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Non-market relationships in health care

Maureen Mackintosh and Lucy Gilson
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Maureen Mackintosh* & Lucy Gilson**
1 Introduction

This paper investigates non-market behaviour, and the non-market relationships that shape that behaviour, in health care. The central concern of the paper is with the implications of non-market behaviour for (in)equity and (lack of) access by the poor. We began the literature review on which the paper is based with the hypothesis that non-market relationships are crucial to the capacity of a health care system to operate redistributively, as well as to the quality of the care provided. We had in mind the role in health system functioning of such non-market mechanisms as the allocation of tax funding among institutions and between categories of health care spending; and of non-market relationships such as those between health care staff and patients who are not paying at the point of obtaining care, or between health care professionals in referral processes.

The literature review concentrated on Africa, Asia and (to a lesser extent) Latin America, and on formal health care systems, including health-seeking behaviour as it shapes responses to formal health care systems. Given the context of health care reform and liberalisation, our concerns run, inevitably and deliberately, against the grain of the current policy literature. We were however interested in evidence that non-market relationships may shape market processes, as well as being shaped by them. On some topics on which we expected to concentrate - such as the non-market relationships sustaining effective referral systems - we have found virtually no relevant evidence.

The paper begins by explaining our conceptual categories of non-market behaviour both in terms of the theoretical literature from anthropology and institutional economics and also in relation to the evidence from health care. We briefly discuss the relation between our categories and those in the background working paper for this workshop (Heyer et al. 1999). We then select five topics from the health care literature for which non-market behaviour appears to be central and for which relevant evidence is available. For most topics, we proceed by showing that the policy literature makes some strong - but often unexplored - assumptions about non-market behaviour, which are frequently unsupported by what evidence is available concerning practice. We show that much policy research moves rapidly from stated (or externally desired) policy objectives to an - often negative - comparison of objectives with outcomes, paying little attention to institutional practices that may explain observed outcomes.

For each topic, we illustrate our argument with particular cases or aspects of the research literature. We examine behaviour under each topic using the conceptual categories of behaviour outlined in Section 2, and seek to move from categories towards more developed arguments about non-market relationships and the norms, experiences and shared meanings that sustain them. We start in Section 3 with a topic that is well researched and illustrates many of the paper's themes: the widespread failure of exemption policies to protect those too poor to pay user fees in (particularly) African health care systems. Sections 4-6 examine: the allocation of tax funding, concentrating on evidence from India; social and mutual health insurance, drawing mainly on African

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1 This paper was prepared for a workshop on Group Behaviour and Development held at the World Institute for Development Economics Research (WIDER) in Helsinki. September 1999. It is to be published in a substantially revised form. Comments welcome. A background paper for the workshop is Heyer et al. 1999.
and East Asian evidence; and community management and participation, using mainly African evidence. Section 7 considers some case studies of health seeking behaviour, concentrating on relations between patients and health care systems.

The main objective of the paper is conceptual: to improve analysis of non-market relationships both in formal health care systems and in more informal processes, in order to assist health care policy. Section 8 therefore aims to draw out of the earlier sections an argument for reconceptualising health care policy, through a shift in its frame of reference towards a recognition of non-market behaviour in health care systems, and of the norms and relationships that shape it.

2 Non-market behaviour in health care: analytical categories

The three main categories of non-market behaviour used in this paper have been drawn from institutional economics and anthropology, and to a much lesser extent from the political science literature's engagement with the exercise of power. They were reworked for our purposes as we attempted to classify the types of behaviour discussed in the health care literature in ways that seemed rooted in identifiable social relationships.

Categories of non-market behaviour

1) Non-market exchange

The literature review looked for examples of non-monetised or non-commoditised exchange, defined negatively as reciprocity not taking the form of exchanges of goods and services for cash. We are interested in these forms of exchange both in contexts where there is also market exchange - to see how non-market relationships shape or are shaped by marketisation - and outside of market contexts. Examples vary from trading of votes for non-market favours, through participation in reciprocal savings schemes to pay health care fees, to participation in reciprocal kin-based networks of home care for those who fall ill.

We classify these non-monetised exchanges into three main categories, illustrated by the examples just given: individualised something-for-something barter; contributions to the creation of a common pool resource in return for access to it; and contributions to looser networks of generalised reciprocity. The categories draw on the debates around gift exchange in the anthropology literature that look back to Mauss (1924). Part of the definition of 'gift' exchange in this literature is the close association of the nature of the gift with the giver and receiver's social location: gifts, in one strand of thought, are inalienable - they remain also with the giver, and create social relations of dependence and obligation - in contrast to alienable commodities (Gregory 1982). Anthropologists have been moving away from this sharp distinction between 'gifts' and 'commodities', towards more complex categories of non-monetised exchange including barter, but retain the emphasis on the process of non-market exchange as shaping social relations among transactors (Humphreys and Hugh Jones 1992).

2) The exercise of unequal power

Our second broad category is the set of types of behaviour classifiable as the exercise of unequal power. The category is particularly relevant to the allocation of tax revenues.
both at national and local level, and we look briefly at some categories from political science concerning non-market competition for tax resources.

Also into this broad category fall examples of the exercise of power within narrower institutional settings: for example, imbalances of power and standing among professional groups, among institutions, or between staff and patients, and its consequence for resource allocation. Attempts to construct countervailing power, for example on behalf of patients, or to undermine existing patterns of unequal allocation on the basis of privilege, require attention to these relationships. We argue that in the health care policy literature the focus on equity as an objective can obscure the exercise of power as a practice.

3) Duty, commitment and 'free gifts'

The sociological literature contains a second concept of the 'gift': the common parlance idea of the 'free gift'. Carrier (1995) calls this concept of gifts, 'gratuitous favours': formal expressions of love and thanks, and acknowledgement of relationships, but socially framed as not reciprocated. There are analogous forms of behaviour understood by health care participants and recipients as motivated by duty or ethical commitment outside of any process of reciprocity. Ethical resistance to material incentives to cheat falls within this category, as does the following of professional rules of conduct for their own sake, and behaviour based in political and ideological commitment. So do norms and systems that operate to extract unreciprocated contributions from the poor.

This category captures the construction of redistribution, in much of the prescriptive health policy literature, as a duty of health care systems and their participants. The policy literature criticises redistributive failure, while paying too little attention to the relationships that can sustain redistributive commitment or make it difficult. Our third category of behaviour is thus designed to include the full range of unreciprocated contributions to health care outcomes, whether they take the form of 'free gifts' from the rich to poor or vice versa. We argue that ethical commitments to others are both important and fragile. 'Free gifts' are hard to sustain on the basis of ethical commitment alone, and are robust only when embedded in other non-market relationships.

Transactional and non-transactional behaviour

Some 'free gifts' are thus forced: understood as given against one's will for no return. This is one example of large number of interactions discussed below between our three categories of market behaviour. Our aim is to move from categorisation to explanation of the ways in which non-market behaviour in health care develops and persists, and we do this in two ways: by examining the relationships that frame the behaviour, and by exploring the norms and the shared or conflicting meanings that shape both relationships and practices.

It follows from this approach that we do not analyse all behaviour of interest to health policy makers as transactional. We are not, that is, imposing a metaphor of exchange upon our evidence. In this, we part company with much economic analysis of non-market

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2 The concept of the metaphor of exchange and its appropriateness as a framework of analysis in the health and social care fields is discussed in Mackintosh (forthcoming a).
institutional relationships that rewrites all relationships among professional colleagues, or between employer and employee, or between nurse and patient, as either monetary or 'gift' exchange. Indeed, such work treats the transactional metaphor as its core explanation of behaviour. Offer (1997), in an interesting recent example, puts forward a broad concept of an 'economy of regard' that would explain behaviour such as ethical professional resistance to perverse material incentives through the need of professionals to sustain the regard of peers.

Almost any human behaviour patterns of the type considered here can be studied through a transactional lens. But to do so also has costs: notably, it tends to elide transactions and non-transactional behaviour as empirical categories, and it imposes a strongly individualist framework of explanation. We have chosen instead to treat non-market exchange as one among several empirical categories for investigation, not as the fundamental analytical category driving the argument.

Given this, our explanatory framework is not a wholly individualist one. We treat norms and established patterns of behaviour as having explanatory power, not as necessarily requiring explanation from individualist premises. Hilary Standing (1992: 476) argues that the particular value of anthropological accounts in health care lies in their stress on 'understanding the meanings attached to behaviour', and 'the importance of contextualising social practices as part of the wider ... environment'. We have drawn on the anthropological literature in seeking to understand the role of culture and meanings in the social construction of health care systems.

By 'meanings' we refer to the social understandings that shape health care behaviour and experience: examples in the paper are the competing meanings given to certain forms of treatment - such as injections - or shared understandings of the legitimacy of certain forms of power, such as that emanating from political position or caste. 'Meanings' is thus a concept at the discursive level, a discursive building block of all three of our types of non-market behaviour. We do not define our conceptual categories on discursive evidence alone (i.e. what people think or say they are doing), but we do regard discursive constructions as highly relevant to the analysis.

By contrast, we understand 'norms', not simply as shared ideas of what 'should' happen, but as institutions in Mary Douglas' sense (Douglas 1987): taken-for-granted patterns of thought and activity, shaped by feedback between ideas and experience. We analyse health care systems as composed of institutions in this sense: of forms of taken-for-granted behaviour understood by the participants in context.

