



Expensive Health

Health-seeking Behaviours in Diversified Medical Markets

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This article analyses how the metamorphosis of a state-funded healthcare system into a market-oriented system in Croatia since the 1990s has influenced the health-seeking behaviour of patients. Through in-depth interviews, patients were asked to identify their satisfaction with various health services and providers. Their answers reveal a complex narrative setup in which the possibility to select another healthcare therapy or provider was linked to their “willingness to pay”. The interview responses uncovered inequalities in the context of healthcare, as well as the politics and powers behind allocating and negotiating value in health-seeking.



“I could have died by then...”

The difference? You ask me about the difference? (...) I can just call and get an appointment tomorrow, if I pay. But when I called the hospital, they told me they have an opening in April next year [laughter]. I could easily have died by then...

A middle-aged woman in the waiting area of a private endocrinology clinic in the city of Zagreb explained the situation for getting healthcare. The clinic was situated on the outskirts of the city in a brand-new building, the waiting room was shining white and looked like an Ikea showroom. The woman in question had problems “with her thyroid, severe, cancer maybe” and I asked about her reasons for choosing private over public healthcare as part of my eleven-year-long research into medical pluralism and medical markets in Croatia. Based on patients’ narratives, this article analyses health-seeking behaviours in diversified medical markets in transition. In Croatia after the 1990s, these markets have followed the metamorphosis of the state-funded healthcare system into a market-oriented system.

Given the joint historico-political moment of transition to post-socialism, processes of healthcare transformation in the context of shifting market conditions have been similar across many East European countries (Džakula et al. 2014; Faith 2007; Figureas et al. 2004; Silverman et al. 2019; Stepurko et al. 2014, 2015).¹ Two authors doing research comparable to mine in former countries of the Soviet Union point out that “[o]ver the last three decades, free health care has shifted to a mix of public, private, and semi-private services influenced by neoliberal ideology” (Temkina & Rivkin-Fish 2020: 340).

Common aspects across Eastern Europe include: the transformation of patients into consumers (Temkina 2020); the mix of private and public services (Węgrzynowska 2021); questions of shifting rights and responsibilities in healthcare with accompanying changes in power and trust (Temkina & Rivkin-Fish 2020; Bazylevych 2009); and problems linked to the existence of traditions of informal payments and corruption (Rivkin-Fish 2005; Praspaliauskiene 2016; Rubashkin et al. 2021).

This article tackles related questions, but draws its analytical power from the viewpoints of the patients themselves, and seeks to follow their pathway selection processes in healthcare decision-making (Khan, Pintelon & Martin 2022). The article will contribute to the wider discussion on the aspects and implications of patient-centred healthcare that

¹ For Russia, see Temkina (2020); Borozhdina & Novkunskaia (2022); Rivkin-Fish (2005); for Ukraine see Bazylevych (2009); for Poland see Węgrzynowska (2021); for Hungary see Rubashkin et al. (2021); for Lithuania see Praspaliauskiene (2016); and for Serbia, see Pantović (2016).

has been present in research on health and healthcare since the 2000s (cf. Anderson 2002; Reynolds 2009; Zandbelt et al. 2007). Newly available possibilities to make individual healthcare choices require both financial and treatment rationales on the part of patients.

The article asks: almost two hundred years after the birth of public health and the development of equity of access to healthcare into a supposedly universal human right², what are the factors and specific cultural-political contexts that have made patients “willing to pay” (Donaldson 2001), and accept a “fee-for-service” system (Bazylevych 2009)? Since post-socialism is still widely used as a common term for a period, an experience, and a context, this article remains duly cautious in reaching broader conclusions in terms of post-socialist healthcare transformations. In particular, the Yugoslav healthcare system, initially set up by one of the founders of the World Health Organization, Andrija Štampar, was specific, innovative, and modernistic in its approach not only in regional, but also in global terms (cf. Dugac 2005; Brown & Fee 2006). Štampar’s incentive to make science and medicine accessible to all (Dugac 2005) started as a state project in as early as the late 1920s and over the following decades resulted in a broad and effective network of day clinics, and healthcare reachable in many rural and remote regions of former Yugoslavia.

