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Sustainable redistribution with health care markets? Rethinking regulatory intervention in the Tanzanian context

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1. Redistribution by government or by design?[1]

There is a paradox at the heart of health care reform programmes in low income countries. On the one hand their stated motivation is egalitarian. Reform proposals are repeatedly justified by reference to the currently inegalitarian distribution of government funding and the aim of 'freeing resources to target the poor' (World Bank 1993, p.119;1996). However, the market liberalization that is proposed as the path to such redistribution is an explicitly unequalizing reform, that is, it promotes and legitimizes the expression of social inequality within the health care system (Mackintosh, forthcoming). A Tanzanian medical academic involved in health policy noted[2] that it was not clear why this process, which he characterized as 'privatizing middle class provision', should result in a more progressive allocation of limited government funds.

Studies of liberalized health sectors find, unsurprisingly, inegalitarian distributive behaviour: exclusion because of inability to pay, market segmentation by social class, and continuing government funding of secondary and tertiary provision[3]. Yet there is rather little analysis within the health policy literature of the reasons for the failure to attain expressed egalitarian policy objectives. Policy analysis continues to be largely prescriptive – generating more refined ways of targetting funds – rather than addressing analytically the requirements of a sustainable redistributive process within a liberalized health care system as a whole (Mackintosh and Gilson, forthcoming).

This predominant policy mindset is in part an artefact of the market liberalization process itself. Market competition tends to expose and undermine cross-subsidy within liberalized public service and public utility sectors (Heald 1997). Hence economic theory and policy that take market competition as their yardstick logically generate an institutional separation of provision through the market from redistribution via government transfers. The policy implication drawn for low income contexts is an institutionalized separation between market liberalization (private finance and provision) and 'targetting' a basic package of publicly financed care for the poor (World Bank 1993). As one Tanzanian commentator characterized the Tanzanian decision to liberalise clinical practice in the early 1990s without any clear regulatory structure: 'The economists won'.

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[1] This paper was presented at the conference on New Institutional Theory, Institutional Reform and Poverty Reduction, Development Studies Institute (DESTIN), London School of Economics, September 2000. It is based on research funded by the UK Department for International Development (DFID) whose support is gratefully acknowledged, as is that of the Open University. The views expressed are the sole responsibility of the authors, and do not represent the polices and practices of the DFID. The paper also draws, with thanks, on joint research with Lucy Gilson. For commentary on earlier versions of these arguments we thank the participants in: a national policy workshop in Dar es Salaam, Tanzania (Economic and Social Research Foundation, April 2000); the Forum on Poverty, Inequality and Health (London School of Hygiene and Tropical Medicine, April 1999); and the UNRISD conference on Technocratic Policymaking and Democratization (Geneva, April 2000).

[2] The quotation is from a set of interviews with policy makers and stakeholders in the Tanzanian health care system.

[3] Gilson and Mills (1995), Mogedal and Hodne Steen (1995), Semboja and Thirkildsen (1995), Tibandebage (1999) summarize evidence on African reformed systems; Dreze and Sen (1995) summarize evidence on India's diverse mixed health care systems.

There are however other voices. Some economists analysing European health care systems point out that the systems, though institutionally diverse, all embed high levels of redistribution within social insurance mechanisms that both help to control costs and to make the redistribution socially robust (Barr, 1993, Besley and Gouveia, 1994; see also Campbell and Ikegami, 1998 on Japan). Some social policy analysts make a related argument: that stable health care systems embody a set of institutional compromises – a 'social settlement' – between inequalities embedded within the system and effective challenges to the system (Williams 1992, Hughes and Lewis 1998). Londono and Frenk (1997), analysing Latin American systems, argue that overcoming their highly exclusionary effects requires reintegration of socially polarized provider and funding institutions.

This paper seeks to contribute to the analytical development of this latter perspective. We label our policy framework 'redistribution by design', by which we mean intervention in institutional change (by government and other health care stakeholders) aimed at influencing the redistributiveness of a mixed health care system as a whole. We argue that such intervention is possible in a liberalized health care system, and that it must be based in a contextual understanding of the informal regulatory relationships that shape a mixed health care system in a particular country and at a particular moment.

2. Informal regulatory mechanisms and the problem of unreciprocated gifts

Our analysis of the health care system draws on institutional economics and on anthropological and sociological analysis of institutions. Across social science as a whole, there is a sharp divide in institutional theorizing which does not coincide with a disciplinary divide: it runs through different disciplines. Both schools of thought identified here define institutions ostensively, as formal and informal rules and organizations, norms, habits and accepted modes of behaviour. They differ sharply however in their analytical framework for understanding these items.

One school of institutional thought distinguishes analytically between institutions and individuals. Much formal game-theoretic modelling of institutions and institutional change falls into this category. The institutional framework forms a set of constraints on behaviour analogous to the rules of a game. This framework requires the counter-factual notion of an 'institution-free world' (North 1990, p.18) and hence an individual free of institutions. No such world need exist; the concept is an analytical benchmark. As North puts it:

> Separating the analysis of the underlying rules from the strategy of the players is the necessary prerequisite to building a theory of institutions.
>
> (*ibid*: 5)

Experiment is a widely used research technique in this analytical framework.

The methodology on the other side of the divide in institutional theory rejects this foundational position. Here, institutions and individuals are not wholly analytically separable. Institutions are things we 'think within', or that 'think' for us (Douglas's 1987, p.124): parts of ourselves as social beings. The institution-free individual is nonsensical in this framework. Scott (1995, p.44) calls this the 'cognitive view' of institutions, in which norms are not seen as constraints but rather as 'scripts' for sense-making and as building blocks of identity. Douglas' (1987) analysis of

institutions focuses on their role in 'making' big decisions for us, particularly those that involve principles of justice.

> Any institution that is going to keep its shape needs to gain legitimacy by distinctive grounding in nature and reason.
>
> (*ibid:* p.112)

The implication is that discursive understandings are taken into the centre of the definition of institutions, and research within this framework is predominantly fieldwork-based.