3We are in good company: while economists tend to have trouble with ethical commitment, for example, as anything other than an individual preference for altruism, sociologists do not. Titmuss, in his famous study of blood donoring, treats altruism not as simply an individual choice but as a norm that can be fostered, an aspect of social integration, arguing that health care systems can allow, 'the "theme of the gift" - of generosity towards strangers - to spread among social groups and generations.' (Titmuss 1970: 225)

4The paper takes, in effect, a social constructionist approach to health care systems, since it treats discursive understandings and social relationships as actively creating the system. There is a growing literature on European health care and social policy written from this perspective (for example, Hughes and Lewis 1998, Williams 1989); an example of field research on the discursive aspects of social (re)construction in health and social care is Mackintosh (forthcoming b).
3 Institution-level exemptions from fees

We begin with this rather apparently rather narrow topic because it illustrates sharply a number of our arguments. In Africa and elsewhere, health sector reforms have brought systems of formal charges - user fees or the 'Bamako Initiative' (BI) systems of revolving drugs funds - to both primary and secondary levels of public health care. Since fees without adequate provision for exemptions will ‘in almost all cases worsen the well-being of the poor’ (Reddy and Vandemoortele 1996 : 78), efforts have been made to install mechanisms of exempting the poor from fees. Exemption mechanisms may also seek to generate health gains for the wider community by encouraging use of specific services which have public health value.

Objectives and outcomes

Institution-level exemption mechanisms are construed in the health policy literature at present as pure redistribution: in our terms, a form of non-market gift in the unreciprocated ‘free gift’ sense. Institutions charging fees may be required to provide some care free, or at a reduced charge. Mechanisms may focus on the primary care level, or on specific services (preventive services, or curative services with a public health focus such as the treatment of TB or STDs). The criteria determining eligibility for exemption may take the form of direct targeting (based on income levels); characteristic targeting (based on characteristics of users or service provided); geographic targeting; and self-targeting (Newbrander et al. 1997).

A rather different mechanism is illustrated by Thailand’s low income card, entitling those falling below an income threshold to free care at primary care facilities, and referral free of charge when necessary (Gilson et al. 1998). More informal institutional mechanisms include deferred payment, or payment by a provider in the hope of repayment by the patient at a later date (Gilson et al. 1999). Occasionally, free care may be supported by funding from an alternative mechanism such as a special ‘solidarity fund’ (Gilson et al. 1999).

The evaluation literature judges the effectiveness of such mechanisms by the extent of under-coverage of the eligible poor and ‘leakage’ to the non-poor (Willis 1993, Gilson et al. 1995, Newbrander et al. 1997). Evidence is sparse, and on ‘solidarity’ funds and informal mechanisms almost non-existent. Five country studies found that the specific targeting mechanisms in place were relatively successful in preventing leakage but much less successful in minimising under-coverage (Newbrander et al. 1997). In Kenya, for example, 100% of the directly targeted exemptions granted in mainstream health facilities on the day of the survey went to the poor, but not all of the eligible obtained exemptions (or used the public health system), whilst two-thirds of the recipients of exemptions targeted on characteristics were not poor. In contrast, small-scale case studies of ‘community pharmacies’, the Kenyan version of the Bamako Initiative, suggested that very few of the poorest within the communities studied had received exemptions; and similar findings were identified for primary health care facilities in Benin supported by BI activities (Gilson et al. 1999).

5 An international postal questionnaire survey of policy-makers in 36 countries identified only five countries where evaluations had been undertaken, on the basis only of measuring the proportion of patients exempted (Russell and Gilson 1997).
Perhaps the most detailed information on exemption effectiveness is available for Thailand. Coverage of the target group appears to have improved over the low income card scheme's lifetime to around 80% in the 1990s. However, poorer regions suffered lower coverage levels than more wealthy regions, and there was signs of continuing 'leakage' to the non-poor (Gilson et al. 1998). Further evaluation of exemptions experience has been identified (e.g. by WHO Oslo meeting 1997) as important for an 'equity-oriented' health reform research agenda.

Frustratingly, however, efforts to explain exemption effectiveness or its lack are almost non-existent. The linear policy-to-implementation framework of research obscures the problem of how institution-level exemption practices are shaped, and how institutional commitment to exemption as a goal can be created and sustained. Outside the public sector, some humanitarian and religious organisations have implemented solidarity mechanisms (Gilson et al. 1999), but there is also little research on where and why these are effective. Two sets of evidence can however be extracted relevant to this paper.

Non-market behaviour: exemption practices

The influence on behaviour of administrative norms and incentives

Health sector reforms typically move the responsibility for implementing exemptions to the facility level. A common experience is then that the administrative regulations established to guide exemption practice work to undermine the giving of exemptions.

First, there is evidence from a variety of settings that introducing exemptions within user fee schemes that have raising revenue as their primary goal creates a contradiction that undermines exemption practice. Financial sustainability has usually been established as the pre-eminent goal in such schemes - linked to the use of revenue to purchase drugs, and even pay for staff bonuses. This turns exemptions into a 'free gift' that health workers and community members are deterred from giving, since it will reduce overall revenue levels, reduce perceived quality, and even limit personal gains (Gilson et al. 1999; Newbrander et al. 1997). It follows that an important advantage of solidarity mechanisms over institutional exemptions is that whilst the individual does not pay, the institution does receive payment. The decision to exempt is thus divorced from the goal of revenue generation, reducing the conflict of goals and incentives.

Second, in the face of the competing goal of revenue generation, the vagueness of the guidance on who should receive protection may further undermine the weight given to equity considerations in decision-making. For example, it is commonly said that the 'indigent' should receive protection, but how does a health worker determine who is indigent? Lack of adequate knowledge of household income levels may lead to personalised decision-making not linked to eligibility criteria (Gilson et al. 1999; Newbrander et al. 1997). Lack of information may also discourage potential beneficiaries from applying: they simply do not know they are eligible (Newbrander et al. 1997). The Thai low income care scheme faced both of these problems. Its high coverage levels seem to result from clear income thresholds, wide dissemination of information about the income criteria, and community-based decision-making done by a combination of health workers and community leaders (Gilson et al. 1998).
Third, hierarchical top-down health care decision making persists through health sector reform. User fee systems are generally associated in principle with some form of decentralised decision-making over protection mechanisms, but the extent to which this transfers power downwards is sharply limited in practice. For example, in the BI schemes in Benin and Kenya, the clear but strict guidelines on price levels given to local decision-makers deterred them from adapting price levels in ways that would protect vulnerable groups (Gilson et al. 1999).

In contrast, again, the Thai scheme has been flexible, allowing learning from experience, and revising implementation procedures over time. Guidelines on who should make decisions locally have been adapted to balance health workers and local leaders, to try and limit the influence of either group, whilst new ways of identifying the eligible groups have been introduced in response to problems with specific income criteria. The evolution of the guidelines in response to experience has allowed continued improvements in effectiveness (Gilson et al. 1998).

The influence of power and hierarchy over behaviour

The mainstream theoretical framework of evaluation classifies all exemptions for the non-eligible as 'leakage'. But they may be better understood as emerging from competing rules and norms, from competing objectives, and from negotiation among unequal groups.

Those with status, prestige and power within communities are frequently offered protection because of who they are, or because they can exercise power over local decision-makers. Governments sometimes institutionalise this, by naming advantaged groups such as civil servants as eligible (Gilson et al. 1995; Russell and Gilson 1997). Sometimes it results from more informal pressures and practices at local level (Gilson et al. 1995). There is remarkably little research on how such conflict between the exercise of power and equity-driven administrative rules is generated and dealt with in specific situations.

Some insight is offered from investigation of the Thai low income card experience (Gilson et al. 1998). Despite clear income criteria for eligibility, the non-poor benefited in several case study communities, including relatives of village leaders, those with close connections to village leaders and those held in high regard within the community. This was seen by some to be acceptable practice because it embodied some reciprocity between the community and its leaders:

'this is a helping each other way'

and

'this is a way to express our gratitude to them. Without their support, our centre would be in problems ... Don't you know that granting a card to those people could mean to make them proud and honoured?'

(Gilson et al. 1999: 41-2).

6 There are examples in Tibandebage and Mackintosh (1999), another paper for the WIDER workshop.
Lack of take-up by the eligible poor (under-coverage) in Thailand appeared to reflect four key factors:

- past poor experience – particularly the receipt of what is perceived as poor quality care and of being made to pay by health workers even when holding a card;
- discrimination by decision-makers:
  
  'They [the village health committee] do not like us. They blame us for not working hard to earn our living ... yes they think we are lazy ... I wonder that they might dislike us because we are so poor'
  (Gilson et al. 1998: 42);
- an acceptance of discrimination because to show hurt or anger would be inappropriate or impolite:
  
  'Let's put it this way. If I deserve a card they will give me one, for sure'
  (Gilson et al. 1998: 42);
- the general marginalisation of the poorest, making it difficult to reach them with information or encourage them to apply for the card because they live in more distant parts of communities and cannot afford to take time off work.

The marginalisation of the poorest also influenced exemption practice within Bamako Initiative schemes in Benin and Kenya. By not being present in key decision-making fora, their needs were sometimes just not considered. The obstacles to this group’s involvement in decision-making included not having the skills (such as literacy) to be chosen for membership and not knowing about meetings and so not attending (Gilson et al. 1999).

