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# THE PATIENT'S PERSPECTIVE ON INSTITUTIONAL LOGICS IN RUSSIAN MATERNITY CARE

The interplay between different institutional logics is a vital topic in contemporary institutional analyses of healthcare. In this paper, we consider relations between professional, bureaucratic, market, and informal logics in the volatile and ever-transforming context of post-Soviet maternity care. We approach this issue from an unconventional angle and study how various logics are interpreted, enacted and manipulated by women-patients. Neo-institutional scholars commonly enlist patients as institutional actors that are involved both in maintaining and changing the institutional order. However, current research neglects the patients' perspective instead focusing on the practices of healthcare providers. In order to fill this gap, we investigate how expectant mothers make sense of and navigate the complex institutional environment of Russian maternity care. In our analysis we rely on empirical data from fifty-nine qualitative interviews with recent mothers conducted in St. Petersburg in 2015–2017. This data allows us to conclude that the institutional dynamics of maternity care are powered mostly by the rivalry of two logics – one bureaucratic, the other market-driven. The professional logic, meanwhile, remains underrepresented and dominated by the other two. Unlike healthcare practitioners, women perceive the bureaucratic logic as chaotic and unpredictable, while wealthy clients employ a repertoire of actions offered by the market logic to exercise more control of their hospital

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routine. Different institutional logics compete for dominance, leaving areas of uncertainty in regard to institutional rules. In some cases, patients use informality to manage such ambivalence and challenge the formal order of healthcare facilities. The common character of this strategy prompts us to suggest that informality forms a distinctive fourth logic that frames some actions and interactions within Russian maternity care.

*Key words*: maternity care, post-Soviet healthcare reforms, institutional logics, institutional actors

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According to neo-institutionalists, organizational fields including healthcare adhere to particular sets of logics which provide a classification matrix for practices, give meaning to decisions and outcomes, and determine the identities of actors (Thornton, Ocasio 2008). One might assume that the social role of the patient is rather universal and coherent, but a more nuanced account reveals institutional logics which frame this role rather differently, allowing for a diversity of actions and experiences.

> We came there [to the maternity hospital], and they met me with questions: 'Do you have heart problems?' – I said 'No'. 'Do you have a contract [for the delivery in this hospital]?' – I said 'No'. 'Do you have an informal agreement with someone here in the hospital?' – I said 'No'. 'So, what have you come here for?' – 'To give birth', I said (36, first child).

The above quotation vividly illustrates the various logics that guide activities within the Russian maternity care system. We can discern the bureaucratic and professional logics; this hospital is formally designated to be a place, where women with heart conditions give birth, so heart problems would be a comprehensible reason to accept a patient. Market and informality also appear in the dialog as the frames of reference, when contract obligations and informal negotiations are mentioned correspondingly. The interviewee refuses to fit into the suggested schemas and provokes a slight confusion, since to give birth in the medical facility, a person should be properly categorized and incorporated into the existing institutional order.

Proliferating debates on how competitive logics coexist within the healthcare field and how their collision and penetration shape medical environments lie at the heart of the recent institutional studies of healthcare systems (Kitchener 2002; Reay, Hinings 2009; Noordegraaf 2015). This paper builds on and contributes to the literature on the subject by investigating the relationship between multiple institutional logics in post-Soviet healthcare. We focus on the case of Russian maternity care that for the past ten years has been a priority for social policy reforms in the country and, probably, exemplifies institutional transformations most sharply.

Following the recent call by institutional theorists to inhabit institutions with people (Bevort, Suddaby 2015) we approach the issue of institutional logics in healthcare from the perspective of patients as institutional actors, who make sense of and enact these logics. Institutional studies rarely include the individual level in their analyses, and if they do, the attention is predominantly devoted to healthcare professionals as agents of institutional change (McCann et al. 2013; Correia 2017). On the other hand, sociological research that explores patients' behaviour – in particular, research on women's practices within maternity care systems – buy into neoliberal assumptions and bring to centre stage issues of individual choice and control at the expense of the institutional embeddedness of actors (Lazarus 1994; Temkina, Zdravomyslova 2018).

In our study we address an identified gap. We use data from semi-structured interviews with urban Russian women to gain insights into how users of childbirth services interpret and navigate different institutional logics. Our aim is twofold: first, to describe how on the everyday level women make sense of and manipulate competitive logics; and second, by tracing patients' practices and experiences within the institution, to gain a better understanding of the relations between competing institutional logics in the transforming context of the post-Soviet healthcare.