We have found the second approach particularly productive of understanding of institutional process and change in health care. Effective health care provision is a relational process, requiring shared understandings between users and providers[4], and carrying meanings of duty, trust, respect and rights. To face exclusion and abuse when at one's most vulnerable is an important element of poverty as it is experienced[5]. Conversely, effective claims on a health care system can be an important economic asset for the poor. Hence health care, because of its moral, economic and social significance, is a potential focus for organized political demands for inclusion, and health care provision has been seen by many governments as an important element of state building and of constructing a relationship between state and citizens[6].

This institutional perspective implies health care market processes will be strongly shaped by norms, expectations, shared and conflicting meanings, and perceived legitimacy of behaviour. We refer to these taken-for-granted working relationships, reinforced by experience, as informal regulatory relationships (Tibandebage and Mackintosh, forthcoming): 'regulatory' in the sense that they exercise a profound influence on market evolution, much greater than the influence of formal legislative rules. We argue below that they strongly shape responses to market incentives.

This analysis implies in turn that, to be sustainable, redistributive behaviour in health care must come to seem normal and legitimate within, in the Tanzanian case and many others, health care systems dominated by market exchange. This paper is concerned with how that objective might be pursued. We define redistributive action broadly for our purpose here, as achieving: persistent improvement in the social inclusiveness of the system, sustained reduction in the impoverishing effect of health care access for the poor, and continuing improvement in the quality of care for the poor[7].

All redistribution in this sense requires some element of unreciprocated gift, in the form of provision of more and better care for the poor than they can pay for through fees or taxes, and

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4 There is an extensive literature arguing this point and demonstrating the consequences of the absence of shared understandings (Mackintosh and Gilson, forthcoming).

5 A detailed argument to this effect for the case of Tanzania, drawing on this research project, is in preparation; see also Kaijage and Tibaijuka (1996).

6 The Frelimo government in the late 1970s was particularly eloquent on this point (Walt and Melamed, 1983), and in India, political organizing has been a key element in the health care achievements in Kerala (G. Sen, 1992). Mogedal *et al.* (199, p.352) note however the lack of evidence of organized public demand for improvement in the African countries they survey.

7 We are aware that this is a controversial use of 'redistribution' which generally refers to a measured contrast between original and post-tax and benefit income; the conclusion returns to this point.

both frameworks of institutional thought offer reasons why such 'free gifts' are problematic. The first framework allows for individual preferences for altruism, especially for individual gifts, but would look for incentives generated by expected reciprocation – future returns, avoidance of negative externalities, informal insurance or non-monetary reward – to sustain a norm of altruism over time[8]. The second framework understands gifts as generating and sustaining relationships through gift exchange, implying that legitimate gifts must carry accepted social meanings. Gifts discursively framed as unreciprocated carry strong and problematic implications of dependency within unequal relationships[9]. Hence, sustaining gifts may require reframing them, for example, as professional duty or response to legitimate and actively pressed claims. In each framework, this problem of sustaining redistributive commitment appears greatly under-researched as compared to the volume of work on sustaining co-operation.

This paper argues that redistributive intervention is possible through shaping the terms of market exchange, and through strengthening the institutional basis of both governmental and non-governmental redistributive commitment. We argue that the means by which such a process of 'redistribution by design' can be pursued is a process of collaborative regulatory action involving government, the public, and other stakeholders in the health care system.

3. Health care markets in Tanzania: the redistributive problem

Policy proposals emerge from analysis. We identify briefly here aspects of the emergent market-based[10] formal health care system that actively run against the interests of the poor. We concentrate on institutionalized processes consistently identified in recent field research in three regions of Tanzania[11]; processes that redistributive policy would need to reverse. These are[12]: the exclusionary effect of formal and informal charges, and associated neglect and abuse of the poor; the lack of government facility-level redistributive commitment demonstrated by the failure of exemption mechanisms; the absence of claims mechanisms for quality and inclusion by users and would-be users; perverse interactions between market incentives and responses generating some very poor quality private provision; poor use of scarce resources, and social polarization sustained by (some) donors.

8 Offer (1997) is an example of this general approach; de Swaan (1988) applies the approach to political commitment to redistribute.

9 Carrier (1995) argues that sociological accounts of gift-giving allow for unconstrained gifts, while anthropological accounts since Mauss (1924) – which have influenced our analysis – generally do not.

10 Market-based in the sense that most health care now requires a market transaction; furthermore estimates of about 45% of health care expenditure being private payment (World Bank, 1996, quoted in Tibandebage, 1999) are likely to be an underestimate.

11 The 1998 fieldwork was undertaken in Dar es Salaam, the capital city, Coast region, a predominantly rural region close to it, and Mbeya, a region in the Southern Highlands. Interviewees in health care facilities (10 hospitals and 36 lower level facilities) included owners and managers in the government, religious/NGO, and private for-profit sectors; patients (272 in total) were interviewed after out-patient treatment at each facility, and household interviews (108) were in wards situated in the catchment areas of many facilities in the study. We are most grateful to the following colleagues for their contribution to the design and undertaking of the fieldwork: A.D. Kiwara, P. Mujinja, P. Ngowi, G. Nyange, V. Mushi, J. Andrew and F. Meena, and also to J. Kajiba for research support. We also thank everyone in the four fieldwork districts who gave their time to facilitate our research.

12 More detailed analysis is set out in Tibandebage and Mackintosh (forthcoming) and in two papers in preparation.

Note that we are *not* concerned with the question of whether liberalization has made inequality in health care access worse since 1991 – we do not have evidence on that point – rather we treat liberalization as the context for health care policy development, hence a context that needs to be understood.[13]

Background: emergent health care markets in Tanzania

Health sector reform in Tanzania has formed part of a broader process of economic and social liberalization (Wangwe et al., 1998). Rapid expansion of government health care provision in the 1960s and 1970s, and the abolition of private for-profit practice in 1977, had produced a health care system dominated by government and religious providers (Upunda, 2000). Severe economic crisis in the late 1970s and early 1980s caused a sustained decline in the infrastructure, staffing and quality of provision in the government health care system (Kiwara, 2000) and a rise in informal charging (Mujinja and Mabala, 1992). In 1991 the Amendment Act no. 26 reversed the 1977 Act, and permitted individual private clinical practice.