It should be noted that narratives and attitudes about socialism in Croatia are highly diverse. Although the shared cultural-political context of post-socialism is well known and aspects of the processes of post-socialist healthcare transformation may be comparable, many researchers warn against overgeneralization of the whole concept of post-socialism (Velikonja 2009; Pehe 2014; Jelača, Kolanović & Lugarić 2017; Bailyn, Jelača & Lugarić 2018).

Methodology, Research Sites and Participants

The data presented here were analysed from in-depth interviews and the life histories of 37 individuals – 17 men and 20 women, with two young men in their 20s, five women in their 20s to 30s and others in their late 40s or older – who formed a segment of my broader research on medical pluralism in Zagreb, the capital of Croatia (with a population of approximately 1 million).³ Final interviews for this article were conducted

² Oliver & Mossialos (2004); Greenhalgh (2018); Topp et al. (2018).

³ My broader study started in 2010 and included 112 individuals in total. Related publications: Tanja Bukovčan 2010: Nije za one slabih živaca – pitanja etičnog i moralnog relativizma u medicinskim etnografijama [Only for those with nerves out of steel – the issue of ethical and moral relativism in medical ethnographies]. *Etnološka tribina: Godišnjak Hrvatskog etnološkog društva* 40(33): 45–56; Tanja Bukovčan 2007: Advocacy and Activism in Complementary and Alternative Medicine Research – a Croatian Example. *Anthropology in Action* 15(1): 35–42; Tanja Bukovčan 2013: Through an Hourglass: Re-thinking Ethnography of the Relationship between Biomedicine and Complementary and Alternative Medicine in Croatia. *Etnološka tribina: Godišnjak Hrvatskog etnološkog društva* 43(36): 90–98.

just before 2020, the year of the Covid-19 breakout, and hence it does not cover shifts in care-seeking behaviours caused by the pandemic. For the purpose of writing this article, I selected those 37 individuals from the larger research group who, in their search for a suitable therapy and cure for their mainly chronic diseases, shifted between public or private biomedicine providers on the one hand and complementary and alternative medicine on the other. My initial field sites were the waiting rooms of general practitioners, public hospitals, private clinics, and practitioners of complementary and alternative medicine (CAM). In-depth interviews were individual and conducted in a separate room if available on site, or at another location later. I interviewed some persons twice for additional clarity and content. Computer-assisted qualitative data analysis was done using the software program NVivo.

Medical Markets and Healthcare Alternatives

Before the 1990s, public, universal, and state-funded healthcare in Croatia was easily accessible and available. The first state-funded health insurance was institutionalized in 1947, and the first day clinic was opened in 1953 (Letica, Popović & Škrbić 1981). Universal health insurance coverage rose to a staggering 85 percent of the entire population in 1979 (Letica, Popović & Škrbić 1981). During the late 1970s and 1980s, budget commitment was relatively high, at 370 euro per capita for health insurance, with biomedicine then being several times cheaper than it is now, since “the fast development of biomedical technology significantly raised the costs borne by healthcare systems” (OECD 2015; cf. Sorenson, Drummond & Bhuiyan Khan 2013). The private healthcare sector prior to the 1990s was virtually non-existent. After that decade, however, healthcare shifted from being exclusively public to being semi-private and private (Temkina & Rivkin-Fish 2020). Today the total budget commitment for healthcare in Croatia has risen to 1,241 euro per capita, yet this is still under the EU average and amounts to 7.4 percent of the GDP as compared to the European average of 9.9 percent (Stišević, Derk & Ropac 2019; OECD & WHO 2017). Even more telling are the figures showing that over the last ten years in Croatia the percentage of the healthcare costs covered by public resources fell from 86 percent to 77 percent, while the percentage covered by private resources rose from 14 percent to 23 percent (Stišević, Derk & Ropac 2019). Of the percentage covered by private resources, 15 percent came from direct payments and 8 percent from private health insurance other than the mandatory insurance (Zrinščak 2007; OECD & WHO 2017). With the growing number of private practices and the burgeoning burden of public healthcare costs for the state, it would be safe to assume that this tendency will continue. In addition to private practices, another segment that was absent from Croatian pre-1990s healthcare was healthcare alternatives. Healthcare alternatives to

biomedicine were restricted to only two registered homeopathic practitioners actively working in pre-1990s' Zagreb. However, by 2020, there were dozens of new therapies, providers, and clinics. In October of 2018 a new Clinic of Ayurvedic Medicine was opened in the centre of Zagreb, after a few already existing centres, and people wearing Balenciaga bags, very expensive brand items, showed up at the Clinic's red-carpet grand opening.

