press reports and personal experience Simis claimed even in 1982, that: “in most segments of the state medical system, which is part of the lives of all Soviet citizens, corruption has become an everyday experience over the past quarter of a century”.

Tichchenko notes that Soviet health care was “free to a very limited extent of unusually low quality average services...it had become a common practice for physicians to receive money or goods as an additional, under the table payment for their services”.

Such contributions apparently increased after the fall of communism. Blasszauer asserts that “the postcommunist countries...are suffering from a moral crisis...The Hungarian health care system is plagued with the practice of tipping, which is often nothing else but bribery, an under-the-counter payment. It has so deeply penetrated the system that no reform seems likely to succeed”.

Borissov and Rathwell refer to the “widespread use of baksheesh or unauthorised payments” in postcommunist health care systems. In a review article on postcommunist health services throughout central and eastern Europe for the Journal of Epidemiology and Community Health, McKee claimed: “most services are theoretically free at the point of service [but] there is a large black economy, with extensive use of tips and gifts to heath care staff, contributing up to 30 per cent of their total salary”.

He did not produce direct evidence for this claim but Delcheva et al later noted “extensive anecdotal evidence that the increasing budgetary gaps are being filled by informal or under-the-table payments” and quoted a 1994 Bulgarian survey in which 43 per cent of the public “had paid for [health] services that were officially free”.

In our own previous study of four countries in postcommunist Europe a majority of the public told us it was more likely than not that "a person seeking something to which they were entitled by law" would none the less “have to offer money, a present or a favour” to get help from most kinds of officials or public employees. In this survey, doctors tied for top place on the list of those whom citizens told us they would have to bribe in this way, though there was some cross-national variation. Doctors were almost half-way down the list in the Czech Republic but they came top in each of the other three countries, if sometimes by a very small margin.

Some other surveys have put doctors in these countries further down the list though their questions have been significantly different from ours. In February 1999 for example, Coalition 2000’s tracking survey put Bulgarian doctors in second place, well behind customs officials, and in April and September it put doctors still lower down the list (private communication from Vitoshka Research). But although these tracking surveys were done by Vitoshka Research, who also carried out our own Bulgarian fieldwork, they used a significantly different question which focused on public perceptions of the numbers of “corrupt” officials rather than on the need for clients to offer gifts. And in all of these surveys, doctors were rated above the average for “corruption”.

Focus groups and in-depth interviews with the general public supported allegations about the need to bribe health care staff: “Doctors take presents for
They said that I needed an operation—it would cost 50 dollars. When I went to the doctor was absolutely calm. I have this tariff—100 dollars—do you what you want. It’s already gone up! (Kyiv, Ukraine—capital) "We paid the doctor for the medical examination. And he himself said: ‘You come from the collective farm and you didn’t bring anything? We didn’t bring anything—no milk, no sour cream, nothing. So what?—I don’t get a medical examination after all?’ (Nikolayevka, Eastern Ukraine—village) "Doctors will even take from old ladies, even an egg is acceptable, everything, a jar of something, antiques" (Olesnice, Czech Republic—village).

Such public perceptions might be dismissed as gossip however, not least because many members of the public have little direct experience of dealing with certain kinds of officials. In our surveys for example, 63 per cent claimed direct experience of dealing with health care officials but only 11 per cent with customs officials. To check public perceptions against experience, and to get the views of officials themselves, we undertook a new study based on interviews with junior officials or public employees themselves. In these interviews hospital doctors topped the list of those who confessed that they had recently accepted "money or expensive gifts" from clients.

New interviews

These new interviews with officials do more, however, than corroborate public perceptions. First, it was never quite clear to the citizen whether "informal" payments in the health services went into the pockets of the staff or went to provide otherwise unavailable drugs and equipment (which may explain some of the differences between Vitosha Research’s tracking surveys and the original survey they did for us). The ambiguity was illustrated by a participant in one of our focus groups who paid for, and received, an anaesthetic during dental surgery only when he could stand the pain no longer. Our new survey of officials eliminates that ambiguity: the doctors, nurses and hospital administrators and other officials that we interviewed discussed, and admitted accepting, personal gifts, not charges for hospital supplies nor even general donations to hospital funds.