The result has been a rapid rise in for-profit private practice, concentrated in the urban areas (Tibandebage, 1999). Turnover of facilities is high and data are poor (Tibandebage *et al*., forthcoming[14]); however data from the Registrar of Private Practitioners show 1,700 private facilities licensed by 2000 (Upunda, 2000). As the private market has developed, formal user fees have been introduced in government hospitals (in 1993) and subsequently in some health centres and dispensaries. At the time of the research, rural government dispensaries were still not officially charging fees.

The economic context is severe and widespread poverty. Tanzania is one of the least developed countries in the world, with a population that is predominantly rural and dependent on agriculture and informal economic activity. Over half the rural population lives at least 4 kilometres from the nearest health centre. Incomes are very unequally distributed (World Bank, 1998/9), and it is estimated that over half of the rural and peri-urban population live below a poverty line of Tshs 145,232/- (US$ 207) per adult-equivalent household member per year (Semboja and Rutasitara, 1999).

Charging, exclusion and impoverishment

In contrast to the expressed view of some providers and policy makers that 'people can pay', with the assistance of family, when they must, this study found evidence of substantial exclusion and self-exclusion, and also of impoverishment from struggling to pay formal and informal health care charges.

Effective health care charges could be high relative to incomes. The mean payments by exit patients for a visit to a lower level non-government facility represented between 20% and 43% of the monthly adult-equivalent rural and peri-urban poverty line in 1998 (Tibandebage and Mackintosh, forthcoming). Charges fell particularly heavily on the urban poor (Table 1), who

[13] We may appear to labour this point. But we have learned from experience that our analysis is repeatedly 'read' as comparing liberalized markets with a hypothetical past, despite absence of any such comparison from the text.

[14] In this study, out of a random sample of 300 private practitioners registered in Dar es Salaam in 1996, over half were found to have closed down or could not be located.

relied predominantly on non-government dispensaries and health centres and on government hospitals. The similarity between payments by the urban poor and the better off is disturbing.

Table 1: Mean and median payments by household interviewees for a recent visit to a health facility, by social group[15] and region 1998 (Tshs)

Area	Group					
	Rural poor		Urban poor		Better off	
	Mean	Median	Mean	Median	Mean	Median
Mbeya (Urban and Rural)	1806	100	5244	3000	3883	2950
Dar es Salaam and Coast region	1957	800	3474	1250	6643	2750

As a result, nearly 70% of household interviewees in Mbeya (urban and rural), over 40% in Dar es Salaam and over 25% in (rural) Coast region recounted experiences (their own, or of people well known to them) of exclusion for inability to pay. These accounts focused predominantly on government hospitals, partly reflecting the use of these facilities as a last resort. Among exit interviewees, 22% of those asked to pay something had been unable to pay in full; those unable to pay fees or informal charges (bribes) in government facilities had almost all been excluded from treatment. The outcomes included death, failure to treat infectious diseases including TB, and the sale of possessions and borrowing to fund treatment.

The sale of possessions was unsustainable, as a doctor in a religious hospital noted. The impoverishing effect was worsened by the absence of a functioning referral system. Patients engaged painfully and expensively in 'self-referral' on the basis of cost, distance, reputation of the facility and self-perception of the seriousness of the illness. In Mbeya Urban, nearly 40% of exit patients at lower level facilities had been somewhere else first with the same ailment, and in Dar es Salaam and Coast the proportion was about 25%.

In principle, an exemption system should have protected the indigent: government-sector health care facilities that charged official fees were given instructions to exempt those unable to pay. However, in the whole study we documented no example of someone being given such an exemption[16]. Some government facilities exempted some young children; health care facilities' staff and relatives were generally treated free of charge; TB and HIV+ patients were supposed to be treated free of charge (a scheme funded by donors) and some did receive free treatment, though some did not. But free treatment on the grounds of poverty alone was not seen as legitimate by many government institution staff: fee-charging health centres privileged income generation, and some hospitals had no institutional commitment to the exemption scheme,

[15] Social group is defined by education, occupation and area of residence. People in the 'poor' category have primary education only or no education, and their main source of income is small scale farming or petty trade.

[16] This is consistent with other studies in Africa (Gilson, *et al*., 1995, Fabricant, *et al*., 1999, Nyonator and Kutzin, 1999).

managers believing it unworkable under severe financial constraint. Urban residents had stopped expecting such exemptions, quoting providers: 'there is no service without money'. Exclusion, rather than exemption, had become the urban norm if someone could not pay.

Poor quality and abuse in the government sector

Patients are vulnerable to abuse in all health care systems.[17] Interviewees offered clear and consistent criticisms of facilities, but were almost universally afraid to make formal complaints about poor treatment. By far the most serious criticisms were of urban government hospitals: endless waiting, neglect, rudeness, demands for bribes and active abuse including abandonment without care if bribes could not be paid. The worst tales of abuse concerned the behaviour of nursing staff, especially in maternity wards. Hospital nurses were caught between many of the worst pressures in the system: low and declining real wages, poor chances of advancement, poor and often dangerous working conditions, and an experience of abandonment by the doctors formally responsible for patient care. This sense of being abused has in the worst cases turned full circle into a culture of abuse of patients.

One urban hospital displayed a particularly serious culture of individual appropriation of resources by staff and of abusive behaviour towards patients (Tibandebage and Mackintosh, forthcoming). The pharmacy lacked basic drugs and patients had to buy their medical supplies; the hospital's activity rates were falling despite the scale of local need. Bribery was widely accepted as being the mode of operation of this facility, and patients who could afford to bribe effectively colluded with this system to the detriment of those who could not pay, as several pointed out. Dispensaries reported that patients returned untreated after long waits and unaffordable demands for payment, that they increasingly refused to attend the hospital. People 'preferred to die at home', unless they could afford, and reach, a local religious-owned hospital.

Perverse incentives and poor quality private provision

All health care markets generate serious perverse incentives, but response to these incentives is diverse, locally specific, and strongly shaped by culture and institutional process. In the Tanzanian context, the private for-profit health care market is narrow and restricted to the urban areas. Most private providers studied were struggling to survive, as were many religious facilities. Financial constraint was of course also severe in all government facilities. Some (not all) facilities' market responses to these pressures were worsening the problems of access and quality just outlined[18].