Even though some south-eastern European countries since the 1990s have been trying to impose state control over the upsurge of the private health sector (for Greece see Kondilis et al. 2007), medical markets have continued to proliferate in Croatia. Hence, in the short span of thirty years, the decision-making processes of patients related to their health-seeking have changed significantly. As in Russia, neoliberal ideology has also played a role in affecting the patients' attitudes (Temkina & Rivkin-Fish 2020). The notion of free choice was applied to medical markets after the 1990s. In the market economy, choosing therapies and treatments meant that patients had to estimate their curative potential and assess their value. "I want to get what I want for my money", said one of the patients who was constantly switching between public and private biomedicine and CAM: "you can't measure one hundred euros' worth of health, of course, but you can surely try to help yourself and that's exactly what I'm doing". Emphasized in this account was the "I", the notion that the choices made by patients to ensure better health were their own personal responsibility, something Artvinli Faith (2007) recognized in his analysis of health policy in Turkey: "the neo-liberal approach transforms basic concepts, defining access to health care as an issue of personal responsibility, not a public responsibility" (Faith 2007: 195).

Neoliberalism does not, of course, cover only the health sector. However, when applied to individual health, to the health of a particular "I",

[t]his logic of choice turns the patient into a customer who is expected to choose the best way to take care of themselves. Staying healthy is then a choice, a clearly defined transaction in which something is exchanged, a product against a price. (Alftberg & Hansson 2012: 417)

One of the patients explained to me what could be described as a "formula" for cost-effectiveness over time that she used when assessing, calculating, and negotiating value in her health-seeking strategies: "This one [provider] is more expensive (...), but she might turn out cheaper in the end, if this helps (...)." Therefore, instead of the free public services of the past for which there were no alternatives, there has now appeared a plethora of choices which, as "clearly defined transactions" (Alftberg &

Hansson 2012), are rightfully payable. For most of the persons I interviewed, the fee-for-service system (Bazylevych 2009) has meant that good service is strongly implied in the fee.

Consumers beyond Health

The second point I address in this article is the onset of consumer-like behaviour among patients (Temkina & Rivkin-Fish 2020), which has led to changes in their expectations and new logics behind their “willingness to pay” (Donaldson 2001). Positive aspects of private healthcare that the patients I spoke with primarily listed were “easy” and “quick access”. Instead of waiting “months” for diagnostic tests or check-up appointments at public hospitals, access to healthcare in the private sector costs money, of course, but was immediate and guaranteed. Many of those interviewed also positively reported the ways in which private practitioners and providers paid more attention and spent more time with them, as expressed by an elderly woman:

You get there, report at the desk and you don’t even have time to take off your coat, they call your name. He [the doctor] spends all the time with you, doesn’t rush in and out, doesn’t talk on the phone, doesn’t yell to the nurse about other patients and things that have nothing to do with you ...

Many patients reported that the whole process and experience of going to private health providers was much cosier, “more human” or “more dignified”, with no cramped waiting rooms or long waiting hours. At the beginning of our interviews, patients would rarely mention medical advantages, but rather spoke about access, assets, convenience, accessibility, appearance, care, attention, time, comfort, or the quality and time-management of the service. From their explanations could be discerned a perceived association between convenience and better service on the one hand, and better medical care on the other. This finding is reminiscent of Cam Donaldson’s (2001) research in the field of health economics regarding the eliciting of patients’ values through the concept of “willingness to pay”:

Some treatment alternatives may not differ in terms of health gain, but patients may still have preferences for one over the other based precisely on the need for something which “goes beyond health”. Examples of “going beyond health” are the preferences patients might have for location of care, the process of care (i.e. non-health-generating aspects of health-care delivery) and autonomy in care. (Donaldson 2001: 183)

The perceptions of expertise and efficient care among the patients I interviewed were similarly dependent on the factors and conditions which “went beyond health”. As consumers, they talked about choosing goods and services and paying for them.