Finally, there are some elements of 'accepted wisdom' within communities that may undermine exemption practice. These include the perception that prices are affordable, perhaps because the situation of the poorest is not adequately considered (Gilson et al. 1999). The fear that the benefits will be captured by those who are not eligible may also limit the number of exemptions offered (Gilson et al. 1997) or prevent information about the system being made available (Newbrander et al. 1997).

The health policy mindset on exemptions thus envisages institutions offering 'free gifts' to poor would-be patients. The evidence tells a more complex story of competing norms and of the use of power for both benevolent and self-serving ends. Section 8 returns to this topic to consider how a better understanding of non-market behaviour might help sustain benevolence in socially divided societies.
4 Tax funding allocation

Non-market economic decisions on the allocation of tax funding have a large influence on health care systems. The public sector in virtually all countries provides a substantial element of the health care available, and public funding contributes subsidy to other non-governmental elements of the system. World Bank data (World Bank 1999: 203) show low and middle income countries' public spending on health care at 0.9% and 3% of GDP on average for 1990-5. Furthermore, overseas official aid - bilateral and multilateral governmental aid - contributes substantial health care funding subject to different political pressures from local tax funding.

Objectives and outcomes

The tax allocation literature shares with the exemption literature a prescriptive emphasis: efficient allocation and redistribution as a matter of political (and administrative) commitment. Two themes dominate the literature: allocation should be guided by estimated impact on the burden of disease, and should be redistributed towards primary care (a recent example is Gertler 1998). Actual tax funding patterns - in so far as we have details for lower income countries - contrast sharply, it is claimed, with these prescriptions, yet there is a shortage of ethnographic and sociological studies of how tax allocation decisions are taken.

Perhaps the most persistent World Bank criticism of domestic tax allocation is of over-allocation to secondary and more generally to curative care (World Bank 1990 :76-7, 1993 : 65-6, 1997, see also 1995, 1996 for regional arguments; see also Barnum and Kutzin 1993, Gertler 1998). The World Bank's emphasis on a 'minimum package' of benefits, concentration of funds on primary care and privatisation of secondary care are all responses to this perceived chronic problem. Since hospital use is skewed (though not as completely as the policy discussion some times suggests) to the better off, this also implies over-allocation to the middle classes (Gertler 1998)7.

Disproportionate benefits to the better off also arise from health care subsidies to public employees. In India in the early 1990s, 15% of central state health care spending was allocated to the Central Government Health Scheme for public employees (World Bank 1995 :27). In Sub-Saharan countries, a survey in the 1980s showed that all governments surveyed funded health care treatment for government employees (cited in Huff-Rouselle and Akuamoah-Boateng 1998).

Another common theme is that under fiscal pressure, governments have tended to give health care staffing priority over supplies and maintenance, 'hollowing out' health care provision. In India in the 1980s, states continued rapidly to expand real public spending on health care staff, while spending on drugs, operating costs and maintenance grew much more slowly, so that by 1991 staffing costs took up 70%-80% of state health care budgets (World Bank 1995: 22-5). The same phenomenon is visible in many African countries, and has been one driving force behind user fee schemes and Bamako Initiative policies for revolving drugs funds (Lafond 1995: 50-51, Gilson and Mills 1995).

7Satia and Deodar (1993) qualify this argument for India, noting that the medical college hospitals serve as general hospitals for the poor as well as specialist hospitals for the middle classes.
The tax allocation literature, finally, documents great variability of commitment by
governments of resources to public sector health care. Among low income countries, the
largest and the most effective commitments before the 1980s were in communist
countries, notably China and Cuba, and by left-wing state and central governments, such
as Kerala in India and Sri Lanka. Liberalisation has sharply reduced public spending on
health care in China (Liu et al 1998). Variability of commitment is considerable among
long standing market-economy developing countries, but is poorly explained by existing
research. In many, the public health care system has largely collapsed since the early
1980s. Dreze and Sen (1995) say for example of India that in some states the public
health care system 'is little more than a collection of deserted primary health centres,
filthy dispensaries, unmotivated doctors and chaotic hospitals' (p.101) Taiwan, at the
other extreme, has been able to build a commitment to an expanding public sector, and
heavy progressive public subsidy for universal health insurance, including 100% coverage
for the poor (Chiang 1995).

Non-market behaviour in allocation decisions

Behavioural explanations of these allocative outcomes, supported by research, are much
less readily available than instructions for reform. Evidence on non-market behaviour
can be classified into the political exercise of power (with commitment to self or others);
the exercise of power through institutional hierarchy; and political barter systems. Much
of the evidence in this section is drawn from India, for which there is historical work on
health care tax funding, plus some African comparisons.

The political exercise of power

There seem to be three categories of such behaviour: group self-allocation of resources by
elites; the effects of competing political power-bases - within and outside the country - on
allocation; and the use of power in the service of a redistributive commitment.

Within health care the most frequently criticised form of self-allocation of resources by
elites arises from the influence of doctors with particular medical and career interests.
Jeffrey's (1998) study of the politics of health finance in India documents this argument in
critical Indian commentary as well as the international literature. Doctors, trained in and
influenced by elitist and, in the colonial period, racially inequitable, curative services, and
faced with the associated material and professional incentives to pursue urban specialist
medical careers, exerted professional influence over tax allocation. This operated through
professional advisory processes, for example the expert groups' role in Indian Plan
preparation (Jeffrey 1988 :150). India, like many other low income countries' governments,
subsidises the private health sector by training doctors and other health personnel (Duggal and
Antia 1993), and funding for medical education appears an area where professional lobbying is effective. Like the funding of civil servants' (and parliamentary members') health care (noted above), these allocational behaviours constitute the exercise of power in group interests (though in the case of medical training the resource created has some public good qualities).

In practice, however, Jeffrey argues that while the Indian Health Ministry views were
-dominated, in the period he studied, by urban medical interests, they were faced in the

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8 A gap in the literature review to date is health care tax funding allocation in Latin America.
Planning Commission with economists and administrators who were more pro-rural, responding to the political coalitions influential at national level. Furthermore, publicly financed health care appears not a powerful interest of the dominant elites, which may be partly because of the predominance of private spending in total health care spending in India (Berman 1998). These competing political interests reduced the leverage of the relatively weak Indian Medical Association, and may help to explain the allocative behaviour which allowed the share of health care in Indian public spending to fall steadily in the 1970s (Jeffrey 1988: 166, 168, 182).

Competing political interests and power bases are also evident in central-local political dynamics around health care funding allocation. In India, health care is constitutionally predominantly a state matter. This has influenced allocative behaviour in a number of ways. It has focussed central state intervention on vertical programmes (World Bank 1995:28-9), often requiring state matching funding and hence has squeezed out some of state politicians' priorities. Narayana (1999) argues that the 'hollowing out' effect in Kerala was shaped by a central state legal commitment to the finance of medical education, faced, in Kerala, with a local political process that excluded closing health centres. The commitment to universal access translated, under the fiscal squeeze in the 1980s, into paying staff to run institutions with few supplies, sacrificing quality.

Central-local conflicts are also constraining the donor-driven move to fiscal decentralisation in Africa. A stated aim of decentralisation is to change allocation patterns, helped by central determination of service norms and basic packages of services, and formulae that shift tax resources towards poorer areas. However, in Uganda, for example, continuing central control of hospital funding is constraining reallocation, while in Kenya and Uganda, resource allocation formulae continue to privilege better off areas. Some donors have a preference for hospital building. Vertical programmes are being defended both by managers and donors, blocking local health care integration (Gilson and Travis 1998:11, 21). Inter-donor collaboration in sector-wide programmes (SWAPs) tries to tackle conflict, by is also driven by a desire to impose external allocational preferences on national governments (Buse and Walt 1996).

Finally, political commitment and ideology in favour of redistribution does influence health care tax allocation behaviour, especially when associated with active popular pressure. West Bengal (World Bank 1995:95-100) and Kerala continue to have better targeted provision of free beds in public health care facilities than other Indian states. In Kerala, collective political organisating to keep health care facilities open is long standing (Sen 1992), and the high proportion of state public spending devoted to social sectors (40% in Kerala 1974-90 as compared to the Indian average of 32%) is rooted in open elections won on support for social provision including health care (Narayana 1999), while in the large northern states with the worst health care record, the issues do not figure in party programmes and electoral politics is overwhelmingly dominated by elite concerns (Dreze and Sen 1995: 103). One can thus document the exercise of legitimate political power for redistributive ends.

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9 An African example is the South African government of National Unity's commitment to redistributive reallocation of tax resources in health care.
Barter

Jeffrey (1988:170) argues that state level allocation of resources in public health care in India appears to respond quite strongly to individual politicians' ability to exert pressure on behalf of constituents, for example in the siting of a primary health care centre. He describes local detailed health care resource allocation decision making as highly personalised, including allocation of personnel and drugs supply. In a context of grossly inadequate resources, local politicians exert personal pressure to get treatment in hospitals for particular individuals; to get particularly professionals allocated to certain posts; or to get particular people into medical schools. Doctors and administrators who do not comply can be penalised in personal and professional terms (1988:172).