Most private for-profit facilities operated in a highly price-competitive manner. Owners observed each others' prices closely, and in local markets price distributions across facilities were narrow (see Figure 1 below). The Dar es Salaam market was particularly price competitive at dispensary and health centre level, and private facilities providing a range of services using reasonably qualified staff were acutely aware of undercutting by cheap competitors. Profits came mainly from charges for tests and drugs. Hence, facilities faced dangerous incentives to slide into a lethal mix of using unqualified staff, over-prescribing drugs of

[17] Note that this was not a clinical study; information on quality concerns the state of the facilities, including observed drug availability, and the handling of patients. The questionnaires were designed, however, with the assistance of a Tanzanian medical consultant and a health economist, and four of the interviewers had clinical or public health qualifications.

[18] A more detailed paper on pricing, competition and facility strategy is in preparation.

doubtful provenance, and prescribing inappropriate drugs on the basis of faked diagnosis. Users too recounted examples, including reluctance to refer when problems were beyond staff competence. Household interviewees could explain why private facilities had business incentives to behave in this manner, and were aware that the worst private for-profit dispensaries were very bad indeed.

Perverse incentives and market segmentation

The alternative to lowering prices and reducing quality was to seek to move up-market, and to compete for the very limited numbers of higher income clients and those paid for by employers. This was hard for private facilities since investment loan finance was virtually impossible to obtain, though some hospital consultants could charge high prices for private clinics in Dar es Salaam. Only doctors could legally own facilities, so they faced three options: use funds from another family business (unusual to have this option); develop slowly from earnings (difficult); or cheat. The latter generally involved a businessman as 'sleeping partner'; it was not strictly legal, and could create pressure for doubtful clinical practice and high charges.

As a result, market segmentation as a strategy was more easily pursued by some religious-owned facilities. The resultant price differentiation at dispensary and health centre level can be seen in Figure 1[19].

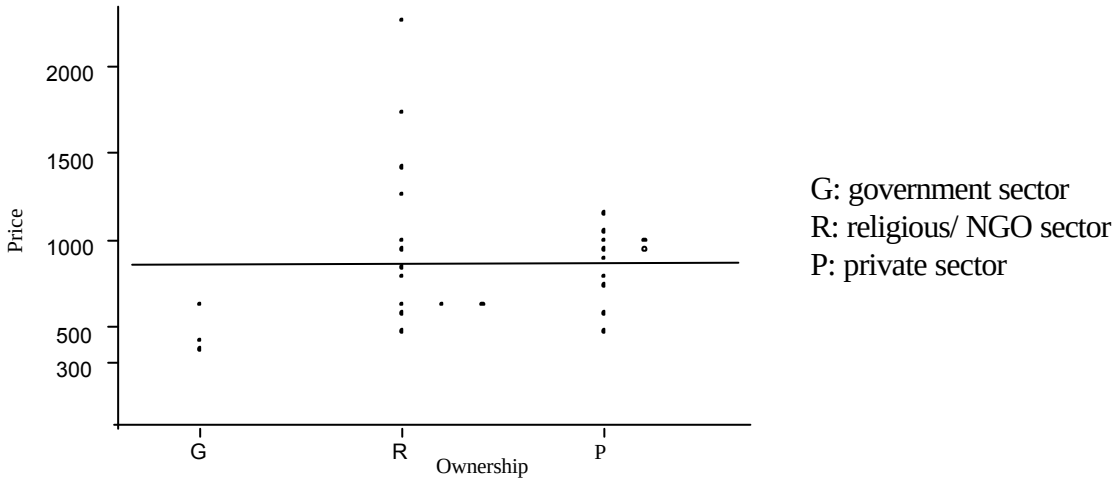

Figure 1: dotplot: mean price charged by dispensaries and health centres for a set of common services, by sector (Tshs)

The religious sector included the most expensive facilities in the study. Some had operated before liberalization, providing, as one interviewee put it, the only 'private' facilities at the time, and often used by employers to treat their workforce. Others were recently established. All the

[19] The mean price for each facility is a 'robust mean' of the facilities' stated prices for a common set of services, including consultation, basic diagnostic tests, simple procedures and specified common drug treatments for adults and children; the robust mean is calculated as twice the median, plus the two quartiles, divided by 4. The data for government facilities include only those facilities imposing official charges. The horizontal line is the median of the mean facility prices (Tshs 862.5).

expensive religious facilities received donations, but did not apply them to subsidizing the prices charged; few offered preventative care.

Poor use of scarce resources

Three scarce resources in this system are doctors, equipment and government funds. The problems just outlined were leading to inefficient use of all three. Low salaries for doctors were being supplemented in urban areas by private practice, but the arrangements were poorly managed and this led to widespread complaint about doctors neglecting government hospital work while also being absent for long periods from private clinics. There were also severe equipment shortages, yet even in a country as poor as Tanzania, one was beginning to see the 'medical arms race' phenomenon: some religious and private facilities were investing in underused expensive equipment as a method of seeking to attract middle class patients.

Finally, clinical professionalism was being undermined. In addition to the perverse incentives just outlined, doctors and other clinicians felt unsupported by updating and professional networking, isolated from a professional community in which information could circulate and within which learning and mutual support could occur. Providers accepted the need for supervision, but complained of formalistic inspection of facilities, unsupportive in clinical terms, as opposed to professional support concerning treatment protocols and patient management.

4. Opportunities: ethical norms, support for access and beneficial market strategies

In the face of the above evidence, a tempting policy response was fatalism: continuing deterioration through unethical and self-interested behaviour seemed inevitable. It is important, therefore, that the evidence tells a more complex story. The path of health care market evolution is by no means set. There is considerable evidence of institutionalized resistance to the most self-interested response to incentives, and of norms of probity in relation to patients and resources.

Norms of probity in the government sector

Norms can be identified in research data as behaviour that is widespread, accepted as usual, reinforced by experience and shared expectations, and quite hard to resist. A set of compatible norms of behaviour can 'set' over time into a stable institutional culture that is reinforced by mutual responses between managers, staff and patients, and that shapes the behaviour of new staff and the expectations of new patients. Institutional cultures in this sense differed sharply within the government sector.

A number of facilities, seemingly against the odds, were providing accessible care in decent conditions, stretching resources effectively for the benefit of users, and treating patients with respect. Health centres and dispensaries that charged officially were not generally also demanding bribes, though one large Dar es Salaam health centre was an exception. In the others, official charges were generally accounted for and largely used for the purchase of supplies and for maintenance. The fees were valued as permitting more effective service provision, though, as noted above, they also generated a culture of exclusion of the indigent.