A Different Kind of Inequality

The third point to be discussed here regarding shifts in the health-seeking behaviours of patients in the newly diversified medical market is the new distribution of inequality throughout the healthcare sector. Unsurprisingly, “willingness to pay (WTP) is associated with ability to pay” (Donaldson 2001: 186). The persons with whom I spoke were regularly using different healthcare therapies, providers, institutions and systems according to their own pathway selection processes in healthcare decision-making. Their high socioeconomic status was the precondition for having the possibility to exhibit diverse health-seeking behaviours and sift through cares and cures, goods and services. The cost of private healthcare is by no means low, given that the average monthly net income per capita in Croatia is around 900 euro.⁴ One visit to a private paediatrician in Croatia in 2020 could cost from 20 to 50 euro, a gynaecologist visit from 50 to 100, and a visit to a specialist, for example an endocrinologist, from 70 to 150 euro. General physical examinations in private clinics are also highly popular and can cost from 500 to 1,000 euro. In case of chronic illnesses or prolonged need for medical care, for example in case of pregnancy, the costs can rise significantly. Like Pantović’s research in Serbia showed (Pantović 2016), my research in Croatia found that some women also paid for private check-ups and treatments with a certain obstetrician/gynaecologist throughout their pregnancy. This specialist would be present at their delivery in the public hospital in which she or he was also working. Considering that the monthly costs of regular pregnancy check-ups could, on average, amount to 100–150 euro (significantly more in cases of high-risk pregnancies), it was evident that only new mothers with an extra 1,000 euro or more in their budget could afford such privileged treatment. Public healthcare was also, of course, paid through mandatory health insurance, but this came directly from one’s gross salary and people did not perceive it as payment. The very rare criticisms of paying mandatory health insurance in my data were ambiguous: “I also pay additionally [a] private insurer, but that’s my problem, I think it’s safer that way. But of course, I pay the mandatory... they take it from my salary every month.” Only 4 percent of the insured population, the employed, pay the full mandatory health insurance contribution of 15 percent (Vončina et al. 2018), which affects the quality and efficiency of healthcare system and poses

⁴ <https://www.ceicdata.com/en/indicator/croatia/monthly-earnings> (accessed October 15, 2021).

problems for its financial sustainability (*ibid.*). Hence, policy makers themselves are aware of the problems in terms of patients being given adequate quality in return for the regular monthly reductions from their salaries (*ibid.*).

Nostalgia for Imagined Equality

Nostalgia and post-socialist legacies come together in broader conceptualizations of how experiences and practices of post-socialism work. However, just as with the concept of post-socialism itself, researchers have warned against an over-generalizing interpretation of the concept of post-socialist nostalgia (Pehe 2014), and against viewing it as yet another “umbrella term to describe a number of disparate and at times contradictory phenomena” (Pehe 2014: 6). Therefore, I have restricted the usage of the term nostalgia to Svetlana Boym’s (2001) interpretation. She sees nostalgia as having a utopian dimension, since its aim is neither directed towards the future, nor strictly towards the past (Boym 2001: 13). Nostalgia, therefore, continually offers new re-readings of both past and present (Boym 2001: 14). The need for new readings is expected in times of massive sociopolitical upheaval, which is why nostalgia is common in all post-socialist settings (Velikonja 2009; Mihelj 2017; Condrache 2020). Boym nonetheless insists that socialism is not the only historical period for which nostalgia has become a kind of coping mechanism (Boym 2001). In the context of healthcare settings in Croatia, the people I interviewed frequently told nostalgic narratives about the universally free healthcare of the past. The narratives were mostly told by members of older generations, that is, to those who were born before the 1990s and had personal experiences of life in Yugoslavia. As one man in his 50s explained: “Before, we could just enter a hospital and would get everything we needed. Today we can’t even get an appointment.” His comment refers to the long hospital waiting lists that are still identified as a pressing problem in the current “strategic plan” of the relevant Ministry of Health of the Republic of Croatia (MZRH, 2020–2022). In 2012 the Ministry initiated a pilot project to analyse the reasons for the long waiting lists and concluded that the main contributing factors were “poor organization of [the] healthcare system in general, [and] poorly defined responsibilities shared between the Ministry, Croatian Institute of Public Health and the hospital management”.⁵ However, the current “strategic plan” still outlines them as an unsolved issue. Problems such as these in public healthcare create opportunities for the private sector, which is now an integral part of the post-transition system of healthcare.