The paper proceeds in four sections. First, we discuss the concept of institutional logic and how it can be implemented to study practices and relations of individual institutional actors in healthcare. Second, we present the methods and empirical data of the study. Third, we explore the experience of women-patients as they navigate the competing logics. We examine what repertoire of actions is afforded to patients by different logics, and how these logics constrain or reinforce one another in regard to regulating women's behaviour. Finally, in the concluding section, we sum up the findings to argue that the conflict between institutional logics in Russian healthcare is still unsettled. In this uncertain situation, informality exists as a mechanism that helps to overcome discrepancies and lacunas uncovered by the legitimate regulatory frames.

## Conceptualizing institutional logics in healthcare

The concept of institutional logic represents yet another attempt by social theorists to find a balance between structural determinism and individual agency, between the stability of institutions and their potential for transformation. Roger Friedland and Robert Alford introduced this concept to describe the sets of 'material practices and symbolic constructions which constitute organizing principles and which are available for individuals and organizations to elaborate' (Friedland, Alford 1991: 248). Logics are supposed to determine interests, identities, values and a repertoire of practices for those who inhabit institutions. They bring order to organizational fields by providing cognitive maps and normative guidelines which structure actions and relations. But they also enable

agency and change as individuals and organizations can creatively interpret and manoeuvre the logics to their own advantage (Thornton, Ocasio 2008). While considering different institutional domains and different institutional logics, scholars tend to share the view of them as rivals and historically contingent. Researchers assume that, in a given organizational field, one of the logics dominates, although this status is not stable. Thus, institutional change occurs as the dominance of one prevailing logic shifts to another (Scott et al. 2000; Reay, Hinings 2009). However, more recent studies argue that relations between logics are not necessarily competitive. Instead of depicting the hierarchy of the logics, these works concentrate on the coexistence and overlapping of different logics across time periods and social environments (Goodrick, Reay 2011).

In respect of the healthcare domain, researchers commonly outline three institutional logics: (1) professional logic, (2) bureaucratic/managerial logic, and (3) market logic. In formulating definitions of these logics, however, they are less unanimous. To describe the logics, the institutional scholar William Richard Scott and colleagues emphasise the values that are central to each of them. They connect professional logic with the principle of the quality of care; managerial logic is linked to equity of access to healthcare services; while market logic is tied to the principle of cost-efficiency (Scott et al. 2000: 166–235).

The sociologist of professions Eliot Freidson (2001) proposes a different approach and views these logics as the mechanisms that regulate professional activity. He associates professional logic with professionals' control over the content and conditions of their work, something intrinsic to healthcare institutions. The two latter logics are perceived as contaminating extraneous influences, the signs of growing consumerism and extensive state intervention in the sphere of medical care provision.

Elizabeth Goodrick and Trish Reay (2011) in their study of the professional work of pharmacists attempted to combine the perspectives of the sociology of professions and neo-institutional analysis. They define four ideal type logics in medicine: professional, market, state and corporate. The two latter logics represent two sides of bureaucratic control over the content and conditions of doctors' work: government control and managerial control in organizations.

The task of defining these logics is complicated by the fact that they differ depending on the societal environment. Post-Socialist societies and their healthcare systems are infamous for the widespread use of informal practices (Rivkin-Fish 2005; Stepurko et al. 2017). Relying on data from Lithuania, Elianne Riska and Aurelija Noveskaite (2011) single out a fourth logic that governs relations in post-Socialist healthcare: the logic of informality. These scholars emphasise how informal economy of peer referrals, gift giving, and extra payments supplement regulation by the state, the market, and professional culture.

Institutional logics do not exist per se; they are reproduced and altered through the activities of institutional actors. When speaking about the connection between the latter and healthcare institutions, researchers almost exclusively

focus on medical professionals (Scott et al. 2000: 35; Goodrick, Reay 2011; Correia 2017), while the role of patients remains under-conceptualized (Bourgeault et al. 2011). In this paper, we employ the concept of institutional logic to examine transformations that are taking place in Russian healthcare. We approach the interplay of the four institutional logics – bureaucratic, market, professional and informal – from the perspective of patients, whose identities and actions are determined by these logics, but who are also able to reflexively interpret the logics, navigate and use them to pursue their interests.

