

## Born in Corruption: Maternity Care after the Change of System in Hungary

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### **Abstract**

By today Hungarian maternity care is defined by both an over-medicalised approach to childbirth and an almost universal corruption problem. The current article aims to explore the relationship between technocratic maternity care and informal payments in Hungary, to provide a framework for understanding the context in which Hungarian women regularly engage with subsets of gendered corruption during the perinatal period. Looking at the development and current situation of modern maternity care in Hungary and assessing the historic development of public healthcare and micro-level corruption lays out the theoretical foundations for the article. Drawing on recent findings in the intersections of informal payments and maternity care the chosen doctor-driven subset of informal payments is introduced. Thematic analysis of in-depth interviews with maternity care professionals resulted in identifying 7 significant problem areas which are interlaced with corruption in maternity care. Revision of the selected interview excerpts led to the conclusion that in the Hungarian context modern, technocratic maternity care and gendered corruption (especially the chosen doctor - model of care) are interconnected and support each other. Further research is needed to discover how these phenomena became interlaced historically and to formulate women-centered policy recommendations for resolving this issue.

**Keywords:** *gender, maternity care, birth, corruption, informal payments.*

### **1. Introduction**

Even though maternity services are publicly funded and free of charge, today, in 21st century Hungary, more than 60% of pregnant women plan to give birth with a personal obgyn contracted



unofficially (KSH, 2019). In most cases the “chosen doctors” are compensated after the birth in the form of under the table payments but publicly available data about birth interventions suggests, most of the time women may be paying for suboptimal care. (Baji et al., 2017, p. 18-19. Rist, 2019)

Researchers working in the fields of sociology of childbirth wrote in great depth about the processes through which modern, medicalised childbirth was normalized, but the issue of informal payments in maternity care remained mostly uncharted territory. In recent years, authors like Petra Baji, Tatiana Stepurko, Nicholas Rubashkin, Imre Szebik and their fellow colleagues addressed certain aspects of under the table payments’ effects on maternity care but many questions remain unanswered. Baji et al. found that women are most likely to be paying to secure a known provider and according to Gaál and McKee’s typology, informal payments are following the fee for service model in maternity care. (Baji et al., 2017, Gaál and McKee, 2005)

In this article I intend to explore how modern obstetrics and informal payments are interacting in Hungary. Is it possible to look at maternity care in Hungary without taking into account system-wide micro-level corruption? Seeking to answer this question, I chose a different approach from recent studies on informal payments in maternity care. Instead of looking at data obtained from mothers, in-depth interviews recorded with healthcare professionals were thematically analyzed to identify key problem areas of maternity care and their intersections.

To put the interview excerpts in context, first I will discuss the transformation of maternity care in Hungary and the significance of medicalised childbirth in women’s health. Given the countries’ historic background as a former member state of the Soviet Union, the development of the Hungarian public healthcare system and micro-level corruption with a focus on maternity care is described as well. The method of thematic analysis and my theme-selection process is explained before discussing the interview excerpts.

## **2. Transformation of maternity care**

Only 120 years ago, pregnancy and birth were still women’s domain in Hungary as well as in all other countries of the world, regardless of their position in the world system. The vast majority of births, approximately 95% happened at home and were attended primarily by midwives (Novák, 2015). Birth was not considered and treated as a medical event, but rather a common, normal

episode of a woman's reproductive life, a family matter. Pregnancy and birth were managed through culturally embedded, local knowledge - something women passed down through generations, something that belonged to them. (Svégel, 2018, p. 238)

This perception of birth and midwifery started to shift when the state's interest in the management of populations took effect. By the end of the 19th century, improving the health of infants, children and mothers became an important issue: to tackle maternal mortality, centralized midwifery training was introduced and enforced on all birth attendants. (However due to the insufficient number of midwives in the country, lay midwives were not deterred from attending deliveries.) After the First World War, the first birth centers were built, but these institutions were mostly used in the capital, Budapest until the 1950s. Countryside women continued to rely on local midwives' care and preferred to give birth at home. (Simonik, 2011, p.15)

The reasons many Hungarian women of the last century were hesitant to give birth in healthcare institutions are manifold: the displacement of birth meant the discontinuation of a significant rite of passage in its traditional form, the separation from family and friends and the fear of death being adjoined with the fear of the unknown. According to a countryside midwife's monograph, in the early stages of medicalisation women instinctively avoided birth centers as they believed, those who gave birth in institutions, died, while those who remained home, survived childbirth. (Szécsi, 2015) This assumption was likely to be a result of intergenerational experience: until the 1950's, the leading cause of maternal mortality was puerperal fever, an infectious disease women were more likely to contract in hospitals, where doctors tended to a wide array of illnesses. The widespread use of antiseptic techniques just began at the turn of the century (Gárdos and Joubert, 2001). In 1953, when about two-thirds of births still happened outside the hospitals and birth centers, a new law took effect, aiming to relocate all births to institutions in the following 4 years. Nevertheless, this change of birthplace took place gradually and was only complete by the 70s. (Novák, 2015)