⁵ <https://zdravstvo.gov.hr/vijesti/ministarstvo-zdravlja-predstavilo-projekt-smnjenja-listi-cekanja-u-hrvatskim-bolnicama/92> (accessed April 14, 2021).

Another frequently repeated nostalgic theme was a revisionist call for the status I have named equality-in-lesser-quality (EILQ). Equality-in-lesser-quality refers to the frequently expressed attitudes by patients that the general standard in hospitals was rather poor in pre-transition Croatia, as compared to today. These same patients, however, still praised the healthcare of the past as the better one. Hospitals were frequently described by patients as “shabby, overcrowded, in old Austro-Hungarian buildings, with bathing and toilet facilities on one floor”. Yet healthcare in this period was deemed efficient, accessible, and equally available to everyone. The idyllic narrative of all-encompassing health equity in the past is evident from statements like “even the homeless could simply walk into the hospital and have a surgery”. The old system of healthcare was usually praised by my interviewees, precisely because of the existing popular memory of equality and equity. According to one public health expert working at the Andrija Štampar School of Public Health:

[The] Croatian healthcare system, although reformed, has retained some of its characteristics from the period of self-management. Its legacy [of] self-management includes the powerful voice of the system’s users and employees, and the strong belief by the public that medical services should be free at the point of use with little regard for the cost of care provided. (Džakula et al. 2007: 119)⁶

Thus, it seems that the desirable perception of equality-in-lesser-quality was centred on a paradoxical nostalgia aimed at a past (Boym 2001: 14) that was reportedly “worse” in most aspects but carried within itself a utopian promise of a better future that is inaccessible today (Boym 2001: 14).

Informal Payments and Other Shady Things

There were other areas of course, in which the past was less than idyllic in many respects (see Koleva 2016). On the margins of the proclaimed universal and free healthcare during socialism, other informal costs were readily present in many Central and Eastern European countries as well as in the former member states of the Soviet Union.⁷ Many societal contexts, from big business to medicine, recognize the distinction between gifts and bribes (Sherry 1983: 160). The distinction is rarely straightforward however, with one easily being mistaken for the other, and “the nature of this ‘mistake’ [ranges] from earnest to contrived” (Sherry 1983: 160).

⁶ Author’s translation.

⁷ See Rivkin-Fish (2005); Praspaliauskiene (2016); Rubashkin et al. (2021); Stepurko et al. (2014); Stepurko et al. (2015).

My analysis suggests that phenomena related to corruption and informal payments in healthcare can be divided into three categories: (small) gifts, direct corruption in the form of illegal payments, and “personal connections”. From the accounts of my patients, small gifts in pre-transition times would be brought equally either before or after the service had been provided: “It was not a big deal, but it looked good” since “it was the right thing to do.” Admittedly, the gifts were rather small (Stepurko et al. 2014) and tended to be consumable foods associated with leisure or celebrations: “I would bring him a bottle of brandy”, or “chocolates, better quality”, or “wine, not cheap”, also “coffee, of course, you know, the red brick...” (a popular vacuum-packed coffee by the company Franck). Some gifts were deliberately intended for more than one healthcare worker: “cookies, big packages, so they could share”, or were homegrown goods: “tangerines, three kilos, organic, I grow them myself”. This type of patient behaviour was mostly directed towards hospital doctors and staff, and much less towards general practitioners. Informal payments of small gifts like flowers, chocolate, or wine by patients to healthcare workers have been documented in many countries (Stepurko et al. 2014: 3).

Stepurko and colleagues (2014: 3) emphasize that “such gifts are not typically expected by providers and the amount and quality of the treatment patients receive is not dependent on it”. In my research data, gifts had not been typically expected, since they could easily be given after the provision of the service, just out of gratitude, appreciation, or acknowledgement of healthcare workers’ efforts. Whether or not gift-giving as part of patients’ health-seeking behaviour is seen as acceptable depends highly on the setup of the entire system. These practices tend to exist exclusively inside the context “of strong norms and regulations which shape staff behaviour” (Stepurko et al. 2014: 3) and “it is recognized that they have to be regulated and monitored” (Stepurko et al. 2014: 3), even though it remains unclear by whom and how. Furthermore, such regulation might be incorporated into the system and might thus influence the behaviour of healthcare workers, but this regulation does not apply to the patients themselves or to their placing an added value on the doctor–patient exchange strengthened by gift-giving.