## Research data and methods

The analysis presented in the paper relies on data gathered in two research projects conducted in St. Petersburg in 2015 and in 2017. The respondents in both projects consisted of urban middle-class women, who gave birth to their youngest child not earlier than three years before the interview. The first set of data includes thirty-five semi-structured interviews with women, who paid for medical services related to the delivery of their babies. The age of informants varied from twenty-five to fourty-four years; twenty-five of interviewed women were first-time mothers. All of them had higher education. All but two of the mothers were married at the time of childbirth.

The second set of data, collected in 2017, consists of twenty-four semi-structured interviews with women, who have used only mandatory healthcare insurance to cover the cost of the maternity services. The age of the informants varied from twenty-three to forty-one years; sixteen of them were first-time mothers. All the women lived with a husband or a partner; fourteen of the interviewees had university education. The data is informative about variations in women's institutional roles within healthcare depending on the amount of their expenditures on healthcare services and their status as 'commercial' or 'free-of-charge' patients. However, the focus on urban, well-off and, in the most part, highly educated women, limits the conclusions that are made in the article and makes them instructive only about practices and interpretations of these particular social group. Both empirical research projects were conducted as collective projects, in which the authors of the article coordinated the fieldwork.

To analyse the data, we adopted a pattern matching methodological approach. This approach is rooted in the legacy of Max Weber and requires researchers first to identify the 'ideal types' of logics in a particular institutional field, then to describe the core components of these types and, finally, to evaluate how closely the empirical data matches the 'ideal types.' The latter step is accomplished through grasping 'symbols and beliefs expressed in discourse <…>, norms seen in behaviours and activities, and material practices that are recognizable' (Reay, Jones 2016: 442). On the basis of scholarly works that have been discussed in the previous section, we singled out the following institutional logics in healthcare domain: the professional, bureaucratic, market, and informal logics.

*The professional logic* is connected to the quality of medical care as the main value. Expert medical knowledge constitutes the legitimate foundation of the medical authority. Professionals control the actions of patients, although they are also subjected to the service ideal and are supposed to act in the patients' best interests.

*The bureaucratic logic* postulates the rational-legal order as the main value and regulative principle. Controlling power here belongs to the administrators; however, medical professionals also frequently exercise minor bureaucratic functions. As the Russian healthcare historically developed as a centralized state-controlled system, the bureaucratic logic to a large extent is related to the governmental interventions in the field.

*The market logic,* considered from the viewpoint of the patients, is associated with the ideology of consumerism. The actions that healthcare specialists perform reflect client preferences on content and terms of the services.

*The informal logic* relies on community values of personalized trust and close emotionally coloured interactions. Although lacking legitimacy in the field of modern healthcare, informal logic occupies shadow areas in the organizational order, where rules are uncertain, ambivalent, or malleable.

The pattern matching approach is particularly useful for comparing logics, for tracing relations between them and for analysing changes in those relations. However, Trish Reay and Candace Jones (2016: 449) also point to a certain challenge of this approach: it relies heavily on established theory in defining 'ideal types' and this constitutes a limitation to the conceptual insights of researchers.

## Institutional logics in Russian maternity care: patient perspectives

### Professional logic

Professional logic is often deemed to be the most proper mechanism of regulation in healthcare. Patients generally share normative expectations about the doctor, who should be competent in terms of possessing expert medical knowledge and sufficient clinical experience. Our interviewees express readiness to take on normative patient's role and follow the instructions of such an ideal-typical doctor: *'It is important to have a real specialist at the delivery, those whom you trust'* (30, second child).

The informants also expect that obstetricians will adhere to another normative component of their professional role: altruistic motives and service ideals. In other words, doctors are supposed to act according to the professional logic and put to the centre stage patient's best interests, not bureaucratic necessity or profit motives:

> If you're a doctor, you know what you are taking on – you're taking on a low-paid job and this … this is your mission. So you are committing yourself to

> this service 100% <…> Why are you rude to people now? You expected that you would have a low salary and hard work, didn't you? (26, first child).

However, prevalent on the level of patients' normative expectations, in the real life of medical organizations, the professional logic is intertwined with and frequently dominated by the other regulative frameworks – the bureaucratic and market logics.