The displacement of birth can be perceived both as an indicator and an essential criteria of the great transformation of maternity care in the 20th century: the medicalisation of birth or, in other words, the technocratic paradigm shift. The medicalisation of birth can be described as a fundamental change of perspective: the perception of birth shifted from normal to pathological, from something that happens in its own pace to a dangerous event of which one should gain control

of. Robbie Davis-Floyd identifies the focal points of the technocratic approach as measuring birth against objectively assessable, quantified standards, and applying technological interventions to normal, physiological processes. Technocratic birth culture relies on the complete handover of power, liability and responsibility from the birthing woman to the healthcare professional in charge. (Davis-Floyd, 2003) The exchange of power comes with a new vocabulary of risk evaluation and the false promise of overcoming death in the domain of pregnancy and birth - if and only if women do as they are expected. This point of view utilizes scientific rationality as the only means to achieve a positive outcome. From this perspective, the female body poses a threat to both itself and the fetus, and labor and delivery can be deemed normal only in retrospect. (Murphy-Lawless, 1998, p.5-7.) Cherniak and Fisher suggest that contemporary obstetrics employs the engineering model of the body, in which body and mind are separable instead of interconnected and decisions are solely based on objectively measurable information. The slightest deviation from the narrow limits of normal requires an intervention to prevent complications. (2008) A birth is considered successful if both the newborn and the mother are alive at the end - variance in their overall wellbeing, like breastfeeding problems, postnatal depression or incontinence, just to name a few, stemming from the psychological and physiological effects of unnecessary surgeries, interventions and disrespectful care, is rarely taken into account.

Contemporary Hungarian maternity care customs align with the aforementioned technocratic - medicalised paradigm as indicated by high rates of surgical interventions and high levels of obstetric violence. Amongst many other indicators used in the medical community, the rates of obstetric surgeries provide a straightforward objective quality control measure against which countries', hospitals' or even individual healthcare professionals' performance can be evaluated. Population-based caesarean-section rates are widely used as an indicator of maternity care availability and quality of care. (Escuriet et al., 2015) The number of caesarean-sections in proportion to all live births could signal an underdeveloped healthcare system, or, on the other side, as suggested by the World Health Organization, when the frequency of c-section rates exceeds 10-15%, it is likely that they are used excessively causing more harm than good. Sandall et al. writes that c-sections may have negative short- and long-term effects on the health of women such as uterine rupture, ectopic pregnancies and placental abnormalities. They could also cause altered immune development in children born via surgical birth, along with asthma, obesity and allergies. (Sandall et al., 2018, p. 1352) The most recent data from Hungary is from the year 2018,

when 41% of all live births ended with a c-section. (WHO, 2015, 2018, Rist, 2019) Data obtained from Eurostat shows a different rate for the same year in Hungary (38.083 %) but allows for a comparison between other EU countries, making Hungary the 5th in line - only Poland, Romania, Bulgaria and Cyprus have a higher rate of c-sections. Another interesting variable is the rate of episiotomies: according to the latest data from 2018, an episiotomy, the surgical cutting of the vaginal opening was conducted in 55% of vaginal births, whereas routine use of episiotomies is contraindicated by the WHO. (WHO, 2015, Rist, 2019)

At the same time the emergence of the homebirth-movement in the 1990s and the grassroots birth rights movement 26 years later can be perceived as indicators of Hungarian women's dissatisfaction with this model of care. (Kisdi, 2013)

### **3. Development of public healthcare and micro-level corruption**

According to a study carried out for the European Commission, when it comes to the expansion of healthcare corruption, Hungary ranks as the 4th worst amongst EU member states - 89% of the population agreed that corruption is widespread in the country and 10% admitted to having had to give an out-of-pocket payment in order to receive treatment in a public healthcare institution. (European Commission, 2017) The *Updated study of healthcare corruption* specifies six healthcare corruption typologies, out of which in the present paper, informal payments are selected for further analysis due to their prevalence in Hungarian maternity care. An informal payment is defined as an unofficial payment for a healthcare service the payee is entitled to through healthcare insurance. (Baji et al., 2017) Informal payments for maternity care are predominantly different from IPs in other areas of healthcare in the sense that more than two thirds of Hungarian women choose a single obstetrician to follow their pregnancies and deliver their babies. Personalized care in public health facilities is not compensated by universal health insurance, but rather comes hand in hand with informal payments affecting the quality of care women receive. (Baji and Sági, 2018, European Policy Brief, 2013.)

For a comprehensive understanding of the issue, I will first elaborate on the development of the Hungarian public healthcare system in which informal payments' developed and locate the time IPs appeared in a similar form as they exist today.