Non-market allocative relations in this case are explicitly reciprocal, 'barter' relations of a personalised kind, between politicians and others. The currency of exchange may be political allegiance, return favours - or cash; it may be immediate reciprocity, or a debt to be returned as a later favour (Jeffrey 1988: 173). The exchange also affects staff-patient relations: some patients can influence careers. Jeffrey argues that this personalised decision making, unlike collective action, does not generally work to sustain the quality of care.

Administrative power and hierarchy

Two impacts of administrative hierarchy on allocation behaviour are noted in the Indian case studies. One is the professional hierarchy in health care, that reduces nurses' and primary care workers' capacity to attract public funding. For example, Jeffrey (1988: 236) suggests that the tendency for nurses to be recruited the disadvantaged classes, and the 'polluting' connotations of their work, has undermined the professions' ability to lobby for pay and status: with consequences for the funding of particularly maternal and child health.

Jeffrey also draws on studies of rural health workers to investigate institutional level allocation behaviour by health care workers. He found that monitoring in the period he was studying was highly focussed on vertical programmes, especially family planning. Workers in the 1970s were being monitored on 'sterilisation achievements', which biased their work and undermined their relationships with villagers. (p.273) The continuing dominance of the family planning agenda is confirmed by a range of studies surveyed by Dreze and Sen (1995 p.102). Workers' supervision was highly top-down and perceived as a channel for political influence on careers. Relations with patients, furthermore, were personalised, and focused on curative care, and the quality of the care for the better off was generally better; such clients frequently paid inducements. Finally, staff were frequently absent (Dreze and Sen: 266-73).

Duggal and Antia (1993) confirmed that primary health centre staff focus on family planning and immunisations, both central government priorities, and that as a result the centres 'lost their credibility as health care institutions'. Their curative capacity is therefore underutilised; people go to private practitioners and government hospitals (ibid: 58). This Indian evidence underlines both the dangers and the scope for change represented by monitoring and rule setting.
Categorising allocative behaviour

Policy towards tax allocation needs to be based on a theory and evidence about how behaviour works to create allocations in practice. The categories used here have some overlap with the political science literature. Reich (1995), for example, divides theories in the political literature into three: behaviour as influenced by 'political will', by 'political factions', and by 'political survival'. These echo the commitment, political power-bases, and barter relations above. Section 8 returns to the policy implications of introducing concepts of reciprocity into the analysis of allocation behaviour.

5 Social insurance and mutual risk pooling

'Social insurance' is a term used with a variety of meanings. The classic cases are European national schemes that - while institutionally very diverse - share the characteristics of being compulsory and having finance related in some way to ability to pay. In a health care and development context, the term 'social insurance' usually refers to formal sector, payroll-based schemes, financed by employers with or without an employee contribution. There are also more and less formal community- and sector-based mutual schemes, generally requiring flat rate payments, sometimes with state subsidy.

Objectives and outcomes

The literature on social insurance for health care in lower income countries seems to divide into two parts. An older literature examined the existing social insurance schemes, being particularly concerned to show that they favour the better off (Vogel 1990). A more recent literature (e.g. Londono and Frenk 1997, Gertler 1998, Yang 1996, Ensor 1999, Liu et al 1998) looks at the problems of creating social insurance, or extending or reforming existing systems, and at mutual schemes.

The new promotion of social and mutual insurance in health care in the multilateral policy literature follows an emphasis on privatisation and individual insurance in the early 1990s (e.g. World Bank 1993). The underlying assumptions appear to be that people will contribute more readily than to tax funding; that costs will be more containable than for private insurance through a mix of risk pooling, effective purchasing and accountability; and that redistribution will be achievable over time.

Social and mutual insurance therefore involve non-market norms and relationships. In a simple mutual scheme, higher risk and lower risk people are insured at the same average charge. Since the poorer tend to be sicker, such an insurance system distributes care towards them on average, so long as care responds reasonably well to need. If the charges for the system are related to ability to pay, then the system becomes more redistributive, since it can include those who cannot afford a flat fee.

10 They also of course involve market relationships, since insurance funds purchase health care from independent suppliers. We failed to find in the literature any 'administrative anthropology' (the phrase is from Lewis and Glennerster 1996) about the non-market relationships that help to make the market exchange function effectively on behalf of patients.
11 The health policy literature tends to miss this point. Normand (1999: 868) for example says, 'Fixed contributions may be the only feasible solution, but produce no solidarity.' This is correct in his own terms - since he has defined solidarity in terms of contributions related to income - but misleading on a broader definition of solidarity. If, through risk pooling, some of the poor gain more health care than they otherwise could obtain, there is some beneficial solidarity implied by fixed-payment mutuals.
By implication, social insurance for health care requires a shared social acceptance of redistribution through health care finance. The experience of European systems suggests that national compulsory social insurance for health care, once established, can be a very socially and politically stable system, reinforcing the norms and values within which it is based, since it embeds redistribution within reciprocal insurance relationships (insurance both against risk of ill health and against the consequences of loss of income for health care), with the additional benefit (if properly structured) of health care cost containment (Besley and Gouveia 1994, Barr 1993).

To what extent does the health care literature illuminate the norms and non-market relationships required to shape social and mutual insurance in different cultural contexts? The studies drawn upon below divide into: rural community risk pooling; urban informal sector schemes; communal insurance based on collective agricultural systems (now dismantled); social insurance for formal sector employees; and the varied social insurance schemes of the richer East Asian countries.12

Non-market behaviour and social and mutual insurance

Rural health insurance in transitional countries

The literature on China and Vietnam traces the collapse of the previously highly inclusive rural communal health care systems under pressure from economic transition. In China, rural health care before the 1980s was organised through the Co-operative Medical System (CMS), rooted in rural mutual assistance schemes developed in the 1950s, integrated into collective agricultural production. The tiered system of rural primary care, township health centres and county hospitals combined hierarchical power, tax-based redistribution and mutuality. Rural primary care was paid for by a mix of peasant families' contributions, part of collective agricultural income, and subsidy from higher government levels; at its peak, the system covered 90% of peasant families (Liu et al 1996:157). In Vietnam, there was a comparable tiered system, providing free consultations but charging for drugs (Bloom 1998).

In the 1980s economic transition, these successful rural primary care insurance and provision mechanisms largely collapsed along with the collective agricultural production relations which had sustained them. China's CMS covered only 5% of rural households in the mid-1990s. China's health care institutions now charge to cover costs, and farmers, like villagers in Vietnam, are no longer willing to support village health workers, many of whom have become unlicensed medicine sellers (Bloom 1998 239). Preventative care has deteriorated, and there is now a high rate of exclusion of poor farmers from health care (Liu et al 1996: 160).

There are however some exceptions to this rule of simultaneous collapse. About 10% of villages retained a CMS system, based in a village welfare fund, despite its formal abolition (Liu et al 1996: 159). Those villages were not markedly richer or poorer than average, though they had lower levels of rural industry, and one higher income province surveyed had few CMS villages. Liu et al (1996) note that some of the continuing

12 Again, the Latin American literature has been poorly surveyed so far.
schemes had local government support, and speculates that the schemes - which the government requires to be voluntary - require 'cohesive social structure' in a village. Unfortunately the study provides no further detail on the social relationships in the villages maintaining the schemes.

**Formal social insurance**

In many countries, social insurance for health care has long focused on those in formal employment and their families. In Asia, India, Indonesia, Pakistan and the Philippines have compulsory social medical insurance for employed workers (Giridhar 1993 274-5). In Africa, many countries have similar schemes covering formal sector employees, which have often been heavily tax-subsidised. Many such schemes display problems of corruption and inefficiency. The Indian Employees State Insurance Scheme (ESIS) is compulsory for formal sector industrial workers, and requires contributions from employers and employees proportional to wages; workers with very low wages are exempted from their part of the payment. (Giridhar 1993 269-270). The scheme is run by a public corporation, which both owns health care facilities and buys bed space in other hospitals. It provides medical benefits and cash sickness benefits, and has some state subsidy. The corporation is in deficit, facing serious problems of high cost and malpractice (fraudulent claims and contribution avoidance). Workers however complain of low quality care and slow payment of benefits, especially in small non-unionised firms (Giridhar 1993 271).

Proponents of this type of social insurance tend to assume that it will 'release' tax funding to spend on the poor (e.g. Abel-Smith and Rawal 1994). The limited evidence available on behaviour casts doubt on this, at least in situations of transition from previously free schemes which have become informally marketised. Ensor (1999) reports that in transitional Asia, people see such social insurance schemes as actually reducing access. Facilities' staff are widely reported to neglect insured patients in favour of those paying individually. Hence compulsory insurance schemes are seen as an additional tax that does not increase benefits, since people continue to pay informally. In Vietnam, for example, voluntary schemes thus have low take-up, and compulsory payroll schemes are collectively resisted.