**Bureaucratic logic**

In academic debates bureaucratic logic is associated with the hegemony of strict organizational rules, with administrative order and hierarchy. Although it might be so from the viewpoint of one who works in the maternity hospital, from the perspective of our interviewees, bureaucracy is represented by rather chaotic and unpredictable interactions. When entering a healthcare organization, patients are typically unaware of its formal regulations. Personnel of the facility do not take the time (or just do not have the time) to explicitly articulate and explain intra-organizational rules to the newcomers. At each of the stages of their institutional 'career', women receive pragmatic instructions from the staff that are relevant for particular situations. On the other hand, the whole schema of actions usually remains undisclosed to the patients. For instance, expectant women are unaware of the timing of the hospital shifts, so the teams of specialists who attend the delivery change unexpectedly to them. Another telling example is related to the division of institutional roles between obstetricians and midwives. In Russian healthcare there is a strict hierarchy between these two groups of practitioners and there is a clear-cut distinction between their professional tasks: a doctor is the one in charge of the delivery; a midwife acts as the technical assistant. But women at labour are rarely informed of this difference. The interviewees report that healthcare specialists do not even introduce themselves when entering the delivery ward. The patients have to guess who this person is, or whether she has the right to administer treatment:

> In Russia, most doctors and midwives, they do not wear badges, so you don't know who attends your delivery, [you know] neither the name of the midwife, nor the name of the doctor <…> and they do not introduce themselves. Who is it? They come to you, talk and leave. That's it (36, first child).

Such lack of understanding of hospital rules significantly limits patients' ability to manage their own routines within the organization and leaves them with a feeling of disorder. The situation is aggravated by the discrepancies between the standards that choreograph hospital life, on the one hand, and the actual tasks and amount of work facing the personnel, on the other. Patients are not able to trace the mechanism of how bureaucratic rules influence practitioners' workloads. But they frequently notice the cases which tell about doctors' extreme work pressure and inefficient work organization:

> There was a kind of conveyer belt there. There were a lot of women in labour. They [medical personnel] didn't have time for everybody. In the maternity ward there were two of us – I and another woman in labour. And there was no one near us, so to speak. From time to time a cleaning lady would appear; she was washing the floor. And we had a chance to ask her: 'Call the doctor!', 'Just bring someone!' <…> The doctor who attended my delivery was actually a specialist in ultrasound diagnostics (28, second child).

Opaque formal rules, actual efficiency of which evokes doubts, nonetheless structure patients' activities within the facility. Soviet medicine is commonly characterized in the academic literature as a sphere with a high level of state intervention and limited professional autonomy, a field where doctors functioned more like bureaucrats (Freidson 1970). Our interviewees provided evidence of the continuation of such a congruence between professional and bureaucratic logics in contemporary Russian healthcare. Women can hardly tell which of the numerous activities ascribed to them is determined by medical conditions, and which by the bureaucratic requirements.

> It was just hell <…> You are not allowed to stay with the child, because you have to run back and forth to have one kind of treatment or another. And you need to be on time to grab this worthless dinner, because the window through which it is delivered is open for two minutes only <…> The next day you urgently need [to visit] several doctors, to get some vaccinations, some injections. The temperature is measured. You need to go to the ultrasound and need to go for some heating procedure <…> [You need to] report something here, to get some documents for the child there… (37, first child).

Another woman explicitly draws a connection between the incomprehensible entanglement of professional and bureaucratic modes of regulation and the Soviet model of healthcare organization. The patient's ability to challenge the rules is limited not just by the non-transparent character of the regulations, but also by the fact that one can hardly discern what frame of reference is at play in a particular case. If some medical procedure is administered, women may wonder whether there is a real health issue or the doctor just wants to adhere to standardized protocol:

> The [name of the medical facility] is an incredibly Soviet organization. If they get you in their paws, you won't be able to do anything. You'll just have to strictly adhere to all their orders <…> It is clear that it is not a prison. But nobody who is thirty-nine-plus weeks [preganant] is willing to quarrel with a doctor <…> You were hospitalized because there were some indications. And then you were told that the labour induction was needed. I said 'I do not want this.' They said: 'It is necessary.' And you can't really [object] (31, second child).

In order to minimize the disempowering effect of the bureaucratic logic, some of the patients try to prepare for the stay in hospital beforehand. Preparatory courses for expectant parents provide such an opportunity. Several classes during the course are usually devoted to explaining organizational rules that

might be useful for patients. For example, women are informed what clothes, food or other belongings they are allowed to bring to the facility, under what conditions the husband can attend the delivery, how to refuse the early vaccination of the child, etc.