The beginning of the 20th century was the turning point for mandatory social health insurance in Hungary: by the 1930's one third of the population, mainly industrial workers, public employees and their family members participated in the national health insurance scheme. A few state hospitals existed, however most healthcare was carried out in the private sector until the early 1950's, when the new communist regime defined public healthcare as the state's responsibility. (Gaál et al., 2011) The new arrangement brought an increase in life expectancy and an improvement in the overall health of the Hungarian population, but the lack of sufficient resources resulted in the emergence and expansion of informal payments. (Gaál et al., 2011, Gulácsi, 2001)

Gaál and McKee, based on their review of 22 studies, outline three distinct explanations for the development of the informal payment-system: the socio-cultural, the legal-ethical and the economic understandings. (2005) According to the socio-cultural approach, informal payments appeared prior to the socialist period. They are voluntary, similar to a gift - a simple display of gratitude for healers, with no adverse effects to the quality of care. The economic concept defines the causes of informal payments as a result of inadequate working conditions, an insufficient level of medical supplies and physicians' low wages. From this perspective, informal payments allowed the socialist healthcare system to keep running. Lastly, according to the widely criticized legal-ethical understanding the low moral standards of physicians and a lack of legal consequences provided an ideal environment for IPs to become widespread. (Gaál and McKee, 2005, p. 1448) The studies cited by Gaál and McKee often apply more than one of the aforementioned approaches to the analysis of the informal payment-systems' emergence. Buda, for one, mentions multiple reasons for the government's apparent decision to turn a blind eye to the healthcare corruption issue: IPs were a means to reduce the likelihood of criticism of the socialist regime coming from doctors, an essential group of white-collar intellectuals. IPs also allowed for the compensation of inadequate working conditions, provided doctors with extra income and a sense of autonomy. He also ties the offering of different objects, services or even favorable positions as bribes to the further strengthening of the feudalistic hierarchical structures in the medical community. (Buda, 1992)

To avoid unnecessary simplification of these accounts, Gaál and McKee advise an alternative to the trifold classification by distinguishing the motives of IPs: the fee-for-service and the gratitude or donation models. (2005) In their later works, Gaál et al. suggest disregarding the gratitude

element and the socio-cultural explanation and rather applying the fee-for-service model in the Hungarian context. (Baji et al. 2017)

After the change of the socialist system, market solutions aiding the Hungarian population in accessing private healthcare appeared in the form of supplementary health insurance companies and voluntary mutual insurance funds. (Vallyon, 2011) Even so the systemic informal payment issue did not decline, but rather a strange brew of privately and publicly funded healthcare services appeared in the form of double practice.

Double practice refers to the phenomenon of a doctor having a private practice while also working in a public healthcare institution. In this indistinct, obscure network, care for an illness often starts in a doctors' private office, but surgeries or diagnostic imaging services are carried out in public hospitals, usually by the very same doctor, for an informal payment. (European Commission, 2017) This course of action increases inequalities as those able to afford private appointments may get privileged access to publicly funded services. Double practice is especially frequent in maternity care: prenatal appointments are often scheduled to an obgyn's private clinic, while births take place in public hospitals.

Until recently there has been no serious attempt to prohibit informal payments or double practice by law. Only slight adjustments were made to legislation but prosecution for bribery or any other offence related to healthcare corruption is rare. Current laws do not allow medical professionals working in public health to accept informal payments in advance, nor can they ask for any money directly. Nevertheless, *de jure*, they are entitled to accept any payments offered after a treatment or an appointment and they are allowed to answer the question if a patient makes a query about the amount they are usually paid for a specific service. (Hollán and Venczel, 2019) These exceptions are problematic on many levels, e.g. the high prevalence of chronic illnesses allows for a murky definition of the time a patient-physician relationship is over.

In 2012, the revision of the Labor Code granted hospital directors the right to forbid their staff members from accepting informal payments but no institute made such a policy ever since. In a 2019 interview, public health researcher Péter Gaál suggests informal payments are a means for keeping healthcare professionals in public institutions - considering their low wages, without IPs many would flee either to private hospitals, or even abroad, risking the collapse of public healthcare in Hungary.

The issues of informal payments and double practice stem from the same root causes, the overall lack of proper funding of public health, healthcare workers' low wages and understaffed clinics and hospitals. (European Commission, 2017) After joining the European Union in 2004, migration of healthcare professionals escalated, doctors within the 20-49 years old age groups are most likely to leave the country and approximately 60% of resident doctors plan to work abroad for at least 2-3 years. The latter groups' main motivations for moving are higher wages, better working conditions and more opportunities for professional development. Great Britain, German-speaking and Scandinavian countries are the most frequently mentioned destinations. (Eke et al. 2009, p. 814) Botezat and Ramos point out that the possibility of a 10% increase in wages increases doctors' inflow by approximately 20%. (2020) Since Hungarian medical professionals' income is about one-tenth as much as that of their Western colleagues, the prevalence of doctors' migration to the above mentioned countries comes as no surprise. (European Commission, 2017) In October 2020 a new healthcare bill was passed in parliament introducing a long term wage settlement plan for doctors and prohibition of informal payments. The new healthcare law came into effect in January 2021, however multiple accounts suggested that obgyns will be the exception to the new bill's section prohibiting double practice.