There is, finally, some evidence that the organisation of social insurance, including the interaction between market and non-market relationships, constrains the scope for universalisation in middle income countries. Taiwan has successfully established a single national scheme with virtually universal coverage (Chiang 1995). However, Korea's National Health Insurance (NHI) scheme, in principle universal, continues in practice to exclude low income groups from care. Yang (1996) argues that the dominance of private fee-for-service at the provider level, and the (in the author's view, consequent) absence of functioning primary care and referral systems, has created high costs. It also shaped the assumptions behind the insurance plans from which the NHI grew, creating social insurance with high co-payments. The resultant high cost, high co-payment, limited coverage framework excludes the poor and creates a 'classic two-tier system' (Yang 1996:241). Yang argues for a more closely managed system, with primary care, referral, and better coverage, but recognises that 'the public' constantly lose the battle for this against private sector lobbies. Only constructing a 'shared understanding' of what health insurance is, and a 'citizen's movement backed by formal consumers' organizations' can shift that balance of power (Yang 1996:251).
Voluntary mutual insurance

Voluntary mutual savings schemes are common in rural and urban Africa, and members are generally positive about the idea of extending them to health care (Asenso-Okyere et al. 1997). Atim (1999) examines voluntary urban schemes, with a case study of a scheme in Cameroon, being particularly interested in the extent to which the schemes display a 'social movement component' of community-organised participation and accountability. The author creates an interesting classification of non-profit mutual schemes based on the social base of the scheme: 'traditional social solidarity networks'; mutual health solidarity schemes with a mass base not restricted by ethnicity or similar factors, and often built around trades unions or enterprises; rural community financing, of a low or high participation type; and South African-type Medical Aid Societies which are professionalised.

The Cameroon scheme is an example of the first type. It was built up as a traditional reciprocal savings scheme, of a type very common in Africa, and extended to include assistance with medical costs. It pays out a lump sum to a member hospitalised for more than seven days, and also pays a lump sum for surgery costs. The scheme is based in a single ethnic group in the capital city, is run by unpaid volunteers, and exerts pressure - as well as offering incentives - on members to register all family members under the health scheme, to reduce adverse selection of only the frail. The scheme is expensive relative to average incomes, and appears likely to be selecting out the poorer members of the community (Atim 1999: 894)

These mutual savings schemes have been modelled by economists as a solution to the 'lumpiness' problem - how to find a large sum relative to income for a ceremony, investment or crisis such as illness. Van den Brink and Chavas (1997: 763-4) argue that the schemes are not 'generalised reciprocity' in the anthropological sense, but something closer to an explicit contract 'co-signed' by the collectivity that is the savings association. The 'sanctioning mechanisms' against default, however, lie in kinship and neighbourhood, and the personal consequences of social ostracism; but that urban associations, in looser communities, tend to add seizure of goods of defaulting members - a more material punishment - to their sanctions (ibid: 765).

Atim, by contrast, sees such associations also as investment in strengthening social ties, especially in an urban area: members of the Yaounde scheme had an obligation to go to each others' funerals for example. So the health scheme, and voluntary mutual schemes more generally with which health schemes might be associated, form an investment in social capital, while drawing on that trust and close neighbourliness to strengthen the health scheme in its turn.

Rural areas of Africa, too, have mutual savings schemes, but rural mutual insurance is rarely integrated into them. Documented examples, such as the Bwamanda hospital insurance scheme in Zaire and the Ghanaian scheme, modelled on it, discussed by Atim (1999): both fall into his 'low participation' category. The Bwamanda scheme has effectively raised the use of the formal health care system by the seriously ill (Criel et al 1999). It is voluntary, requires a flat payment per family at the time of harvest, and has a coverage of around 65%, and a less than proportional representation of very low income (and the highest income) parts of the population. There is currently discussion underway
in the local area about the possibility of differential charging for the poor. The article contains very little about the social involvement of the population in the scheme.

The Ghanaian scheme, Nkoranza community financing scheme, was modelled on Bwamanda, and Atim notes that, despite the fact that the district has 'a myriad of associations and social groups', 'none of these are formally linked to the scheme in such as way as to enhance solidarity within it' (Atim 1999: 887). There is, Atim says, widespread evasion of the requirement to register family members; coverage is disappointing (about 23% after 5 years), and there have been financial irregularities. Atim attributes some of these problems to the lack of involvement and accountability to members in the scheme.

Voluntary mutual insurance in rural areas is made difficult by acute social division. The experience of the Sewagram scheme in Maharashtra, India illustrates this problem (Giridhar 1993). The scheme, originally established in the 1960s, allowed coverage through a prepayment per year for preventive care and treatment. This could vary according to ability to pay, a principle accepted by some villagers. However, in one village studied, 'the richer sections of the community did not support the scheme fully' (Giridhar 1993 286), while the landless labourers increased participation; as a result the scheme could not cover hospital care. The scheme is being developed and decentralised in a number of villages, and is referred to as promising but problematic 13.

European social insurance systems grew out of long practice of mutual societies and voluntary schemes, including trade union-based mutuals (de Swaan 1988), and gained some of their legitimacy from those roots. Section 8 reflects on some of the implications of this section for creating mutual social 'roots' for health care financing.

6 Community participation and community management

'Community participation', carrying as it does strong meanings of voluntarism and collective action, is often presented as the antithesis of both individualised market relationships and of top-down health care planning. Community participation was a central strategy within the primary health care (PHC) movement heralded by the 1978 Alma Ata declaration, reflecting both the shift towards 'basic needs' approaches within the broader development debates, as well as a global reaction against the dominance of the 'bio-medical' model within health care.

Community participation therefore quickly became associated with national community health worker (CHW) programmes, which sought to involve community members as health extension agents within their own communities (Walt 1990). These national CHW programmes built on small-scale projects undertaken by non-government organisations, as well as national initiatives such as the Chinese 'barefoot doctors'.

A second variant of community participation is 'community management' within the Bamako Initiative (BI), launched by UNICEF and WHO in 1988 (Jarrett and Ofosu).

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13 Dave (1991) also discusses the Sewagram scheme, plus a range of other community pre-payment schemes in India, and notes that Sewagram was one of only two that took ability to pay into account in setting prepayment levels. In highly unequal communities, this may make broad commitment difficult to obtain, but the article does not discuss this problem and has little detail on the social organisation of the schemes discussed.
Amaah 1992, see Section 3 of this paper). The BI promoted community management of the funds collected at local facilities as central to its strategy of revenue generation-with-service-delivery improvement. Like the CHW programmes, the BI was rooted in the experience of small-scale projects of community financing often undertaken by non-governmental organisations (e.g. Dave 1991).

However, the successful implementation of community participation within any health care programmes or activities remains elusive.

‘Nearly two decades after Alma-Ata, the strategy originally conceived as a commonsense and straightforward approach is recognised to be fundamentally more complex’

(Zakus and Lysack 1998: 1)

The large literature on community participation in the health sector is not comprehensively reviewed here. Most of it lacks sufficient detail to inform an understanding of non-market behaviour. Few reports of CHW programmes reflect on the factors facilitating or constraining their impact, and even fewer consider CHWs’ own motivations. The BI-related literature is even more limited in its review and interpretation of behaviour.

This limited investigation of behavioural issues contributes to another common weakness of this literature - that the term ‘community’ is used very loosely (Jewkes and Murcott 1996). As Zakus and Lysack (1998: 4) note in a recent review article on community participation, the health literature often ‘elicits powerful images of a harmonious and equitable place where reciprocity and mutual concern prevail’, perhaps because the notion of community as a geographic area is confused with that of a community rooted in shared identity and values. As a result, the great diversity of interests and concerns within communities is rarely investigated or understood. The voice of community members or groups are rarely heard in this literature, which instead largely reflects the voices of the expert, the medical or public health professional, the planner or the economist.

Objectives and outcomes

Zakus and Lysack (1998: 2) sum up the notion of community participation as ‘a strategy that provides people with the sense that they can solve their problems through careful reflection and collective action’. The framework of thought is thus one of generalised reciprocity: participation is non-market behaviour in the sense of joint action that benefits the group as a whole, in sharp contrast to individualised market exchange.

Service delivery improvements expected from community participation arise from extra resources generated through volunteer labour (such as community health workers) or financial contributions (as in BI schemes); from better determination of the local needs to be met through service delivery; and from the establishment of more accountable relationship between providers and patients. Accountability has been particularly emphasised in recent international debates around ‘health systems reform’. It brings together two not wholly compatible themes: patient choice, and indeed consumerism in higher income countries (Ovreteit 1994), and the promotion of management and accountability through community health committees as in the Bamako Initiative (McPake et al. 1992).
Expected positive health outcomes may also be a direct consequence of greater personal understanding of ill-health resulting from participation in health care programmes and the wider diffusion of health knowledge within communities. Participation is expected to promote personal responsibility in taking preventive and promotive health actions as well as a levelling of the power imbalance between providers and patients. Thus, 'for many working in the health field, training community members to provide some rudimentary health care was part of a larger development ideology... [which] envisaged such people as catalysts who would help communities understand about ill-health and the factors causing it, and help them to change such conditions' (Walt 1990: 20).

The catalytic role of CHWs was also associated with the understanding that they would particularly work to empower and assist the more dis-advantaged groups in any society (Werner 1981). The notion of community participation was, thus, tied to that of equity in the Alma Ata declaration. And finally, community participation is seen as a goal in its own right. Community action within the BI was, for example, understood at least partly as a means of 'increasing the social control by communities over local health development action' in line with 'the current popular movement for more democratic and local control in society' (Jarrett and Ofosu-Amaah 1992: 165, 166).

The types of behaviour expected through 'community participation' thus range from individuals taking more responsibility for their own health care, through involvement in decision making about health care, to contributing resources (Green 1992). There are some evident tensions between challenging inequity and building collectivity; between service delivery and local control; between individual action and common objectives. The literature provides some evidence about behaviour in practice.