If an expectant mother is motivated to make sense of the intricacies of hospital bureaucracy, and if she can invest time and effort in this project, she can even use the bureaucratic logic to her own advantage. One of our interviewees had set a threefold goal: to give birth in the particular maternity hospital, to have a partner supporting her during the delivery, and not to spend money on the medical services, except for mandatory insurance. After a thorough investigation she found out how she can justify her demands by means of existing regulations.

> According to the law of our Russian Federation <…>, the hospital must accept you [with a partner] absolutely for free, if they have a free delivery ward <…> And if you come to the hospital with your husband <…>, and they say that they do not have free wards, then you must take an official note from them that they refused you [to have a delivery with a partner] at this time, this day, because they did not have free wards. And if it turns out that at this time there was a free ward, you can sue the maternity hospital and then they will all be punished. And I remembered this. I thought: that is how one should behave (32, first child).

Later this interviewee had a conversation with the head obstetrician of the chosen hospital, who allowed her to fulfil the plan. But not all expectant mothers are willing or able to invest time and effort in advocating their rights. For solvent patients the market logic can lend a helping hand to downplay the deficiencies of the hospital bureaucracy.

#### Market logic

The post-Soviet health care reforms were aimed at introducing the market logic to all segments of Russian healthcare. Market competition should have become a guiding principle in the case of services covered by mandatory healthcare insurance, as well as in the case of services covered by clients' direct payments or voluntary insurance. However, after more than twenty-five years of reforms, the system of mandatory insurance appears to be an insufficient vehicle of healthcare marketization. De facto it operates as yet another link in the bureaucratic chain. Our interviewees recall the instances of the deliveries covered by mandatory insurance, where clients' demands were hardly taken into account:

> If you use the childbirth voucher[1], of course, everything is very deplorable. It depends on whether you are lucky, I would say. You know, like Russian

[1] The system of childbirth vouchers is a state-funded program that was introduced in Russia in 2006 to supplement the mandatory health insurance in the fields of maternity and infant care.

> roulette. With the childbirth voucher [you will receive] overcrowded wards for ten, for eight people. Well, and the attitude [of the personnel] corresponds [to the conditions] (44, third child).

Thus, the market logic in the case of Russian healthcare is most developed in the sphere of so called 'paid deliveries' – the cases when the costs of medical services are covered by the voluntary health insurance or through contracts between expectant parents and the medical facility. For solvent clients, who are willing and able to invest in high quality maternity care, hospitals in major cities provide a wide array of services. These services are grouped in a variety of 'packages' from which clients can choose. As one of the interviewees noted rather ironically: '*Well, there's a price list in the maternity hospital. Prices differ from 50,000 to 120,000* [roubles]. *It depends on the maternity hospital and on whether you want to hire a pianist who will play live music while you are in labour*' (26, first child).

The introduction of the market logic significantly changes the 'public face' of the facility that is turned to the clients. Maternity hospitals sell what lay people can actually assess – comfortable conditions of labour, polite staff, and the prolonged periods of time that doctor and midwife will spend with a client. Women compare conditions at maternity hospitals, and in particular in the postnatal wards, to a hotel or sanatorium. There are some visible signs of professionalism like the doctor's PhD degree or status in the hospital hierarchy that can also be used to boost the price of the service.

The market logic is also used to partially shield patients from the unpredictability of the bureaucratic mode of regulation that leaves women with very limited possibilities of control. The medical care in the case of 'paid' deliveries is considered by our interviewees as more structured and comprehendible; medical personnel describe to women which procedures will be accomplished in the medical facility, who will be in charge of these procedures, etc.

> It's about the 'free-of-charge' delivery – the mother is usually abandoned in this case, she is left to herself. <…> I wanted to protect myself somehow, to protect myself as much as possible. It is clear that 'paid' birth does not guarantee [good results]. Well, at least you are treated as a human being (29 years, first child).

However, the implementation of the market logic in healthcare is constrained by several factors. First, the bureaucratic logic that regulates the work of health professionals within maternity care facility limits what actually can be chosen by the client. If the money is paid, a woman expects special attention from medical personnel. But it can happen that a doctor or midwife whose services are purchased at the time of the delivery will be on her regular shift in the hospital. Or that several women with whom the doctor has a contract will have deliveries at the same time.