In rural dispensaries and health centres, none of which imposed formal charges, small informal (and illegal) charges were made 'for syringes' (when a patient required an injection), or 'for kerosene' (for the fridge or for sterilization). In most, these charges were not characterized by interviewees as 'bribes', but rather as 'contributions'[20]. The fees were low relative to charges elsewhere – Tshs 100 or 200 (10p or 20p) – and in some cases village leaders had been involved in their initiation. Interviewees clearly believed – probably rightly – that most of these funds went into supplies, not individual pockets. These facilities relied on donor-funded drug supplies, and in several, interviewees were at pains to say that they believed most went free of charge to patients when available. These positive views contrasted with interviews concerning two other rural facilities, where bribery and resale of drugs were consistently held to occur.

Furthermore in contrast to the urban hospital described in Section 3, a rural government hospital was achieving much better provision. Some bribery was recorded, but not associated with abusive behaviour, and balanced by many more positive comments. Uniquely among government hospital patients, two interviewees said that they had successfully resisted demands for bribes. The evidence from independent sources for positive institutional norms of behaviour is consistent: data on drug availability (reasonable), financial data (much lower costs per patient, effective recording and use of fees), activity rates (rising), management interviews (displaying a lack of tolerance of abuse), dispensary interviews (patients successfully referred), exit and household interviews (many positive comments, evidence of exemptions for young children and the elderly) (Tibandebage and Mackintosh, forthcoming). There is no inevitability about deterioration of institutional culture in the government sector.

Accessible charitable provision

The other face of market segmentation in the religious sector was the existence of a sub-sector we label 'charitable'. The behaviour of these facilities' staff and managers displayed quite different norms from the high charging facilities described above. These facilities were applying donations to keeping down prices and to sustaining access. The mean charges of the dispensaries and health centres in this charitable category are shown at the lower end of the religious sector charges in Figure 1; one religious hospital in the study also fell into this category. Some were providing care as cheaply as government fee-charging dispensaries and health centres. All provided preventative as well as curative services, and all allowed some deferments and waivers of payment in crises. They also had a reputation for treating people humanely. Those in charge expressed commitment to affordability as a key objective and the observed charges and fee structures support their statements: they sought, for example, to cap costs per episode at manageable levels that could be predicted in advance.

Facilities in which the institutional culture was charitable in this sense were found in all the areas studied, and were relied upon by users when the government sector failed them. One interviewee, referring to a rural religious hospital, explained the expectations generated by shared experience:

> Service can be given [in emergency] prior to money. But at [the government maternity] hospital, one has to pay first before any service is provided.

[20] These interviews were mainly conducted and recorded in Kiswahili, and the distinction between the terms (one carrying disapprobation, the other not) is consistent in that language.

Interviewees stated that in these circumstances they would return to these facilities with the money owed, and the facilities' staff confirmed that this often happened. One reason was, of course, awareness that the patient might need to return in the future, but there was also a recognition of good service. It was these charitable facilities that particularly gave the religious sector as a whole its good name.

Beneficial private sector market strategies

Given the price competitiveness and financial pressures outlined above, one would have expected private providers to concentrate on curative care, and particularly on the sale of drugs and diagnostic tests. However, a subset of private facilities in both Mbeya and Dar es Salaam did provide mother and child health (MCH) care, including ante-natal care and care for the under-5s including vaccination, for low or no charges. Why were they cross-subsidizing preventative activity from fees for curative provision? The reply from the owners was, in essence, 'marketing': offering preventative care brought people into a facility, they got to know it, might come to trust its motivations and might return, for assistance with delivery and for the curative care which provided the dispensary's profits. The facilities that offered this service tended to have curative care charges that were moderate as compared to the non-government sectors as a whole.

This private sector behaviour increased the amount of preventative care; it created expectations that primary non-government providers should provide preventative as well as curative care; it built up relationships between groups of patients and particular facilities; and it encouraged the facilities' staff to take a long term rather than a short term view of their relationships with lower income patients. All private facilities studied sometimes deferred payment at times when patients could not pay, and long-term relationships may mean that patients are more likely to pay when they can.

Shared knowledge among users and the role of reputation

Policy makers interviewed during the study tended to view users of the health care system as irredeemably uninformed. Contrary to these predictions, we found patients and household interviewees rather well informed about the facilities accessible to them, and also about hospitals at a rather greater distance. Patient and household interviews contain rather consistent responses concerning the strengths and weaknesses of different facilities, and interviewees were well able to balance cost and quality of care as they perceived it, in responding to questioning about value for money.

Firm findings include extensive exchange of information about facilities. People developed and acted upon their perceptions of the appropriate facilities for different problems and for different capacities to pay; facilities thus developed distinct reputations that affected their activity levels, incentives and behaviour over time. People's knowledge and use of facilities was localized, but within local areas people could discuss charges, response to those unable to pay, staff attitudes to patients, and particular skills (such as good at treating children, or good with burns), as well as availability of drugs and tests.

Sectors as well as facilities had reputations. We asked household interviewees which sector provided the best value for money, and virtually everyone understood the question and could explain their answer; the majority identified the religious sector as offering the best value, though

in the area of the better government hospital, described above, more identified the government sector, and some (generally the better off) chose the private sector. Shared opinions can of course be misguided. But the scale and consistency of market information contrasts with the absence of 'voice' in the sense of the fear of complaint and the lack of organized capacity for influencing the behaviour of facilities.

5. Collaborative regulation for redistributive ends

Mixed health care markets are, as just illustrated, very diverse, and the early stages of emergent market development offer opportunities for influencing the later path of development. If regulatory intervention can push the system towards increasing inclusiveness and probity, by valuing and involving good providers from all sectors, then the health care system can be a redistributive force in the medium term, rather than exacerbating inequality and poverty.

Rethinking regulation as collaborative action

Effective regulatory intervention is only possible if the resource constraint on inspection and enforcement can be side-stepped. The only means of doing so is a process of collaborative action to build on desirable norms of behaviour, to value and strengthen providers who successfully serve the health care needs of the poor, to strengthen the legitimate claims of low income patients, to achieve legitimacy for formal regulations via negotiation, and to find synergy between supervision and support. The government has few resources for inspection, but it has considerable total resources which can contribute to shifting the direction of evolution of the system if well used.