Second, and more important, our interviews with officials themselves add a unique insight into officials’ motivations, which cannot be gleaned from an analysis of public perceptions. The primary purpose of this paper is therefore not to reiterate the oft-repeated claim that doctors frequently take gifts and bribes from their clients in postcommunist Europe. Instead, our primary purpose is to see what our survey of officials can tell us about the reasons why doctors were so much more likely than most other officials we interviewed to confess that they took "money or expensive presents" from their clients—even in countries where overall levels of bribe-taking were notoriously high.

Subjects and methods

This paper is based primarily on interviews with officials in Ukraine, Bulgaria, Slovakia and the Czech Republic. We used a very tight interlocking quota to ensure an even spread across different kinds of officials and, at the same time, cross-national comparability. In each country we aimed for 60 interviews in each of five broad categories of state services. More precisely we aimed for 20 interviews in each of three occupations within each service category: doctors, nurses, and hospital administrators (within health services); university teachers, university administrators, and school teachers (within education services); officials in pensions, benefits, and housing offices (within welfare services); traffic police, ordinary police, and police administrators (within police services), and court officials, customs officials, and passport officials (within a more heterogeneous category of legal services). Our interviewers exceeded their targets, producing 1,307 interviews in all, including 292 in health services, 85 of them with hospital doctors. We have downweighted the data to have the equivalent of exactly 20 interviews with each specific occupation, in each country.

Ensuring that the quota structure of officials is exactly the same in each country allows us to average our findings across countries, focusing attention away from the admittedly fascinating cross-national variations and onto the differences between types of official. No type of official occurs more frequently in the sample drawn from one country rather than another. Consequently the difference between two types of official in the combined data set is guaranteed to be the exact average of the differences between these two types of official within each of the four countries.

In addition, interviews with officials were spread across the regions within each country, and across different types of settlement—including small towns and rural areas as well as large towns and the capital city (though the quotas recognised, for example, that there were very few universities in villages!). Interviewers were also instructed to obtain a mix of ages and genders where possible. While there can be no absolute guarantee that any quota sample is fully representative (and refusal rates are not appropriate for quota samples) we think this was the most effective way to construct a sample for a comparative study of officials. Random sampling from government lists of officials would not have been feasible and help from the authorities, even if available, would have raised fears about confidentiality and thereby prejudiced participants’ responses.

Questionnaires were written at Glasgow University. Translation, piloting, sampling, and interviewing was carried out by professional agencies working to ESOMAR standards: OPPW Prague under the direction of Ladislav Koppl, MVK Bratislava under the direction of Pavel Haulik, CSD Sofia under the direction of Alexander Stoyanov, and GfK-USM Kyiv under the direction of Tatjana Koshechkina. Their questionnaire translations were checked by
native speakers in Glasgow and revised in consulta-
tion with the agencies. The questionnaire was cut
sharply after the pilot stage to avoid respondent
fatigue but still contained over 160 fully-structured
questions. Each agency had a large professional
field force, spread across the country, which was
experienced in quota sampling locally. Interview-
ing, face-to-face, was carried out between July and
September 1998.

Earlier work
For comparison we also make occasional reference
to our earlier public opinion studies in the same
four countries. Fieldwork was conducted by the
same agencies. We used both quantitative and
qualitative methods. The quantitative research was
based on representative samples of the adult popu-
lation (aged 18 plus). These were multistage
random samples, strictly representative of the
regions, and of rural as well as urban areas, within
each country. There were 721 sampling points and
4,778 interviews in all. (The project also included
an additional 1,272 interviews in ethnic minority
areas but they are outside the scope of this paper.)
At each sampling point respondents were selected
by the “random walk” method, except in Bulgaria
where respondents were selected from electoral
lists. Just over 17 per cent of selected respondents
refused to take part. Interviewing, face-to-face,
took place between November 1997 and February
1998, using a fully-structured questionnaire of 215
questions.