The topics of gift-giving and gift-receiving behaviours are classic anthropological themes that highlight how much of societal behaviour revolves around the practices of exchange and reciprocity. “The expectation that there will be something in return presupposes the establishment of an enduring relationship”, Benson and Carter point out (2008: 3), since “by accepting the gift, the recipient is obliged to re-enter the cycle as a giver” (Benson & Carter 2008: 2). In the context of providing medical services, doctors are the expected givers of (good) service and through this, they re-enter the cycle of exchange.

The second category of informal payments mentioned in my data were illegal cash payments. The older the people with whom I talked, the more common, even acceptable, this practice seemed to them. “We had to pay for the hip operation... in our family, a cousin, we gave [the doctor] the blue envelope, it’s not like he asked for it, I guess, but he accepted it.” The phenomenon of giving “envelopes” has been analysed in detail by Rima Praspaliauskiene (2016). In her research, she encountered the custom of giving white envelopes and saw them “as a practice of health and care” (Praspaliauskiene 2016: 582):

An envelope of money given to a doctor transcends the material patient–doctor transaction and emerges as a productive force for coping with illness, medical encounters, and misfortunes. (Praspaliauskiene 2016: 582)

Praspaliauskiene (2016) notes that the procedure was comparatively similar to what I heard in Croatia, but the colour of envelopes was white in Lithuania in contrast to blue envelopes in pre-transition Croatia.⁸ I posit that bribing doctors was not only a sporadic practice, a sociocultural phenomenon, but also a widely accepted cultural narrative. Older patients with whom I spoke would readily mention “the blue envelopes” as something that was common, but would rarely name a single instance of ever seeing it themselves or experiencing it in any other context than merely as a story they had heard. Shame, embarrassment, and the need for discretion were affectively linked to this practice, and in the account mentioned above, the blue envelope was hidden in the wine bag and given by one member of the family to the doctor when he was alone in his office. The gift and monetary bribe thus went together and could not be distinguished from each other. The transaction was never mentioned again and never verbally acknowledged as ever taking place. The practice of cash payments seems to be even rarer today, according to my interviewees. However, related research by Stepurko and colleagues (2015) suggests that the practice might have been modified, but nevertheless still occurs due to “insufficient resources (low income of physicians) and inadequate governance (poor political–regulatory context)” in addition to earlier socialcultural customs (Stepurko et al. 2015).

The third category of value-driven health-seeking behaviours in the informal realm was the search for “private connections” or “acquaintance relations” (Bazylevych

⁸ Unfortunately, there are no clear-cut historical explanations as to why the envelopes in question in pre-transition Croatia were blue. The leading historico-cultural assumption is that the workers received their monthly salaries in those blue envelopes and were just re-using them for a similar purpose (Jelača, Kolanović & Lugarić 2017). However, there is no evidence to corroborate that claim.

2009). This phenomenon is known as “*guanxi* in China (...), *wasta* in the Arab world (...), *jeitinho* in Brazil (...), *pulling strings* in English speaking countries (...), *blat* in post-Soviet spaces (...), *vrski* in The Republic of North Macedonia (...), *veze* in Serbia, Croatia, and Bosnia and Herzegovina, and as *vruzki* in Bulgaria” (Williams & Yang 2017: 59).

Older respondents readily explained that in pre-transition times one would need a “personal connection” or would feel compelled to seek one in order to access better care. A common phrase in connection-seeking would be, as many reported, “do you have anyone in [for example] Vinogradska?” The person asked could be anyone, a friend, a neighbour, a colleague – anyone who could have acquaintances working in a hospital. The question itself meant that the seeker was searching for a doctor working at that specific hospital, Vinogradska, who would admit, take care of, and perhaps operate on the person himself/herself or a member of his/her family. In such cases assumed efficacy of care and success of the cure depended on the pre-evaluated benefit of having a “connection”. Finding a connection did not automatically mean that the doctor in question would require or should be offered payment in the aforementioned blue envelope. However, since this instance of connected care was deemed more valuable, a payment could be part of it.