#### **4. Informal payments' impact on maternity care**

Multiple accounts about the Hungarian informal payment issue mention that maternity care is among the most severely affected fields. (Bognár et al. 2000, Antal, 2016) By now, in middle class families, informal payment is considered a necessary element of maternity care - a sphere in which predominantly healthy people are looked after. Even so, in the Hungarian context there are only a handful of studies addressing this issue specifically. Out of these few, two accounts examined women's experiences and took a predominantly empirical approach aiming to shed light to women's motives, the prevalence of IPs and the association of IPs and obstetric interventions. Both of these studies found that the act of paying is intertwined with having a chosen, personal doctor (an obstetrician who agreed to be present during delivery prior to the birth): Baji and Sági state that in the sample they examined, all women who had a chosen doctor, paid informally. (2018, p. 82) In a study of internet-using women who gave birth in the 5 years prior to completing a questionnaire in 2016, Baji et al. found 79% of women with a chosen obstetrician gave an informal payment. Preliminary results of a countrywide cohort-study from 2018 display that 97% of



pregnant women planned to give birth in a public hospital, 35% with a chosen doctor, 29% with both a chosen doctor and midwife and 5% with only a chosen midwife present and 2% decided on a private maternity unit. Altogether, only 29% planned on giving birth with the help of the midwives and obstetricians on call. (KSH, 2018)

Drawing on the results of the Baji et al. study of 2017 and the patient-typology of Tatiana Stepurko's ethnographic study in a Kiev hospital, I suggest making a distinction between the informal payment given to a chosen doctor (or midwife) and the informal payment paid to the on-call personnel based on the different motivations for these payments. (2013) The gift or money given to on-call obgyns and midwives after birth may be compliant to what Gaál and McKee describes as the donation hypothesis: a payment out of sheer gratitude, rooted in cultural traditions and absolutely voluntary. While the payments handed to chosen doctors and midwives is a perfect example of the fee-for-service hypothesis: it's based on shortage on both sides of the relationship. In this framework patients (pregnant women) are short of personalized, women-centered perinatal care in public health, therefore they aim to secure a provider they get to know during pregnancy to deliver their children. Such private services are not compensated for by health insurance, so obgyns get paid by their private clients informally. (Gaál and McKee, 2005, Baji et al. 2017)

In the following paragraphs I will focus on the chosen doctor - model as giving birth with a chosen provider is more widespread than using the on-call health professionals' services. The hypothesis I would like to test is that in Hungary the synchronous development of the system of informal payments and modern, technocratic birth culture was not a mere coincidence but they have a certain level of interconnectedness. To corroborate this concept thematic analysis of interviews with maternity care workers are utilized and compared to relevant literature. Further research is needed to examine their level of co-dependency and interconnectedness, especially in light of the most recent changes to the Hungarian healthcare law attempting to prohibit IPs and double practice.

## **5. Methods**

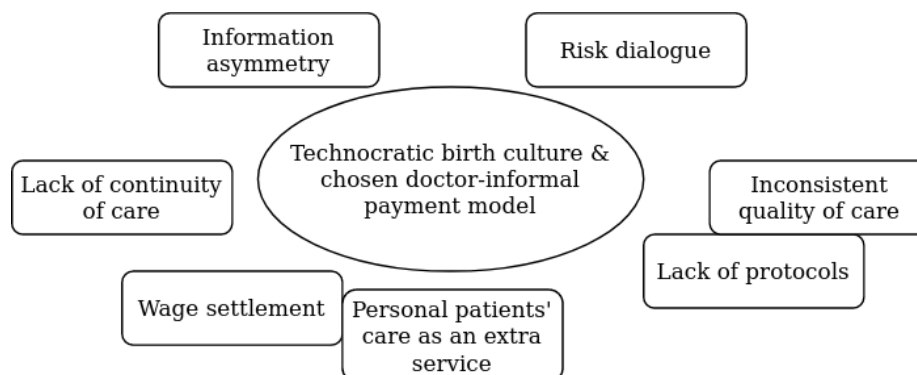
The interviews analyzed were recorded in 2016 by members of the Hungarian birth rights NGO Emma Association. In 2015, Emma Association started a research project in three distinct roma communities about Roma women's maternity care experiences. Later they conducted interviews with healthcare professionals of the three hospitals the previously interviewed roma women most

frequently mentioned. The chosen hospitals represent the Hungarian public health institutions in their progressivity levels: a small city-funded institution, a county-funded level 2 hospital and a level 3 teaching clinic with a neonatal intensive care unit were included in the sample. Members of the association approached the institutions aiming to record interviews about caring for roma women with healthcare professionals from all walks of maternity care: health visitors, midwives, doctors on different levels of hierarchy. The personnel were selected for interviews by the heads of each labor and delivery department and Emma Association’s members recorded open-ended in-person interviews with them. 25 interview transcripts were shared with me by Emma Association, members of a local working group on corruption in maternity care. I decided to use the interviews for the current article because even though their intended focus was different, informal payments and obstetric interventions were mentioned in almost every one of them.

Interview transcripts were analyzed thematically and several themes were identified. A theme is defined as a repeated pattern relevant to the current discussion. Coding was conducted deductively. After coding and identification, themes were selected based on their relation to the hypothesis, namely the interconnectedness of interventionist obstetrics and the chosen doctor-based informal payment system. Both manifest and latent variables were included in the analysis. (Marks, 2004)

The themes left out of the current analysis were mainly those that affect all subsets of Hungarian healthcare: e.g. the issues of understaffed institutions, burn-out syndrome of healthcare professionals, no sense of appreciation by patients, a generation of experienced doctors missing because of migration, an overall sense of fatigue and work overload, especially with administrative tasks, a lack of proper medical instruments and devices (both in quality and quantity) and varying attitudes towards Roma patients.