This alternative approach to regulation reflects wider shifts in policy thinking. Tanzanian policy makers generally gave 'regulation' its most common meaning: a benign public interest body setting and enforcing the legislative framework and associated regulations, including licensing procedures and quality standards for facilities' staffing and premises. Economic analysis generally retains this rule-setting approach, while analysing the rules as contractual agreements creating incentives for self-interested service providers (Bishop *et al.*, 1996, Mackintosh, 1999).

By contrast, the socio-legal literature on regulation (Baldwin and Scott, 1998; Ayres and Braithwaite, 1992) recognizes a more interactive institutional relationship between regulator and providers[21]. 'Regulation', as in this paper, includes not only formal rules and decision-making procedures, but also informal working relationships and 'customary assumptions, often barely articulated, about the substantive purpose of the activities being pursued' (Hancher and Moran, 1989).

Tanzanian debate was moving towards such a broader view on regulation. Deep concern was expressed in government at the lack of capacity to enforce quality standards and the consequent dangers to patients:

> The system is not policed enough, it is not inspected properly, it lacks proper supervision. This is not a commodity we are selling, it is people's lives.

[21] Some economists, for example Helm (1994) also explore these issues.

The Registrar of private facilities is understaffed and poorly equipped, and the Ministry of Health's own inspectorate unit is small. The Registrar relies on district medical officers 'who are very often in a worse situation' for inspection for licensing purposes (Upunda, 2000). Non-government interviewees were critical, furthermore, of 'double standards', that is, of failure to apply to government facilities standards set for the independent sectors. One interviewee summed up the problem as a lack of 'a culture of regulation' in health care, that is, a culture of enforcing compliance with common standards in all sectors including the government facilities.

As a result, said one policy maker, 'the government cannot play the game on its own'. Instead, he suggested, the government had to involve private and religious providers' associations in drawing up and enforcing rules and standards 'in a mutual way', and in helping to 'weed out those who are not genuine'. It was hoped that decentralization and the creation of district health boards would encourage such local collaboration in planning and supervision.

Collaborative regulatory intervention can also pursue a number of approaches that do not rely on inspection:

- *Promoting better competition*
  Intervention can aim to improve the outcomes of competition for patients and for good providers in all sectors, and try to ensure that competition works to undermine poor providers.
- *Promoting more collaboration*
  Competition and collaboration are not opposites; collaborative professional and institutional cultures can help markets work in more desirable ways.
- *Promoting negotiation*
  Governments can seek to create negotiated processes that legitimise rules and ensure that incentive structures make sense to providers; such negotiations also shape the government's own regulatory culture.

  All such approaches require the government to accept non-government providers and the general public as regulatory actors, and to see government provider behaviour and the negotiated use of subsidy – rather than just rule-setting – as regulatory tools.

Valuing success in religious and government primary care

Section 4 showed that access for many people was being sustained by the behaviour of some lower level government facilities and by charitable religious facilities. Both were subsidized by government and donor funds; what marked them out was that they used the subsidies well. They provided some elements of a safety net for the poor, but their continued existence was not assured. Regulatory intervention can aim to sustain them by embedding the redistributive 'gift' they provide – something for nothing, or more for less – in a framework of recognition, improved incentives, and greater policy leverage that might also make their subsidy more sustainable.

One approach would be accreditation schemes[22], to provide a well publicized 'label' for facilities that provide cheap, good quality charitable or public provision. Such schemes, if well

[22] Tanzanian policy makers found this a rather unfamiliar idea, though it is occasionally suggested in the health policy literature (for example, Brugha and Zwi, 1998, p.116).

designed, can combine elements of self-regulation, the experience of explicit standard setting, benefits to participants in terms of sustainability, and also elements of beneficial competition, that is, competitive behaviour that is in the interests of patients and in line with regulatory objectives. Such competition can help to keep down prices without price controls (which experience suggests are likely to work badly if imposed), and without trying to create uniformity in a diverse system.

For example, an accredited group of approved, low charging charitable providers (facilities, not owners) would have a number of benefits:

- it could be self-managed, as a group of independent facilities which could set standards and maximum fees, in discussion with government;
- facilities in the group could be eligible for non-profit status in return for low charges;
- they could be required to meet some minimum standards of accountability, in terms of record keeping and accountability to communities;
- such a group could be attractive to donors, providing a further incentive for others to join and assisting sustainability of donations;
- the group and their fees could be publicized so that patients would know what to expect and could compare their provision with that of others;
- the group would provide a policy benchmark for charitable provision; other facilities could use a religious label, but not a 'charitable' one.

Such a scheme might help to sustain donations to the most accessible facilities, and at the same time provide a set of desirable incentives for public education and the expansion of charitable provision. The more users' expectations can be raised, and alternatives to very poor and/or expensive primary provision offered, the better the system for the poor.

In the government sector, some of the same objectives could be pursued through benchmarking schemes that involved local communities in developing and publicizing good practice. Officially sanctioned diversity is increasing in the government sector and can be built upon. The study showed high levels of community reliance on rural dispensaries as facilities of first resort, and offered some evidence that community involvement played a role in sustaining probity. A district could identify a group of rural facilities that were doing well to be a benchmark group. Such facilities could be expected to develop higher levels of community scrutiny and involvement. The label would constitute much needed recognition for probity and good practice, encouraging continuing donor support. Allowing such a group to set small health contributions agreed by communities using the facility regularly would constitute a beneficial incentive to resist bribery in favour of 'home grown' mutual partial pre-payment schemes.

Supporting private cross-subsidy of preventative care

Another redistributive 'gift' in the system that needs sustaining is cross-subsidy of preventative care by private primary providers. As argued above, there was a market logic to this behaviour, but 'long termism' of this sort by financially fragile providers is easily undercut. For-profit providers play an important role in determining quality of urban primary care; they can be reasonable accessible (though not to the poorest), and can also, with the right incentives, be sub-contractors for government-supported services. Regulatory intervention needs to improve sustainability while building on the incentives good quality providers have to prevent poor quality providers undercutting them.