Strategies of building and retaining complicated and complex relationships between doctors and patients required knowing the rules of the game so one could play it, either as a patient or a healthcare worker. Therefore, strategies of allocating and negotiating the value of caring and curing existed as informal practices in the previous era of nominally unpaid healthcare. Some of these older behaviours have been retained in a somewhat modified form. Research participants confirmed that small gifts are still exchanged in public hospitals and with the same logic both before and after the service has been rendered. These gifts are interpreted as symbolic and as gifts of gratitude and appreciation.

Public opinion and attitudes towards the giving of envelopes has obviously changed to the extent that respondents unanimously claimed that envelope-giving does not exist anymore. One of the important findings of my study is that neither gifts nor envelopes are exchanged in the *private* health sector today: “it did not even cross my mind to bring anything”, emphasized one of the interviewees. Unambiguously monetary transactions have replaced the culturally evaluated transactions of the past.

The third category of value-driven health-seeking behaviours, personal connections, still exists, but with a significant shift, giving rise to the phenomenon of semi-private healthcare (Temkina & Rivkin-Fish 2020). In this form of healthcare, patients move from private to public healthcare (see Pantović 2016 for Serbia) and continue their treatment in the public health sector with the same doctors, avoiding the waiting lists

or getting some other benefit that would not otherwise have been accessible to them. According to my interview participants, this was a deliberate strategy used by some patients.

Conclusions

The central premise of this article is that both the willingness to pay (Donaldson 2001) and adhering to a fee-for-service system (Bazylevych 2009) form a constitutive part of the medical market in Croatia today, compared to the pre-transition period. This premise was corroborated by patients' accounts: health-seeking behaviours have become dependent on parallel payable healthcare and healthcare alternatives, and on the consumer-like expectations of patients which "go beyond health" (Donaldson 2001). They are also centred around patients assessing the general quality of their experience with healthcare providers.

At the beginning of this article, I asked: what has made some people in Croatia willing to give up relatively low-cost universal public healthcare in favour of paying more for private treatment? In the context of changing medical markets which modify and redefine the way we conceptualize and commodify our health and wellbeing, the patients interviewed for this article associated their ability to select between different therapies and providers with a curative potential. Patients drew direct attention to the fact that a higher level of quality is now accessible – if one has the money. At the same time, some patients' narratives evoked an imagined health equity in which all citizens had equal access to the less biotechnologically advanced healthcare offered by the pre-transition state. In my research I discovered 1) nostalgic narratives that had emerged and refer to past access to free healthcare and call for equality-in-lesser-quality; and 2) the paradoxical fact that older health-seeking behaviours came with hidden – but widely known – costs in the form of informal gifts or the seeking and sustaining of personal connections. These costs were in no way significantly lower than the costs of private medical care today.

Interestingly, patients indicated that their selection of care and cures did not involve a meticulous, detailed analysis of available medical treatments. Instead, their decisions were situational, contextual, individual, changeable, affective, and "intuitive", and they stemmed from personal experiences and perceptions. Patients liked having choices and negotiated politics and power from the basis of their own mindful bodies. Contributing to this is the fact that when entering the market, medical clinics behaved as would any other commercial enterprise. Popular culture, gala events organized by large private clinics for their opening, and the successful public relations campaigns of specific clinics, therapies and practices seemed to be an increasingly important factor

in patients' decisions. Market-based healthcare and its accompanying inequalities have become socially legitimized through patients' attitudes that were based less on a careful evaluation of the pros and cons, options and costs, and more on the fact that patients enjoyed following their bodily intuitions at any given moment. Market-based healthcare allowed them to do this rather than go through treatment regimes decided upon by institutions, the state, or political decision-making. This attitude is likely to be one reason why patients do not resist or protest against the obvious inequalities throughout the present-day healthcare sector.

At the time of its emergence, the term medical pluralism was applied to problems surrounding the hegemony of biomedicine, but today this definition seems inadequate (cf. Raffaetà et al. 2017). The increasing complexity of medical pluralism today should alert scholars to the problems of financing, state budgets, migration, solidarity, neoliberalism, inclusion, exclusion, and the near-utopian aspirations towards a universal right to health. Patients' expectations stem from a complex mix of past, present, and more hopeful future, but for the time being, these expectations are not being met. When the selection of health pathways is directly dependent on an individual's socioeconomic status, health equity is a distant reality.

Competing Interests

The author has no competing interests to declare.

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