Fig. 1. shows the themes selected for further analysis:



## 6. Technocratic birth culture and the chosen doctor-informal payment model

### 6.1. Information asymmetry - the cornerstone of negative birth experiences?

As the displacement and medicalisation of birth facilitated the discontinuation of traditional knowledge transfers, the hegemony of obstetric thinking superseded the perception of birth as a normal process. Evidence-based and woman-centered information about pregnancy and birth became difficult to access and information asymmetry developed in maternity care. (Murphy-Lawless, 1999, Pairman et al. 2019) Information asymmetry is related to the concept of healthcare as “credence goods” in health economy: the consumers (patients) do not know how much or what exactly they should purchase, rather the seller (the medical establishment) decides on the amount and type of “goods” the consumers are offered. This very dynamic is sustained by the extreme information advantage healthcare professionals have over patients that is strongly affecting maternity care as well. (Pairman et al. 2019, Gaál and McKee, 2005) The theme of information asymmetry, the perception that women in general are lacking some kind of knowledge medical professionals take for granted, appeared on multiple occasions in the Emma interviews from different perspectives. Some professionals have an understanding that women should acquire the necessary knowledge themselves: *“She reads on the internet and everywhere and on the other hand women are not really prepared for birth and it is astonishing how little they know about their own bodies’ functioning, for which one doesn’t need to be a doctor. They should be aware of the basics.”*

While others hold the lack of knowledge responsible for negative birth experiences: *“They don’t always understand what happens in the delivery room so they look at it (their experience) negatively.”*

The shared notion in these excerpts is that members of the medical establishment define what is a “proper” knowledge of birth or what are the “basics” - meanwhile, when women are affected negatively by not understanding what is happening to them, healthcare professionals do not draw a connection between the negative experience and their own role in it. Women are held responsible for their own negative birth experiences. And at the same time on another account there seems to be an explanation for this issue:

*“No one is stupid fundamentally, and if one explains it to them, they understand. And the colleagues don’t have the time for this.”*

A lack of time for thorough explanations is a shortage women may try to compensate for in the chosen doctor-informal payment model. Nonetheless information asymmetry and the paradigm shift in women’s perception of normal birth do not leave much room for them to choose an obgyn by objectively assessing their attributes as a healthcare professional. As one account explains, *“One thing I know today is that if a woman spends a lot of money on a famous obstetrician, it is very likely that they are going to operate on her during their day off”* The underlying assumption in this excerpt may be related to Baji et al.’s finding that women with a chosen doctor are more likely to have a c-section than those with only the on-call provider present. (2017) Their findings also suggest that women may not be able to determine whether obstetric interventions such as the induction of labor, caesarean section or episiotomy were medically necessary, as the occurrence of these did not affect the frequency of informal payments (2017). Modern obstetrics’ self-definition and portrayal in popular media outlets as a “good science”, the only right instrument to ensure maternal-neonatal wellbeing leaves little room for questioning an individual doctor’s limits of decision-making capacity or common practices. (Murphy-Lawless, 1999, Stone, 2009)

Another related issue is that Hungarian women are rarely choosing their doctors based on their positions in the hospitals’ hierarchy or by considering their caesarean-section frequency. As someone explained, referring to younger doctors without much authority taking on private clients, *“...the women trust them, but in reality the doctor is not the one held responsible, the patient develops a sense of false security. They buy the illusion”*

Similarly, according to Stepurko et al.’s study of a Kiev hospital, women do not have any means to assess an obstetrician’s professional skills, so they often rely on online forums, friends’ or relatives’ recommendations to choose one. (2012)

## **6.2. Assessing risks as a means for control**

In the technocratic model of care, the discourse around pregnancy is strongly influenced by frequent evaluation and re-evaluation of what could go wrong in this period. Modern maternity care defines birth as “a pathological event demanding hospitalization, medical surveillance and medical intervention.” (Scamell, 2014) Cartwright and Thomas, drawing on Ulrich Beck’s

foundational work on risk society writes that the medicalisation of childbirth has changed the defining discourse around it: from a discourse of danger (something unavoidable, against which a wait and see approach is applied) to a discourse of risk, bringing an activist approach to the management of birth. (2001) This discourse accompanies Hungarian women from their first antenatal appointment, when they are faced with an assessment and their pregnancies are categorized as low- or high-risk. This distinction determines what kind of care the women must seek: high-risk pregnancies must be cared for by an obstetrician, while women with a low-risk pregnancy may opt for midwifery care.