The qualitative research which preceded the
quantitative studies consisted of 26 focus-group
discussions (with 187 participants) and 136
in-depth interviews carried out between July and
October 1996. Like most qualitative research, this
aspect of our study aimed more at providing
understanding, illustration, meaning and interpre-
tation rather than representative findings. The scale
of qualitative work is usually far too small to
provide any guarantee of that. We have used our
large-scale representative surveys to quantify our
qualitative fieldwork to illustrate and interpret them.

None the less, we did try to make even the quali-
tative aspects of our study as representative as pos-
sible by holding an unusually large number of
focus-group discussions and ensuring that within
each country they ranged from capital cities down
to villages and also that they ranged widely across
the regions within each country. (In addition, one
focus group in each country except the Czech
Republic was held in an area where an ethnic
minority was concentrated.) Participants were
selected by the local staff of the survey agencies, all
of which had very extensive experience in focus-
group research. The aim was a spread of occupa-
tions, ages and genders except that in each of the
capital cities we held one focus group with a mixed
group of participants, and a second restricted to
highly educated participants. Discussions were
chaired by the agencies’ specialist and very experi-
enced “focus-group moderators”.

Both the focus-group discussions and the
in-depth interviews were semi-structured. Both
were based on the same 11-page schedule of
questions/topics, written in Glasgow and translated
by our survey agencies with the translation checked
and corrected in Glasgow. Simultaneous translation
was provided for the authors who attended the
majority of the focus groups. All 26 were video-
recorded, and transcripts made in the vernacular
and in English by our survey agencies.

We used SPSS for the quantitative analysis.
Although significance tests are not strictly appro-
priate for quota samples we have included them
(based on the F test) as a convenient heuristic
guide. For the qualitative data we used
QSR:NUDIST (Revison 3) to analyse the
English-language versions of the focus-group tran-
scripts and in-depth interview reports. Although
we have used selected quotations from the qualita-
tive research only to illustrate findings from the
quantitative research in this paper, we have
presented more extensive and systematic analysis of
the qualitative research elsewhere.81

Results
In our survey of officials, we asked: “If a member
of the public offered you money or an expensive
present for solving their problem would you . . .

(i) welcome it as a token of thanks
(ii) reluctantly accept it, because it would be impo-
lite to refuse
(iii) reluctantly accept it, because official salaries
are so low that you could not afford to refuse
(iv) feel offended and refuse
(v) refuse for other reasons.”

On their own admission many officials (17 per cent)
were willing to accept “money or expensive
presents” from clients “if offered”. But doctors (32
per cent), nurses (28 per cent) and hospital admin-
istrators (26 per cent) topped the list. The balance
of reasons for accepting gifts varied. Nurses were
twice as likely to cite low salaries as other reasons,
but doctors and hospital administrators put about
equal weight on low salaries and other reasons.

Health care workers also topped the list of those
who confessed that they had actually accepted a gift
from a client in recent years. We put three questions
in quick succession to all officials. They were
designed to model the way that we might, in a less
structured interview, persist in an attempt to get a
clear answer on a sensitive topic. First: “In the last
few years, say the last five years, did you ever accept
a present from someone whose problem you dealt
with as part of your official duties?” Then, even if
they had answered “no” to that first question we
asked: “If you did accept something, was that only
after you had solved the person’s problem?” And
even if they still denied accepting anything we
asked: “If you did accept something, was that only
a small present — flowers, chocolates, or a bottle for
example, or was it something more than that?”

Through this sequence of three questions about
Why did officials take ‘gifts’ from clients?