Second, patients can make conscious choices mostly in regard to the level of comfort of delivery or postnatal ward. They can hardly assess and control

the most important factor: the level of expertise of the healthcare professionals. The market logic implies that consumers can make choices according to their preferences, but in the sophisticated professional domain of healthcare, the expectant mother usually does not have enough expertise to actually make informed choices. Consumer demands are considered less relevant than medical indications. This makes women admit that market logic is helpful for providing comfortable conditions for giving birth, but it does not dramatically change the position of the patient within the institution:

> I said: 'All right. If I will pay [according to the contract] and also pay to you [informally], can I give birth in the position in which it will be more convenient for me?'-'No.'-'OK. And if I want anaesthesia, can I ask for anaesthesia?'- 'No'. So it's the doctor who decides. Anaesthesia is prescribed only according to the indications, in general, everything is according to the indications (26, first child).

In cases when neither bureaucratic, nor market logic corresponds to patient's demands and particularities of her condition, a woman can mobilize the fourth logic – that of informal personalized relations – to navigate the volatile and ever-reforming setting of Russian maternity care.

## Informality

The introduction of the market logic has widened patients' opportunities for receiving the kind of service they want. However, informal practices that have formed the cornerstone of late Soviet maternity care have not been completely eliminated (Rivkin-Fish 2005; Shishkin et al. 2014). Although contemporary women prefer official payments to informal ones, there are certain aspects, in which informality retains its importance. First, clients are willing to receive informal insider knowledge about the reputation of different doctors and medical facilities. Informality thus helps to implement market choices:

> I'm from a family of medical workers. So we knew that there was a very good doctor, who was in charge of maternity ward. He studied with my dad and my husband's parents. But this didn't give me any special treatment, actually. They just knew that he's a good doctor. And we paid just like everyone else, officially (28, first child).

Second, informality is employed when dealing with complicated medical bureaucracy. Interviewees describe how informal arrangements including informal payments help them to avoid the chaos and incomprehensiveness of the regular way of entering the maternity care facility. In the quote below, a woman who needed a particular treatment in labour due to her health condition describes how, instead of blundering down bureaucratic paths, she found an obstetrician with particular qualifications through the informal connections of another doctor: '*If you come to your acquaintance or to your doctor, then*

*you… In general, it costs fifty thousand in cash. And the private doctor* [who monitored the informant's pregnancy] *said to go to her, to his colleague in the* [name of the facility]' (31, second child).

However, it is important to note that the symbolic meaning of informal payments and informal connections with doctors cannot be reduced to corruption and bribes. Like in the late Soviet period (Rivkin-Fish 2005), such payments are seen by some women as a form of a gift and a way to establish a long-term relationship with the practitioner.

## Conclusion

The volatile context of perpetually transforming Russian healthcare prevents the unquestioned domination of any particular institutional logic in the sphere. In this paper, we have considered the issue of the entanglement of these logics from the perspective of patients as institutional actors. While on the level of normative assumptions our informants accept professional logic as the most appropriate regulative framework in healthcare, in reality their activities within medical organization are, to a large extant, shaped by bureaucratic and market logics.

The claims for dominance of the former logic are grounded in the Soviet period and reinforced through several waves of post-Soviet statist reforms. For the patients, the bureaucratic logic usually appears as a complicated and hardly comprehensible set of organizational rules that, inconvenient and seemingly chaotic as they are, strictly regulate women's routines within the institution. Patients who spend time and effort on understanding those rules can effectively manipulate them and use bureaucratic regulations to their own advantage. However, patients are limited in using the bureaucratic logic to their own advantage or challenging it by the obscurity of bureaucratic regulations and the fact that, in Russian medical institutions bureaucracy, it is hardly discernible from the professional logic. In many cases one cannot tell whether she is subject of (appreciated) professional control, or (undesirable) bureaucratic control.

Although according to neoliberal reforms, the market logic should have spread through all segments of healthcare. Yet, it is limited mostly to the services covered by voluntary insurance and out-of-pocket payments. The market logic allows patients to exercise choice in relation to material conditions of delivery. It also partly restrains the fussiness and unpredictability of bureaucratic logic. However, the implementation of market principles can be restricted by the logics of professionalism and bureaucracy.

The constantly changing constellation of the three main logics and the unsettled rivalry between market and bureaucratic logics result in uncertainties and discrepancies in institutional rules that patients overcome with the help of informality. Not quite legitimate, informality is employed to find a qualified professional, to identify services that are worthy of additional payments, or to navigate the bureaucratic surrounding in the easiest and most effective way.

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