The discourse of risk applies to the healthcare professionals maneuvering maternity care as well: as modern obstetrics claims to minimize risks and relieve compliant women from the burden of responsibility, the medical establishment aims to decrease risks of litigation. Risk evaluation processes are connected to defensive medicine, or, as Losonczi writes, an approach more self-defensive than protective. Interventions may be carried out when a doctor's safety could be compromised, not only when they are medically necessary. (1991) According to Lothian, when labor begins, a shift of risk assessment takes place and the focus moves from evaluating risks for the fetus and mother to those of the hospital and healthcare professionals. This position was represented in the interviews as a significant motivation for interventionism on multiple accounts:

*“A colleague’s saying goes like “good medical records start with addressing the honorable court”, like if we were writing it for them. We are not healing as we would like to, as we know best, but as it is defensible.”*

*“If everything goes well, then it’s all good, if not, then we can go to court.”*

It was also framed as a possible reason why hospital midwives may not be keen on seeking independent praxis:

*“they (the midwives) can’t even imagine to sit in a birth by themselves and work taking independent responsibility...they are really afraid of legal consequences too. ”*

In Hungary the risk-aspect of pregnancy and birth is accentuated by micro-level corruption as well: in 1991 Losonczi already took into account a possible association between the risk discourse and informal payments when she wrote about the ever-increasing level of high-risk pregnancies

requiring regular medical attention in the group of middle class women (of good financial standing).

In 2017 Baji et al. confirmed that specific intervention rates are higher with a chosen doctor and among the explanations for this phenomenon they suggest that women may associate interventionist obstetric care with quality. Taking the discussion further, I would like to offer a reflection: since women are primarily rewarding obstetricians' presence with informal payments, it is possible that chosen doctors spend more time with and give more attention to the laboring women than their on-call colleagues, the probability of them observing the slightest deviations from normal increases:

*“No one was ever reported for operating on a patient. Who would dare to take responsibility for not reacting to the slightest deviation? No one. Why would we do that? This is not the right direction. Some coolness is necessary for this profession. I never pull the leg of the head obstetrician on duty for operating on someone.”*

As the logic of technocratic birth culture and defensive medicine dictates, these observations increase the probability of medical interventions. Thus informed consent may be reduced to informed compliance or, as it regularly happens in Hungarian maternity care, medical interventions may be carried out without the consent of the woman in labor. (Szebik et al., 2018, Baji et al. 2017) For many women, the antidote to risk-taking is accepting modern obstetrics' authority over pregnancy and birth - nevertheless, this approach does not take into account the risks that come with technocratic maternity care itself. It is not considered either that at the end of the day it is the woman herself who will bear the consequences of medical decisions.

### **6.3. Inconsistent quality of care and a lack of protocols laying the foundations for the chosen doctor-model**

Differences in quality of care can be identified on multiple levels: between individual doctors, between care from the on-call personnel and chosen doctor (and/or midwife) and between hospitals as well. All of these are related to a lack of central guidelines for maternity care in Hungary and were referred to in the interview transcripts. Aside from the lack of centralized regulations, the theme also appeared as the lack of local guidelines as well. E.g. one doctor mentioned having and regularly revising a set of written guidelines while another from the same institution clearly stated

not having anything of the kind. Accounts from another hospital were generally mixed, though more oblivious, some obstetricians and midwives referred to a protocol but it is not clear whether it was a proper written guideline or just a general set of common rules and understandings. There was one hospital where a doctor stated they have a TÜV-certified quality control system. It is no wonder that in many interviews, the themes of a lack of quality control and differences in care have emerged.

Even though the inconsistent quality of care is apparent in other segments of Hungarian healthcare, it was selected as a theme because it is an important driver of the chosen doctor-system: according to the European Policy Brief on corruption in maternity care, the main motives for IPs are securing more attention, better quality of care and a more skilled obstetrician. (2013)

Interviewees underlined this notion, the theme of differences in quality of care was represented as a motive for choosing a doctor: *“by building a relationship with an obstetrician, women are seeking to validate a certain principle for themselves”*. In this case, the underlying assumption may be that the chosen doctor is able to reflect on women’s individual needs. The difference between care from on-call and personal obgyns emerged in a controversial form as well: at the same time it is perceived as a belief system associated with women and something healthcare professionals are acting on as well:

*“First, we need to change the consciousness, the women’s consciousness, so they believe that if they just go in an institution, they receive the same care, but this is something obstetricians need to be made aware of, too.”*

On a different level, the wide range of intervention rates and differing rules about what a laboring woman is allowed to do indicates that the quality of care is highly inconsistent in Hungarian hospitals. To give an example, the lowest episiotomy rate registered in 2018 was 15,86% while many institutions have a frequency above 80% and yet there’s no empirical evidence on how the stretchiness of one’s perineum changes depending on where she resides. (Rist, 2019) On the other hand in some institutions women can only give birth in a supine position, while others allow vertical positions or water birth as well. Choosing a doctor may be as much of an aim to choose a maternity ward as well as securing a known provider because of the differences between hospitals due to a lack of guidelines: *“Today the quality of care of a maternity ward depends on the head of the department's attention to detail, enthusiasm, and power. This is why disparities are so wide.”*

The lack of systemic quality control could also explain these differences: *“From Hungarian healthcare, it is the quality control that is missing the most. Measurable indicators that would need to be taken seriously. We have indicators but just on the level of clowning around.”*