Non-market behaviour in community participation and management

Agents of communities or contributors to service delivery?

As with broader decentralisation within planning and administrative systems, community 'participation' can range from being better informed or consulted, to exercising decision-making powers (Arnstein 1969). CHW programmes have often been intended to promote individual self-responsibility and empowerment within communities (the CHWs of Columbia are actually called 'health promoters'). In practice, however, national CHW programmes have tended rather to extend the coverage of the formal public health system by 'bridging gaps between fixed health facilities and local communities' (Walt 1990: 168). In some countries the link to communities may be quite limited as CHWs become increasingly involved in facility-based activities rather than in undertaking community-based tasks such as home visiting.

Offering their services voluntarily or for only a nominal payment, CHWs may thus have allowed, from the state's perspective, a relatively costless extension of the primary care network. This construction of CHWs' work as a largely unreciprocated gift to the state - instead of a reciprocated contribution to the community - is reinforced by evidence that national CHW programmes have rarely involved a real shift in decision making power to

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14 See also Section 3 on community decision-making on exemptions.
communities. Although initially expected to be selected by communities, in practice, they have largely been chosen by community leaders and health service personnel. In Burkina Faso, 'the communities' involvement only consisted in choosing CHWs according to the given criteria and organising their support' (Sauerborn et al. 1989: 1169). A survey of CHWs in Botswana in 1987 showed that only half were selected through community structures, with the majority applying to their local council (which managed the local health services), whilst a parallel study in Colombia found that the only community members consulted in the selection process were the community action committee, while the health staff made the final decision (Walt 1990).

In contrast, the Bamako Initiative explicitly sought to ally a direct decision-making role for community representatives to community resource contributions to support of the local health facility (McPake et al. 1992). 'Community action is at the heart of the Bamako Initiative. The long-term effect of such action, at village, sub-district and district levels, is to increase the effectiveness of services and the esteem in which staff are held' (Jarrett and Ofosu-Amaah 1992: 169). It promoted structures in which community members, preferably elected, together with health workers would make decisions such as price levels, exemption guidelines, and revenue use (McPake et al. 1992). In practice, however, community committees often work within quite tight parameters. For example, they usually have only limited control of price levels, and while they often have a greater role in revenue use decisions (McPake et al. 1992), they may work within guidelines concerning the proportion of revenue that can be devoted to things other than drug purchases.15 Committees are often better at talking to communities than at drawing ideas from communities (McPake et al. 1992), and, as with CHW programmes, decision-making can be influenced, perhaps even dominated, by health workers who also sit on 'community' committees (Gilson et al. 1999).

There thus seems to be a gap between the policy construction of the exchanges involved in community participation and management, and the evidence of behaviour. The policy construction is of a model of reciprocity: involvement in decision-making in return for service improvements that benefit the community served by the local facility. CHWs, therefore, give their time to contribute to the pool of community resources, and personal financial benefits are very limited if even offered. Abel-Smith and Dua (1988: 96), moreover, reflect the Zakus and Lysack (1998) definition of community participation in defining community financing as 'people who live together in some form of local social organisation getting together and undertaking collective action - a concerted action for the benefit of people who share a common interest or purpose'. Even the BI schemes, built on fee-for-service payment mechanisms, see community management as turning the pool of fees collected into a community resource, including some cross-subsidy of the poor by the rich (Jarrett and Ofosu-Amaah 1992).

However, the limitations on community decision-making powers is likely to limit the community members' conception of their inputs as reciprocated in this broad sense (or at all). The literature says little on the expressed motivations and explanations of community members who become involved in health care. Zakus and Lysack (1998: 6), for example, simply comment that the 'rewards for community participants are largely

15See also Section 3 on the conflict between financial sustainability and exemptions.
philosophical, emotional and symbolic as compared to health professionals and managers for whom participation offers tangible professional and career advantages'.

**Power and conflict**

Exploration of the practice of community participation identifies two primary means through which power is exercised. The first involves the imposition of the strategy of participation on communities by the health service; and the second, the manipulation of participation strategies to their own ends by some groups within communities. Both imply a more conflictual experience than the reciprocal and collaborative images dominating the policy prescriptions.

National CHW programmes and BI schemes have been the product of national decision-making, strongly influenced by international agents such as WHO and UNICEF. The framework for their participation strategy was set outside the communities in which they were to be implemented. Furthermore, 'although ministries of health might be able to control the health activities of CHWs and their links with the health service, they had no special expertise in matters of community development, in talking to communities or in rallying community support for CHWs' (Walt 1990: 23). The experience of CHWs in Burkina Faso involved 'asking villagers to contribute effort and money for externally designed and vertically planned programmes' - in effect 'turning the PHC philosophy upside down' (Sauerborn et al. 1989: 1169). Those involved in BI activities often saw the solutions to community health problems as coming from outside the community - from government, non-governmental organisations or donors (McPake et al. 1992). Imposed participation strategies may thus fail to promote greater self-reliance.

The imposition of participation may also create a conflict between the public health system's intentions and what the community (or elements within it) wants. Communities may perceive participation as a strategy for reducing their level of state services, and hence withhold participation in order to oppose what it fears and expects. In Indonesia, opposition to community-based rehabilitation resulted from community concern that these projects would provide an excuse to remove the local health centre and reduce funding for monthly public health nurse visits (Zakus and Lysack 1998). Similar fears have also undermined enthusiasm for CHW programmes (Walt 1990), whilst conflict over how to use revenue generated, as a result of differing expectations, has also been reported within BI schemes. Communities may wish to use resources for things other than drugs or supervision (McPake et al. 1992).

Community participation has also been manipulated by groups within communities. A key concern of both CHW and BI programmes has been the representativeness of those selected to be CHWs or to make decisions for the community. CHW selection criteria, such as literacy, may limit who can be chosen, or CHWs may be selected by more powerful groups within the community, such as health workers. In some cases, there is evidence people have been chosen to be CHWs on the basis of political or kinship reasons rather than merit (Walt 1990). Similar problems have affected the selection of community committee members in BI schemes (McPake et al. 1992, Gilson et al. 199x).

A key consequence is that representatives of the most disadvantaged sections within communities are very rarely brought into the formal fora of decision-making, and their voice and needs rarely heard (Gilson et al. 1999). The lack, or limited role, of women in
such structures is just one example of the broader problem (McPake et al. 1992, Gilson et al. 1999). Stone (1992) suggests that because they are usually by-passed within community decision-making, the poor and the dis-advantaged may be least supportive of participatory processes, preferring external agents (such as health care providers/managers) to be in charge of community health activities. On the other hand, they may neither have the resources to participate (time, money etc.) or may simply not be informed of opportunities to participate (Gilson et al. 1999).

Where the interests if the poorest within society are brought to the fore through the practice of participation, the consequence has often been forceful opposition - including documented cases of the killing or ‘disappearance’ of CHWs (Walt 1990). By challenging traditional social relationships, activities involving community participation may be undermined.

In practice, therefore, community ‘participation’ often reflects the exercise of unequal social power - where involvement is imposed on communities, or where individuals are selected to ‘participate’ by elites or because they are elites. In addition, the exercise of unequal social power may conflict with community participation as other forms of non-market behaviour - as when an individual motivated by duty or commitment is simply not chosen as a community ‘representative’, or ‘deterred’ from fulfilling their personal goals.

Reciprocity or free gift? Rewards for participation

Is participation undertaken for financial reward, for other individual non-financial benefit, as part of more generalised reciprocity, or from duty or commitment? The main issue of motivation considered within the participation literature is whether CHWs (and by extension, community committee members) should be paid for their services. Initially it was assumed that CHWs would provide their services voluntarily or at nominal cost, for the ‘good of the community’. In practice, however, CHWs have usually been paid in some way - either through a salary or honorarium, or through benefits such as free health care. And a common problem of CHW programmes has been a high attrition rate, often attributed to poor job satisfaction including low remuneration (Walt 1990; Sauerborn et al. 1989).

This experience has generated a debate around whether voluntarism is a reasonable expectation of poor and already heavily-burdened villagers. Many suggest that some form of remuneration is an essential supporting element within any form of community participation and that expecting poor (especially the poorest) villagers to pay for the costs associated with participation (such as travel costs) is simply unrealistic. At the same time, however, there has been concern that once an external agent is involved in paying CHWs or other community ‘representatives’ they may shift their allegiance from the community to their employer (McPake et al. 1992). CHWs paid by the state in Botswana and Colombia, for example, saw themselves more an employees of the state than as

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16 These experiences might perhaps be seen as reflecting the broader tension between the notion of health empowerment through participation and the notion of community. Zakus and Lysack (1998) suggest that as health empowerment strategies stress the development of advocacy and social activism they inevitably conflict with the notion of community, the essence of which is cooperation.
There has therefore been considerable pressure on communities to find innovative ways of rewarding their CHWs, such as providing (and perhaps tending) fields for crops/livestock production, but little demonstrated success in sustaining such approaches (Walt 1990).

However, a survey of volunteers working within the Sri Lankan CHW programmes in the late 1980s identified a range of motivations (Walt 1990). Over sixty per cent saw volunteering as a route to more formal employment, given that in the mid-1986 the Ministry of Health had announced that health volunteers with required qualifications would have preferential access to training and jobs as public health midwives. Yet more than a third put service to the community as their primary motivation, with other motivations including self-improvement through further training. In a country like Sri Lanka, as in other settings where voluntary CHW programme have existed (such as Indonesia, Burma and Thailand), the religious or cultural ethos or norms of the society is likely also to be an important factor promoting 'duty' or commitment expressed through voluntarism (Walt 1990).