Some clients gave presents (usually small ones) out of gratitude: “When you see the demanding work of nurses—you feel like giving them something. I gave some coffee to nurses”. (Bratislava, Slovakia—capital) “The doctor told me I was not expected to offer him anything, but I insisted, I was doing it out of gratitude.” (Tenevo, Bulgaria—village) But others were not grateful: “You give only if you have been given some hint that they want something.” (Kurdjali, Bulgaria—a medium town) But others were not grateful: “You give only if you have been given some hint that they want something.” (Kurdjali, Bulgaria—a medium town) But others were not grateful: “You give only if you have been given some hint that they want something.” (Kurdjali, Bulgaria—a medium town) But others were not grateful: “You give only if you have been given some hint that they want something.” (Kurdjali, Bulgaria—a medium town)

We asked whether officials generally took gifts mainly because of greed, or poor pay, or importunate clients. Officials themselves put the blame mainly on “poor pay” but the public put that explanation in third place, well below “greedy officials” or even “clients desperate to buy favours”.

Poor pay?

But the poor pay thesis is worth investigating further. Other things being equal, it is plausible that poor pay might encourage officials to take bribes, even if it were not the only nor even the main reason for bribe-taking. Most people in postcommunist Europe are badly paid of course. But could unusually poor pay explain why those in the health service accepted gifts more frequently than other officials?

Some of the public sympathised: “Doctors work for symbolic wages.” (Sofia, Bulgaria—capital) “Insufficient salaries, that’s the cause of all that bribing.” (Bratislava, Slovakia—capital) “If they paid a doctor well . . . he would be afraid to lose his position.” (Khartsysk, Eastern Ukraine—medium town) But others were doubtful: “Some [doctors] would go on accepting bribes even if their salaries were adequate.” (Bratislava, Slovakia—capital) And more categorically, a sceptical nurse suggested that “wage increases would not affect bribe-taking.” (Dolny Kubin, Slovakia—village)

Nurses complained far more than average that they “could not live on their salary”. But doctors and hospital administrators were about average.

Table 2 Was greed, poor pay, or importunate clients the main reason why officials accepted gifts?

<table>
<thead>
<tr>
<th></th>
<th>Main reason why officials take presents and bribes is...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>officials are greedy %Officials are badly paid %People are desperate to buy favours %</td>
</tr>
<tr>
<td>Doctors</td>
<td>14 56 31</td>
</tr>
<tr>
<td>Nurses</td>
<td>19 38** 43*</td>
</tr>
<tr>
<td>Hospital administrators</td>
<td>8 59 33</td>
</tr>
<tr>
<td>All officials</td>
<td>13 55 32</td>
</tr>
<tr>
<td>By contrast—the opinion of the public</td>
<td>39 25 36</td>
</tr>
</tbody>
</table>

Notes:
1. This and subsequent tables are based on a total of 1,307 interviews with junior officials and state employees, including 85 with hospital doctors, 125 with nurses and 82 with hospital administrators.
2. In this and subsequent tables a single asterisk (*) indicates a statistically significant difference from the average for all other officials (taken together) at the 95% level. A double asterisk (**) indicates a statistically significant difference at the 99% level. Significance levels have been calculated in the conventional way using SPSS. Strictly speaking such significance levels should not be applied to quota samples but they may nonetheless be a useful heuristic guide.

Table 1 By their own account: whether officials ‘would take’ or ‘had taken’ gifts

<table>
<thead>
<tr>
<th>Would accept money or an expensive present, if offered</th>
<th>as token of thanks</th>
<th>could not afford to refuse</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>14 18**</td>
<td>32**</td>
<td></td>
</tr>
<tr>
<td>Nurses</td>
<td>9 19**</td>
<td>28*</td>
<td></td>
</tr>
<tr>
<td>Hospital administrators</td>
<td>8 12</td>
<td>26*</td>
<td></td>
</tr>
<tr>
<td>All officials</td>
<td>14* 9</td>
<td>17</td>
<td></td>
</tr>
</tbody>
</table>

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Many people in postcommunist Europe (including a quarter of the "officials" in our survey) have significant “second incomes”. Nurses were about average in this respect but hospital administrators were above average and doctors were 18 per cent more likely than the average official to report a second income. (Only university teachers were more likely than doctors to report a second income.) Doctors were also well above average in the extent to which they said their “family income” was enough for a “fair” or “good” standard of living (exceeded only, and then only marginally, by customs officials), while nurses and hospital administrators were somewhat below the average.