And just like between clinics, there’s a strong variation in individual obgyns practices, but again, these different approaches aren’t corroborated with or questioned by scientific evidence: *“Yes, of course there are differences. We don’t talk about these as long as nothing bad happens.”* Even the administration of drugs can be unregulated and linked to personal preferences or beliefs of doctors: *“The use of oxy always depends on who is the lead obstetrician on duty and how they administer it. More or less everyone does the same, but eventually this is not written down.”*

The lack of written guidelines seems to be connected to the main aim of avoiding risks and at the same time explains Hungarian women’s preference for a chosen doctor: *“You can do whatever you want, as long as there is no trouble. This is a guideline.”*

To minimize these differences, a new maternity care guideline was developed and published in December 2019, however it is not likely to facilitate nationwide change in maternity wards. Members of grassroots birth rights group Másállapotot a szülészetben were allowed to attend one session of the development process; however their suggestions were not represented in the final guideline. They criticized the guideline for not adhering to scientific standards of evidence-based care and only offering recommendations for providers and institutions instead of setting clear expectations and rules for professional conduct. Instead of rewarding those medical professionals or institutions where the quality of care transcends the standards, the new guideline only allows them to continue. Moreover, the problem of informal payments was not even mentioned in the guideline.

#### **6.4. Care for personal patients as an extra service and wage settlement - would the increase in doctors’ wages solve the informal payment problem?**

In the Emma interviews, doctors often mentioned taking on personal patients as a means to secure a certain quality of life through the extra income. Applying the notion of informal payments as a fee for service, addressing shortcomings on both sides of the healthcare system, the themes of wage settlement and personal care as an extra service were identified. These themes are strongly linked to the chosen doctor-informal payment model: *“I will tell you a number, for about 1-1.5*



*million forints I would not accept informal payments...one thing is sure, to deliver a third-time mother's baby, to do this, I am not needed...I would not be crowding here night and day to do the professional tasks I live off now”* Personal care for women is seen by healthcare professionals as an extra service as well, requiring extra payments: *“Now does my sense of vocation obligate me as well to make myself available for someone in my free time? This needs some kind of regulation. This is extra work, this should involve compensation.”*

Parallel to a 2017 representative study on doctor's attitudes towards informal payments, obstetricians spoke of the drawbacks of this system as well. (Szinapszis, 2017) One widely accepted negative side effect is that the chosen doctor-model is pulling back young doctors' professional development. To quote a resident obstetrician: *“In two years I did not get a single gynecological surgery...a few c-sections, but not too many”*. It is also seen as a contributing factor to the standard of care being suboptimal: *“If women would not hire doctors, if they would not give informal payments, that would be the solution...there is a better chance with the on-call doctor that not a frustrated, burnt-out colleague will care for you but a smiley, patient colleague, who knows that if their working hours are over, they can leave but now being here with you is their job...more likely than going in and calling a colleague away from their wife, from their family”*

Multiple accounts aligned with the results of the Szinapszis survey on informal payments and declared a clear preference for wage increases over informal payments and second shifts at private clinics. (2017) *“If we could secure a wage standard that is approaching the German, Austrian standard, then I don't think that there would be a single obstetrician sacrificing their free time.”* However, opinions were divided, whether wage settlement would solve all aspects of the informal payment problem at once: *“How am I supposed to convince someone to do a laparoscopic hysterectomy when in the same amount of time they could do a few D&Cs and a vaginal hysterectomy and makes five times as much money? ... Q: Do you think there is enough money to break this group? A: Don't you think they would do the same if they were given ten times as much?”*

My main point here is that the chosen doctor - IP model is different from other segments of healthcare ridden with informal payments because birth is unpredictable. To reference Gaál and McKee's model and build on Baji et al. 's finding, the extra service women are rewarding with a fee is the well-known doctor's presence and availability. (2005, 2017) Therefore doctors engaging

in personalised care are kept at a constant standby, obstetricians and midwives are compensated for being constantly on call and being available to attend a birth in the middle of the night or on their days off, leaving their partners and families at any given time. Nevertheless, as suggested by the above interview excerpts this position may increase the probability of interventions aiming to make birth more predictable (through inductions and elective caesareans) or faster (by administering synthetic oxytocin or indicating the need for a caesarean mid-labour).

### **6.5. The need for continuity of care in public health**

The interviews in which the theme of continuity of care was identified were predominantly recorded with midwives, displaying a fundamental understanding of women's need for continuity of care in the perinatal period: *“there are personal births already, a lot, because the presence is needed...like the mother for a little child, to be there, to see her”*. *“There is more and more, mothers request it but only a few can afford it here. What is essential for the mother is that she is in contact with a person, she gets to know them better, she opens up to them better and at the end she trusts them better”* An interviewee also reflects on women's need for psychological support from a familiar provider and even have a clear preference for working as a chosen midwife: *“it's easier to work with those who we get to know a little. Eventually we develop a relationship of trust, she puts her trust in me, that I want her good, to give birth nicely, and she accepts what we say, we can guide them better. It is good to develop a connection in time also for that.”*

It's interesting to see the theme appear in such a context, because midwife-led continuity of care models were the norm before the hegemony of technocratic birth culture developed. If a midwife learned about a pregnancy, she followed its course, gave advice to the woman, helped with the delivery and visited and supported the new mother and baby through the early days of the postpartum period. (Borbély, 2011) And yet midwife-led continuity of care is a scarce phenomenon in current day Hungary: it is mostly available through the few independent midwifery practices attending home births and there are a few hospitals where selected midwives are allowed to care for low-risk women independently. In Hungary there are no midwife-led units or independent birth centers available.