This discussion suggests that policy towards community participation needs to come to terms with its involvement in unequal structures of power. The policy voice of the technocratic 'expert' overlooks the complex realities of communities and societies. In its Alma Ata guise, 'participation' represents a reaction to the impact of unequal social power on health and particularly, the poor health experienced by the poor and understood as rooted in social inequality. It is intended as a strategy for challenging that power - both the power of bio-medical practices and social-political power. At the same time, participation may come about as a result of the exercise of that power: imposed on communities by the state, run by individuals chosen by local elites to be CHWs or community committee members - often because they are themselves members of elite groupings.

The participation that results from the exercise of this power is rarely if ever effective in achieving the health and health care goals with which it is ostensibly associated. The consequences vary from active conflict between the agents of the state and community members, or within communities; to passive resistance; to the exclusion of the most disadvantaged from decision-making positions. Although rarely examined in detail, participation is shaped within communities by fear of losing power or status, or the desire to enhance status or power - in other words by the existing structural distribution of wealth or power (Walt 1990). Section 8 suggests that effective policy must start from a recognition of these conflicts.

7 Health seeking behaviour

Our final topic differs from the others in that it is not a 'policy' topic in the same sense: it examines some aspects of health seeking behaviour by populations in relation to formal health care. This allows us to review some research evidence on norms and meanings of a type we found to be largely absent in the rest of the literature. We use this material to inform both the conceptual argument and the policy discussion that follows.

The decision whether to seek health care has been investigated and modelled in various ways, drawing on anthropology, economics and, the dominant discipline, epidemiology. Economists and epidemiologists commonly draw their evidence from household
questionnaire surveys, and use it to investigate what factors explain the choice of care decision (including no care, self care and various types of places/providers of care). Explanatory variables investigated are usually limited, including individual/household demographic and socio-economic variables, characteristics of the perceived illness and health services characteristics (e.g. Kroeger 1988). Economists are particularly interested in the influence of the costs of care (both total costs and cost components) on demand for care.

Anthropological investigations, by contrast, tend to explore the influence of a very different set of factors, such as perceptions of health and ill-health, and the meanings associated with forms of care, using various qualitative approaches to data collection. A further set of studies, often involving combined use of quantitative and qualitative data collection approaches, have investigated in greater detail specific health care choices, and specific factors influencing health care utilisation.

From this diverse literature, we consider three aspects of non-market behaviour:

- behaviour concerning provision of home-based care within the family;
- sharing information or financial resources between families, neighbours, friends about illness and/or health care providers or to enable health care to be sought;
- users' perceptions the health system, focussing on interactions between users and health services staff, and issues of risk, trust and staff attitudes and behaviour.

The evidence we have found on these issues is quite limited — perhaps reflecting the dominant epidemiological and economic disciplinary perspectives - and this section takes the form of reflections on a number of case studies -

Self-care and home-based care

Self-care is commonly identified within studies investigating health care seeking behaviour as a potential choice of care decision, but is primarily defined as activity such as personal purchase of drugs for self-treatment of relatively minor illnesses. Home-based care, on the other hand, is generally defined as caring for people with chronic and severe health problems, such as HIV/AIDS, 'at home' i.e. outside health facilities. Thus, whereas self-care may be an individualised response to illness, home-based care is an activity associated with caring for another — often, but not always, a family member or a friend.

Duty or loyalty, and non-market reciprocity within kinship networks, seem the most likely sources of home-based caring behaviour. A Mexican case study (Castro et al. 1998) identifies two key factors shaping the solidarity and support provided to gay men suffering from AIDS — kinship and gender. Although kinship ties may lead family members to provide some form of assistance in caring for a sick brother or son, the pattern of support is gendered. Men tend to provide resources obtained through their jobs, whereas women are the ones literally to take care of the sick person. Norms of support may, therefore, be shaped by broader power relations within the family in determining the type and balance of support provided by different family members.
This study also points to three other behavioural features of the provision of home-based care. First, in some instances the gendered pattern of care provision was itself 'moulded by other interests related to the care of the sick' (Castro et al. 1998: 1478). For example, the act of caring sometimes conferred on the female carer the right to particular benefits, such as access to the sick person's property after their death. In these cases, therefore, family duties, power relations and material interests all interact in determining the pattern of home-based caring behaviour.

Second, the study also found evidence of opposition to the provision of care – even to the point where sick people were abandoned in public health facilities or left to die in loneliness. In some cases, this discriminatory behaviour specifically reflected a fear of, or rejection of, homosexuality. However, supportive behaviour was often undermined by time and the physical and emotional exhaustion of providing care, leading to burn out in some cases' (Castro et al. 1998: 1479). In other words, the failure to care was also a consequence of the demands that illness placed on already materially-vulnerable families.

Third, some behaviour identified in this study represented a combination of support and rejection – as where a person or family provided material resources while expressing moral rejection. Duty, thus, compels some support but it is provided in ways that indicate disapproval – for example, one family paid for their son to live in his own apartment but segregated from the rest of the family. Illness clearly provokes very strong and varied 'caring behaviour' among family members, and also friends, derived from a complex of factors that may have rather little to do with concern for material gain. In the AIDS case study, driving concerns included the fear of falling sick oneself, and moral judgements informed how the illness is perceived. Thus, '.... when relatives judged that one of the family members became infected 'accidentally' or via a blood transfusion, they usually provided more support than when they considered that infection was a consequence of 'deviant' or 'immoral' behaviour. (Castro et al. 1998: 1479)

Resource support

There is some, although limited evidence, on forms of non-market behaviour around resource support for health care within communities. Such support includes:

- sharing information about health care providers, drawn from personal experiences, between families and neighbours as one input into decision-making about if and where to seek health care in times of illness (e.g. Gilson et al. 1994);
- sharing medicines known to be efficacious, with those in need (e.g. MacCormack and Lwihula 1983);
- drawing on networks both to access care and to ensure 'good' care provision: for example when 'knowing' a health care provider can speed up the process of being seen or can ensure access to drugs otherwise not available (Gilson et al. 1994; Whyte 1992);
- women sharing domestic responsibilities to allow each other to do paid work and so have the financial resources to pay for health care (Moser 1998);
- providing financial support (loans or gifts) to other to enable them to pay for necessary medical care (Moser 1998; Sauerborn et al. 1996)\(^\text{17}\).

\(^{17}\)More formal systems of mutual financial support were discussed in Section 5.
The underlying motivations for such types of behaviour are, however, little investigated. The extent of reciprocity in sharing information or medical supplies appears to be largely uninvestigated, as is its patterning by kinship. Kinship ties are certainly one factor that may allow access to care, when these benefits are derived from a relative working in a health facility, although this support may also be a consequence of social power, as when the social standing of a person guarantees them faster or better treatment by the health worker. Kinship is also sometimes associated with the provision of financial support to meet health care needs (Sauerborn et al. 1996).

Moser (1998) also identifies a more generalised neighbourhood reciprocity underlying health care mutual support. Based on the 'trust deriving from social ties' (p.4), women neighbours within three poor informal urban communities in Lusaka, Manila and Guayaquil (Ecuador) shared their food, water, cooking and child care responsibilities to allow each other to do paid work. They also borrowed money from each other and nearby relatives to meet daily needs, including illnesses – in one area, more than half borrowed informally to meet medical expenses.

Sauerborn et al. (1996) also found that some households in their study in Burkina Faso were supported in meeting illness costs through financial gifts from extended kin, but found that these households were the more wealthy in the communities studied. Poorer households did not benefit from this type of support – and this reinforces Moser’s (1998) finding that falling incomes threatened the ability of households to enter into reciprocal arrangements of this type. Below a certain income level, households become unable to repay loans and so both cannot enter into such arrangements and enter a new, and dramatically worse stage of vulnerability (see also Booth et al. 1995).

Overall, therefore, it appears that the provision of resource support as a form of non-market exchange is governed by a mix of duty and reciprocity, operating between kin, friends and neighbours, and that its form is sharply gendered. Inequality influences the scope for exercising influence. The research strongly points to the importance of level of income: reciprocal arrangements for material support are more prevalent among the less poor, and are specifically undermined by material deprivation and growing economic vulnerability at the household level.

Unequal power and staff attitudes

Another set of relevant research evidence concerns staff-patient relationships within public health care systems. A commonly identified deterrent from using public care is perceived poor quality, and a particular issue of concern is the role of poor provider attitudes. There is a growing number of examples from within public health systems of provider attitudes varying from rudeness to discrimination, and even cruelty (e.g. Gilson et al. 1994, Jewkes et al. 199818). These represent the breakdown of professional and ethical behaviour, that is the breakdown of the types of non-market behaviour expected within the health system.

18Tibandebage and Mackintosh (1999) - another paper for the WIDER workshop - also discusses patients’ perceptions of abuse and neglect in some public hospitals.
Jewkes et al (1998) found, in a literature review associated with field research in South Africa, that there is little published exploration of abusive behaviour by (particularly) nurses, although it has been widely discussed in 'newspaper articles and township legend for decades', and although relevant case studies exist (Jewkes et al 1998: 1781). Qualitative research in contrasting maternity hospital situations, involving both patients and staff, and not initially addressing abusive behaviour, showed the strength of patients' expectations of abuse and neglect, and the frequency of the experience, in one midwife unit, and to a lesser extent in the others.