There is an emerging culture of private sector self-organization: one association (APHTA) represents particularly the interests of the private and elite religious hospitals (Kaushik 2000), and one local association brings together smaller independent providers (Mbeya Private Health Care Providers' Forum) (Dyauli 2000). These organizations share information, are developing a role in policy making, and seek to identify opportunities for professional collaboration.

To build on these beginnings a private sector role in undermining bad private primary provision requires a scheme with 'teeth' in the sense of damaging consequences of non-membership. A policy workshop during this project discussed a hypothetical Accredited Private Providers' scheme that would have such teeth: only members of the scheme would be eligible for some financial or in-kind subsidy for preventative care (following a successful scheme in one region), and also eligible to be contractors to new mutual and 'social' health insurance schemes[23]. Donor or government support to market the accreditation 'label' could have beneficial effects in terms of raising the expectations of users, and at the same time be a valuable marketing tool for the individual members. Such a scheme would value good practice and help to ensure good use of scarce subsidies.

If membership also brought duties, including provision of preventative care and negotiated minimum professional and book-keeping standards, and rights of scheme self-management and negotiation on behalf of members, then it could both develop self-regulatory capacity and offer real incentives to eject poor providers. Collaborative behaviour is however generally difficult for private providers in Tanzania's emerging market culture; several private sector workshop participants expressed doubts about willingness to collaborate in this way.

Strengthening legitimate claims: involving the public

Commentary on the role of the public in African health care systems has tended to concentrate on documenting misguided forms of pressure – for example, for injections[24]. However, this study also found other more positive norms of behaviour: active seeking of information and engagement with the market. A Tanzanian policy maker, surprised at the findings, noted the implied opportunity for strengthening public pressure on the system.

However the balance of power at present greatly favours providers. Regulatory intervention needs to build on patients' and households' shared knowledge to strengthen their involvement in shaping the health care system, and at the same time to educate users and re-educate staff[25]. The above proposals included incentives for raising expectations via publicity and involving the public in promoting beneficial competition. Strengthening effective claims also requires some forms of formal organization and involvement, not least to legitimise involvement of non-professionals in health care. Organized action around health care issues, by giving people confidence, is also likely to strengthen informal pressure on the system. The general policy

23 A number of such schemes are being developed; those relevant to urban primary care include the government's planned scheme for civil servants and mutual informal sector initiatives (Kiwara, 2000).

24 Some anthropological research, for example Birungi (1998), provides more comprehending exploration of people's attempts to reduce the risk of using the formal health care system.

25 There is some evidence that on clinical matters shared educational processes involving both staff and users are more effective than one-sided education (Brugha and Zwi, 1998).

proposition is that any moves towards a norm of public scrutiny and involvement are likely to strengthen quality in the system.

Strengthening people's ability to complain implies reducing fear of victimization. Encouraging existing experiences whereby village and community leaders assemble and take up with a facility a consistent set of complaints can help to protect individuals. More formal consumer-type organizations in the health care field are another possibility, particularly in urban areas. A 'consumer' group could campaign for improved care, and take up specific cases where regulations were not observed, thereby lessening the imbalance of power between professionals and patients[26].

The legitimacy of 'lay' participation in managing health care delivery – already emerging – could also be greatly strengthened. Facilities' management boards (including non-governmental facilities) can have community representatives (as some of the cost-sharing schemes already require), larger facilities might have quality assurance committees with community leaders as members. Local processes of consultation on services or fees is another possibility, perhaps via existing organizations and communities such as churches. A local government could have an independent health care scrutiny group, with the right to question managers. There are of course severe resource limitations on what can be done, and the appropriate approach will vary sharply by area. But the basis for a cultural shift towards a norm of public scrutiny and redress already exists.

Embedding exemptions in mutuality

Exemption mechanisms are bedevilled by conflicting incentives and lack of legitimacy (Section 3). Establishing legitimate redistributive 'gifts' of this kind, theory and evidence from elsewhere suggest[27], implies separation of exemption mechanisms from the incentive to charge fees, better information on who is able to pay within a society where extreme poverty takes diverse forms, more legitimacy in decision making, and clear principles on who should pay and why. The implication is that exemption schemes require collaboration between communities, facilities and, for very impoverished communities, external funding.

Some community level and informal sector health insurance schemes underway in Tanzania seem promising in terms of these criteria. Some community health fund schemes provide exemptions (Kiwara, 2000) and those decisions are separated from the facility management's incentives to make the facility 'pay'. The legitimacy of the decision making is increased by the extent of local information, by its public nature, and by the fact that the cost is borne by those making the decision. Current schemes typically require a flat fee, hence are regressive in funding terms, but may make health care access more manageable for the non-indigent poor by cheapening it and making costs predictable. Subsidies to schemes for very low income communities can be linked to the maintenance of an exemption mechanism, improving incentives for cross-subsidy. Embedding redistributive obligations within schemes of broad community benefit – and valuing the fulfilment of those obligations – appears to be a route to sustainability.

[26] India has recently strengthened consumer rights in health care.

[27] Mackintosh and Gilson (forthcoming) summarize evidence on exemption scheme failures and successes.

Attacking perverse incentives within facilities

Regulatory intervention should seek to 'economise on benevolence'[28] as well as value and support it, and there are incentive problems within facilities that create access and quality problems, and that could be mitigated by learning from local good practice. Two such problems concern over-prescribing and the conditions of service of nurses (see Section 3 above).

The 'dispensary' format creates problematic incentives in a fee-for-service system, especially where clinical staff who do not feel a long-term commitment to the facility and its patients both prescribe and take the money. We found this management structure generating overcharging and apparent over-prescribing in one large religious dispensary. Conversely, a different religious facility had a salaried doctor and a separate dispenser/ cashier; the two appeared, from our observation, actively to try to keep down costs for patients within the facility price structure. Management training concerning organizational structure could thus substantially improve charging and prescribing behaviour from the patients' point of view.