Compared to different models of maternity care, midwife-led continuity of care has been linked to better health outcomes: intervention levels are lower, breastfeeding rates are higher and mothers' overall satisfaction is better when they are seen by the same midwife or small group of midwives

throughout pregnancy, birth and the postpartum period. (Sandall et al. 2016) As mentioned in relation to the risk dialogue, midwives are not necessarily keen on gaining independence because of the increased responsibility, Szöllősi et al.'s 2016 findings also support this: their research concluded that 32% of hospital midwives would not like to work on their own. They have asked mothers about their provider preference too: 75% of women answered they would choose an obstetrician over a midwife for prenatal care. Hungarian women who want continuity of care are probably drawn to the chosen doctor-system because midwifery independence in public healthcare is still in its infancy and they may identify the obstetrician's presence as a sound attempt to decrease risks.

The obstetrician-led care model, however, does not have the same positive effects on health outcomes but, as Baji et al. has shown in relation to the chosen doctor-model of care, often results in more interventions and less satisfaction with the birth experience. (2017) One midwife precisely described the distinction between the role of the midwife and the obstetrician: *“More and more choose a midwife and a doctor too, but more and more choose a midwife. A doctor is not always necessary. Lot of women do this because they know that the midwife will be there from the beginning while the doctor is there only when the cervix is two fingers dilated and the epidural comes, and then at the birth.”*

Drawing on the interviews and scientific evidence, introducing a midwifery-led continuity of care model to Hungarian public healthcare could work as an ideal substitute for the chosen doctor-informal payment system of care. In this model all women would be able to receive personalized care regardless of their financial situation allowing for a decline in information asymmetry. Developing care protocols for independent midwifery practice could also alleviate the need for transparency and equal standards of care throughout the country.

## **Conclusion**

Plenty of evidence confirms that systemic corruption and informal payments in healthcare have a negative effect on health outcomes, just like contemporary interventionist obstetrics takes a toll on maternal and neonatal health and wellbeing. (Baji et al. 2017, Sadler et al. 2016, Solnes Miltenburg et al. 2018, Miteniece et al. 2017, European Policy Brief, 2013)

In Hungary the development of technocratic maternity care shifted to high gear during the socialist regime, when informal payments started to interweave the newly funded public health institutions. The first part of the hypothesis I wanted to test, namely that in Hungary the synchronous development of the system of informal payments and modern, technocratic birth culture was not a mere coincidence needs further research. However the Emma interviews and available literature provided sufficient evidence to support the second part of my argument: the chosen doctor - informal payment system and highly interventionist obstetrics are interconnected in the Hungarian context. They have several shared underpinnings, such as the dialogue of risks in pregnancy and childbirth causing women to seek personalized care in order to hand over the responsibility over their bodies and obstetricians to mitigate the likelihood of litigation. Information asymmetry prevents women from properly assessing the care they receive and doctors may take advantage of their upper hand by carrying out unnecessary interventions or interventions without consent. For women, the lack of available protocols and guidelines along with sharp differences in clinics' handling of birthing women accentuates the perceived risk of giving birth with a risk of unpredictability. This aspect allows for the chosen doctor-model to look like ideal means for mitigating the risks that come with birthing in the public health system. On the other hand, doctors' performance cannot be compared to a uniform standard. Low wages for healthcare professionals create an environment defined by shortage, in which the fee-for-service model of informal payments proliferates. Nevertheless the time and energy shortage that stems from taking on personal clients is rarely accounted for - it is women taking the toll for this deficit. At the same time, wage settlement is not a cure-for-all in this environment: women's need for continuity of care and the embedded tradition of informal payments seems hard to challenge all at the same time.

Appropriate policy measures are urgently needed to stop healthcare professionals from contributing to the further development of preventable health problems. However it is hard to formulate such interventions, as the Hungarian model of care is unique in many aspects. To resolve the issues of suboptimal maternity care, any course of action should take into account both the technocratic culture of birth and the effects of the chosen doctor-informal payment system and develop its instruments accordingly. As long as obstetricians' attendance of personal clients' births is unregulated, technocratic birth culture remains hard to challenge and until quality of care has such discrepancies among institutions and individual healthcare workers, Hungarian women may try to ensure their access to what is perceived as better quality care through contracting a

chosen doctor. Even those few who accumulated evidence-based, woman-centered information about the physiology of pregnancy and birth may resort to the chosen doctor-system because of discrepancies of public hospitals' quality of care and because only a handful providers are known for being committed to such care standards.

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## Appendix