Taking all these indicators together, it is clear that doctors were under much less economic pressure than the average official, that nurses were under more pressure than average, and that hospital administrators were not too far away from the average. So it is unlikely that poor pay can explain why doctors accepted more than a small present so much more frequently than others.

Indeed, the general idea that poor pay explains gift- or bribe-taking is sharply contradicted in our survey. Poor pay clearly did make our officials more willing to accept gifts “if offered”. But amongst those who were willing to accept, it was those with the highest salaries and the best family incomes who actually accepted them more frequently—no doubt because they had the most power to help clients, and thus the most power to extort.

**Moral self justification?**

A second possible explanation for the high levels of gift-taking in health services is a “culture of justified gift-taking” which is more deeply entrenched in the health services than in other public services. Our earlier qualitative studies had indicated that health care staff were often direct in their demands: “The surgeon said the patient must give so much to the surgeon, so much to the neuropathologist, so much to the anaesthesiologist, and so much to the assistant. He directly said how much.” (Horodok, Western Ukraine—small town) “You enter the doctor’s room, and he sends the nurse away on some errand and before even starting says, ‘I charge 3,000 levs, or 10 marks. Will that be all right with you, or not?’ And you cannot say no, since he is not going to examine you. Or if it’s not money, he says ‘Two kilograms of cheese, or lamb or pork’.” (Tenevo, Bulgaria—village; in 1999 the currency was reformed so that 1,000 old levs became one new lev.) And in the patient’s view doctors were often quite shameless about it: “This doctor took the money, an amazing sum, and the wife died. He knew she was dying but he took the money.” (Khartsysk, Eastern Ukraine—medium town)

We now explored whether officials themselves thought “it would be right” for an official to “ask for something” from a client in return for “extra work”.

<table>
<thead>
<tr>
<th>have another</th>
<th>family income is enough for &quot;fair&quot; or &quot;good&quot; standard of living</th>
</tr>
</thead>
<tbody>
<tr>
<td>cannot live</td>
<td>above median</td>
</tr>
<tr>
<td>on salary %</td>
<td>above median</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Have other source of income %</th>
<th>Family income is enough for &quot;fair&quot; or &quot;good&quot; standard of living %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>44**</td>
<td>43*</td>
</tr>
<tr>
<td>Nurses</td>
<td>60**</td>
<td>25</td>
</tr>
<tr>
<td>Hospital</td>
<td>44</td>
<td>25</td>
</tr>
<tr>
<td>Administrators</td>
<td>41</td>
<td>26</td>
</tr>
</tbody>
</table>

By contrast—the economic condition of the public na na 26

Table 3 Poor pay?

There is a third possible explanation: opportunity. Doctors were twice as likely as the average official to report that their clients frequently offered them both “small presents” and “money or expensive gifts”. Nurses and hospital administrators were close to the average, though nurses, unlike the administrators, reported getting offers of small gifts very slightly more than average while getting offers of “money or expensive gifts” very slightly less than average.

Only two other sets of officials reported offers of “money or expensive presents” almost as frequently as doctors: traffic police and customs officials. What have doctors, traffic police and customs officials got in common apart from these offers of money from clients? And what distinguishes them from others in similar but distinct occupations who did not receive such offers so frequently? What distinguishes
Discussion and conclusions

Our earlier evidence from focus groups, in-depth interviews, and public opinion surveys all suggested that citizens in the countries surveyed frequently gave gifts to those who worked in health services. These new interviews with officials themselves have confirmed that those who worked in the health service were more likely than any other officials to accept gifts, doctors most of all. And doctors were especially likely to have accepted large gifts—“money or an expensive present”—from their clients.