Another major set of problems centres around nurses, working conditions and pay, and the interaction of those with nurses' behaviour to patients (see Section 3 above). Nurses are by no means the only group about whom patients complain nor the only group with poor working conditions, but the nurse/ patient relationship is central to patients' experience of care or its absence. There is an evident problem of nurses' motivation and self-confidence. Interviews in government hospitals suggest that, while low pay is a serious problem, aspects of working conditions are also highly demotivating, including the loss of allowances, dangerous working conditions, doctors frequently absent from hospitals, a feeling that their work is not valued, and difficulty of access to training and career progression. The better functioning institutions in all three sectors had addressed some of this latter set of problems, seeking to provide nurses (and other staff) with access to benefits such as loans, providing responsibility within settings where there is also supervision, and making staff feel both valued and expected to behave well. The successes illustrate the important of recognition, support and the capacity to do a job well in motivating staff in turn to treat patients with respect.

Blurring the boundaries: extracting cross-subsidy

Section 1 noted the turning away from cross-subsidy within the dominant policy framework, and Section 3 the tendencies to social and economic polarization emerging in the health care system. Such polarization, likely to be exacerbated by the history of mutual mistrust between government and private sectors in Tanzania referred to by many interviewees, can reduce redistributive commitment and make future reintegration at higher income levels very difficult.[29]

The alternative approach is deliberately to try to reduce polarization, seeking instead to increase cross-subsidy of the poor and to keep the independent providers at all levels committed to expanding access to competent care. Blurring the boundaries between sectors has some potential benefits for all parties: it increases mutual understanding; it makes experiment easier; it allows the cultures of different sectors to influence each other, potentially allowing desirable cultures to help to break bad ones; it allows more efficient sharing of scarce resources; it

[28] The phrase is from James Meade, see Atkinson (1993).

[29] Health economists writing on Latin America, faced with very polarised systems in much of the subcontinent, are particularly eloquent on this last point (see Londono and Frenk 1997)

reduces stigmatizing of the government sector; and it allows independent providers access to government resources.

The suggestions here focus on the scope for mutually beneficial agreements with élite health care institutions, that is the government referral hospitals and the non-government hospitals that charge high fees. The latter often have non-profit status. These élite hospitals are important to the health care system as a whole because they are training institutions; because (partly in consequence) they influence the culture of the system as a whole; and because they possess needed skills and equipment and are advisory and supervisory facilities. They can be drawn into contributing more effectively rather than 'floating off' further from the system; again, the ideas build on existing successes.

One option is intra-mural private practice in the government or charitable hospitals. It is not easy to extract cross-subsidy from this, and we encountered one charitable religious hospital that was finding it difficult, but there are successful experiments in Tanzania. Opportunities for private income can help to retain good staff, help to sustain a culture of high quality care, and can, if well managed and well used, generate income for the facility, helping to ensure that lower paying patients also have access to equipment and specialists. The professional standing offered by a referral hospital post, and the teaching role that comes with it, is sought-after, and can reasonably be conferred in return for an expectation of commitment to lower income patients. Having a private wing run by a joint venture partner with explicit cross-subsidy targets can also help to ensure benefits to government wards.

Conversely, expensive hospitals with non-profit status can reasonably be asked for explicit contributions to the capacity, quality and inclusiveness of the health care system as a whole in return for that status. Illustrative contractual commitments might include an expanded contribution to training doctors and other clinical staff, including support of trainees and collaboration with other institutions; allowing other institutions access to scarce equipment at low prices; exchanging staff with other institutions to assist with updating skills, including management skills; and providing specified services to patients referred from government hospitals at lower cost. Some experiments along these lines are emerging.

A more unusual suggestion would be the provision of public wards in private hospitals. These might be government-supported units with access by patients on official government terms, established through a contract between the institution and the government that included a commitment to partial cross-subsidy of the units by the institution in return for non-profit status. We should add however that of all our suggestions, this was regarded by policy makers as the least plausible!

More generally, creative negotiating can create more efficient use of scarce resources through cross-boundary collaboration. Successful private practice pays doctors better than government service, but government service can still offer professional standing, greater security, skills updating, and access to resources and professional colleagues, while private practice can also be lonely and unstable. The government sector – which has trained most doctors – also needs to retain them. If joint working across sector boundaries is maintained, there is scope for effective mutually beneficial agreement on contracts. Similarly, joint equipment purchase and maintenance schemes between institutions would undermine informal charging by technicians,

improve maintenance, increase practical collaboration within the system, and increase access. And co-supervisory relations among groups of facilities across sector boundaries could help to sustain a culture of professional reflection on provision, and are actively being considered in some districts.

6. Conclusion: sustainable redistribution by design

The distributive behaviour of a health care system depends on the social, economic and cultural institutions of the system: its norms of behaviour, its levels of public scrutiny, the scope it offers for middle class retreat to a protected segment. The study on which this paper is based supports other research on reformed African health care systems that conclude they are generating 'sustainable inequity' (Nyonator and Kutzin, 1999) and lack a strategy for including the poor (Stierle *et al*., 1999, Fabricant *et al*., 1999). This paper has argued that tackling the problem involves rethinking both analysis of, and policy mechanisms within, mixed health care systems.

Rethinking analysis implies investigating mixed market-based health care systems as diverse institutional arenas, in which responses to market incentives are strongly shaped by culture, norms of behaviour and feedback between expectations and experience, and in turn shape market evolution. Rethinking policy implies formulating policy processes – we have called them collaborative regulatory interventions – that can pull the system as a whole towards greater inclusiveness and better quality, particularly at the lower end. All this is quite distinct from the alternative vision of a largely unregulated market supplemented by tightly 'targeted' government action, and it mirrors recent pleas for less 'technical' policy responses to social injustice[30].

We have sought to be extremely specific about the scope for and nature of such 'redistribution by design' in the current Tanzanian context, arguing that it must build on existing institutional probity and effectiveness. We argue that the gift relationships implicit in redistribution are fragile, but can be made more sustainable by embedding them in broader reciprocal processes and shared understanding of legitimate claims. The interventions proposed aim to shape government sector behaviour as well as that of non-government providers (the categories overlap since some people work in both), treating government facilities as regulatory actors open to scrutiny and challenge. None of these proposals offers a 'fix' to bring the poorest into the system. Rather, we have argued that only a movement towards inclusiveness, and away from social polarization, exclusion and abuse can (though accepting continuing inequality), construct the basis for continuing redistributive action.

[30] This is developing theme in policy debate; see Stierle *et al*., (1999) for a health care example, or the papers for a recent UNRISD conference on Technocratic Policy Making and Democratization (Geneva April 2000).

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