Tichtchenko argues that what might have been justified as “resistance to the totalitarian regime” is now simply “the use of the medicalised power of the regime for individual survival or enrichment . . . not a resistance to totalitarian power but its effective reinforcement and proliferation into micro and macro social relationships” 12.

But any programme of reform needs to take account of the reasons underlying this behaviour as well as the behaviour itself. We looked at several possibilities.

The popular excuse of poor pay does not work. Nurses were under great economic pressure, but doctors (by their own account) were not. Compared to Western doctors they were certainly poor, but not compared to many other people within their own societies. Moreover, we found that while poor pay increased willingness to accept gifts “if offered”, it was the better paid amongst the willing. The “tips” such as flowers and chocolates went to those, like nurses, who were worse paid, while the “money and expensive presents” went to the better paid elite and the powerful such as doctors.

Self-conscious moral justification, opportunity, and bargaining power were much more effective explanations. Doctors were under less economic pressure than most other officials, but they were especially likely to justify informal payments by clients for “extra work”, especially likely to feel that their government tolerated informal payments, and especially likely to be offered money or expensive presents by clients. They combined a strong bargaining position with a culture that justified gift-taking to an unusual degree.

It might be argued that clients just felt uniquely grateful to doctors, and that doctors’ inhibitions were overwhelmed by such gratitude. We have no direct evidence on the gratitude clients felt towards specific officials. But we did ask the public why they would offer a small present or an expensive present if something was asked for or if an informal way of charging was not used.

- Table 5 Officials’ perceptions of their government’s tolerance for gift-taking

The government regards low-level officials accepting money or expensive presents from ordinary people as

<table>
<thead>
<tr>
<th></th>
<th>intolerable</th>
<th>tolerable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a corrupt practice to be eliminated</td>
<td>30**</td>
<td>47*</td>
</tr>
<tr>
<td>an unfortunate but unavoidable way of charging</td>
<td>41</td>
<td>18</td>
</tr>
<tr>
<td>Total tolerable</td>
<td>50</td>
<td>59</td>
</tr>
</tbody>
</table>

Table 4 Moral self-justification?

<table>
<thead>
<tr>
<th></th>
<th>ask for something %</th>
<th>accept (or ask for) something %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>35**</td>
<td>78**</td>
</tr>
<tr>
<td>Nurses</td>
<td>28**</td>
<td>80**</td>
</tr>
<tr>
<td>Hospital administrators</td>
<td>13</td>
<td>67</td>
</tr>
<tr>
<td>All officials</td>
<td>15</td>
<td>60</td>
</tr>
</tbody>
</table>

Table 6 Opportunity?

<table>
<thead>
<tr>
<th></th>
<th>More than rarely, a client offered...</th>
<th>At least rarely, a client offered...</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>a small present %</td>
<td>money or an expensive present %</td>
</tr>
<tr>
<td>Doctors</td>
<td>57**</td>
<td>21**</td>
</tr>
<tr>
<td>Nurses</td>
<td>33</td>
<td>7</td>
</tr>
<tr>
<td>Hospital administrators</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td>All officials</td>
<td>30</td>
<td>10</td>
</tr>
</tbody>
</table>

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cent. The pressure to behave politely added to those figures but none the less a majority not only claimed that gifts given beforehand were extorted by officials but also that even gifts given afterwards were either extorted or given because clients feared they would need further help in the future. Health needs arouse intense emotions, but emotions of fear as well as gratitude. In the absence of clear evidence we cannot assume that clients felt uniquely grateful to doctors rather than uniquely afraid of them.

Acknowledgements

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References

12 See reference 2:18.