The authors attribute the staff behaviour to a mix of factors. Staff felt their working conditions were poor and, in the unit where behaviour was worst, out of their control. They felt their professional skills were not respected, and that they were themselves vulnerable, and they responded with scolding and even violence to establish patients' compliance. These responses were institutionally legitimated by ideologies of patients' inferiority, and groups perceived as reprehensible, such as teenagers, were particularly likely to face punitive behaviour. Patients in the lowest income area were the most likely to face abuse.

The bad behaviour, the authors suggest, is sustained by an interacting set of norms and responses: nurses seeking to establish professional and social status threatened by working conditions and by medical, social and racial hierarchies; habitual dismissal of patients' knowledge and understanding; patients' informal resistance tactics including 'cheeky' behaviour and sharing gossip; and managements' and the profession's social sanctioning of the behaviour by failure to resist it. Power and inequality are thus central to the norms that generate these failures of professional behaviour.

Poor provider attitudes are not the province of nurses alone. Failure by clinicians to provide advice to patients - and deliberate misinformation - are documented in a case study of clinical practice concerning sexually transmitted diseases in Brazil (Griffin and Lownes 1999). The authors stress the interaction of the norms and beliefs of staff and patients, and note that the clinicians' responses were gendered: women were particularly likely to be refused information or misinformed, and were faced with an acceptance that they would be blamed for illness.

Risk, information and trust: case studies of injections and vaccinations

There are also in the literature a few broader studies of interactions between patients and health care staff involving the understanding and management of risk. Some of the most interesting examine injections and vaccinations, including the meanings given this form of treatment, and the information provided. One particularly informative example comes from Uganda (Birungi 1998). The study explores the use of injections by the population and the interaction between household members and the formal, public sector health system in relation to the administration of injections. There is significant demand for injections as a form of therapy in Uganda. The proportion of treatments including an injection that are offered at formal health facilities is nearly five times the desired level established within the Uganda Essential Drugs Management Programme. Legally injection use is restricted to 'biomedical experts'.

\[19\text{Not formal complaints: no one formally complained for fear of reprisals, a finding reflected also in recent research in Tanzania (partially reported in Tibandebage and Mackintosh 1999)}\]
In practice, however, lay people are increasingly controlling injection use by owning their own syringes and needles. They either ask a trusted relative, friend or popular provider (recommended by a relative or friend) to use this equipment in administering an injection to them, or require that their own equipment, however dirty or poorly sterilised, be used by health professionals at a health facility. The equipment is even used in hospitals, where those accompanying patients are assigned responsibility for sterilising their own equipment before it is used by the medical professionals.

Birungi explains this behaviour as a reaction to the breakdown of trust in the Ugandan health system as a whole. The mistrust of the health system is well founded in the severity of the economic and health service of the 1980s: '...one of the most significant micro changes was that professionals could only survive by ignoring their standard ethics' (Birungi 1998: 1456). The reactions of health professionals to collapsing salaries and broader economic deterioration included not simply poor attitudes towards patients, but establishing their own drug shops or clinics, misappropriating public equipment and supplies, and introducing informal charges for services provided in public facilities.

These actions had direct impact on the public's access to the health system, and trust of it. Public facilities have come to be perceived as dangerous places, and 'public injections' as very risky. Their concerns have only been exacerbated by the AIDS awareness campaigns emphasising the dangers of using unsterilised equipment. People have responded by 'domesticating' the therapeutic injection relationships, seeking to reduce risk by bringing these relationships 'home' to kin, neighbours and colleagues: 'You can be sure when the injection is provided by a person you know.' (Birungi 1998:1460) Injections have been drawn into local social relations of sharing and trust, including sharing needles in families.

A second study, of local understandings of vaccinations in Karnataka and Sri Lanka, echoes the themes of people assimilating treatment to local categories of thought, and of reasoned distrust of staff (Nichter 1990). Vaccination staff did not always themselves know what illnesses the vaccinations seek to prevent, and little attempt was made to explain to parents in terms of local illness categories and understandings. Hence, people had false expectations of the 'health vaccination'. Patients were also suspicious of the government vaccinators' motives: some, especially in India, see the vaccination as explicitly a transaction related to pressure to accept family planning, or even as covert family planning. For example, if an auxiliary nurse-midwife assisted a birth, then the family would be in her debt, and would have to receive family planning and vaccinations to fulfil the midwife's quotas.

Trust was thus low: people did not believe the government vaccinators competent, and expressed this as believing they had poor 'aim', and that they vaccinated children who were too weak to 'stand the shock'. They cited side effects in their support. People were told it was their 'duty' to be vaccinated: the result was some lying about vaccination history. There was confusion between curative and preventative injections in both countries. Generally the government was using military campaign metaphors and seeking acceptance of vaccinations, rather than generating demand for vaccinations based in understanding, and this was likely to have problematic long term consequences.
The evidence in this section throws into sharp relief the interacting sources of vulnerability of the poorest would-be patients in terms of the non-market (as well as the market) aspects of health care. The poorest were least likely to be able to participate in reciprocal provision of care and resource support; most likely to be vulnerable to and discouraged by poor quality and bad behaviour; least likely to be informed and able to use information to develop effective strategies of self-protection and home care. These experiences were also gendered.

The studies also emphasise the importance of ‘lay’ people as carers and as providers of resources to support care seeking. Non-market caring by ‘lay’ people reflects a complex of differing motivations, mixing, in some instances, the desire for material rewards with other factors including moral judgements of culpability of the ill person, fear and response to risk, societal norms of the duties owned to kin, and reciprocity among kin and neighbours. Finally, the case studies of injections and vaccinations illustrate the patterns of reinterpretation through which vulnerable patients seek to manage risk.

8 Non-market behaviour and health care policy: concluding arguments

This section draws together the conceptual arguments in the paper, and applies them to a discussion of the potential for reframing - changing the mindset - of health care policy to reflect a better understanding of non-market behaviour.

Respecting the logic of non-market behaviour

We have traced, under most topics reviewed, the gap between the (usually implicit) assumptions about non-market behaviour that frame health care policy and the (patchy) evidence. The gap arises, in good part, from a policy mindset that treats non-market behaviour as if it followed no logic, or had no dynamic or its own. Non-market responses are thus expected to be malleable: prescriptive policies - such as institutional exemption rules, the appointment of CHWs to work for largely ‘symbolic’ reward, or prescriptions to redistribute tax funding away from the middle classes - are regarded as in principle unproblematic, their implementation a matter of political or institutional will.

The policy literature does of course recognise problems with this approach in specific cases, for example in the renewed emphasis on accountability processes in social and mutual insurance. But the prescriptive policy approach remains dominant, as illustrated by review of some very recent literature. We have argued that this mindset has led to:

- the roots of persistent policy failure in non-market behaviour being very poorly researched;
- health care policy design and intervention that generally does not recognise - hence does not seek to shape - non-market behaviour.

A shift in approach could start from the evidence presented here that non-market behaviour in health care is shaped by institutions in Mary Douglas’ sense (see Section 2): interacting sets of shared understandings and norms of behaviour, embedded in experiences of health care within highly unequal social structures. Policy makers thus

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20This is in contrast to market behaviour, in relation to which the importance of proper incentive design is recognised in principle.
have to understand the frames of reference of others as well as their own; lasting change in health care systems implies sustainable change in the norms and relationships shaping non-market behaviour.

This shift in perspective is particularly needed in the areas of health care policy concerned with the redistributiveness of the health care system. We have documented some of the ways in which non-market behaviour in unequal societies can work against policies supposedly addressing the interests of the poorest, for example:

- exemptions guidelines may conflict with other non-market and market incentives;
- tax allocation behaviour may actively conflict with expressed redistributive intent;
- social insurance mechanisms may deteriorate from within, or prove impossible to extend to the poorest;
- 'participation' policies may demand unsustainable free gifts from the poor to communities and to the state;
- failures of the public health care system may interact with the vulnerability of the poor to worsen their access to care.

There is thus nothing inherently equalising about non-market behaviour. If it is to support redistributive intent, then policy needs to stimulate change in non-market behaviour. Here are some implications for policy design.

Minimising conflicts and shaping sustainable redistributive behaviour

Non-market behaviour - like market behaviour - does respond to incentives: we have argued that some (not all) of it is socially constructed as 'exchange'. And there is quite a lot of evidence in this paper about how different forms of non-market behaviour interact. For example, the support provided to sick family members responds the gender-based power differentials in society, and mutual support and savings schemes assisting with health care costs are also sharply gendered. Health care reform, as part of broader economic liberalisation, has contributed to widening power and income differentials, and in many parts of the world undermined the capacity of the poor to contribute to reciprocal networks of support.

This is the context within which health care policy has imposed new (non-market) redistributive duties on low income communities. Sections 3 and 6 trace conflicts between new community fee-based health care financing mechanisms and exemptions and community management policies with (externally imposed) redistributive intent. Section 3 argued that the institution-level exemption mechanisms are constructed in the health policy literature as a non-market 'free gift'. In communities where poverty is focused and persistent - rather than a widely experienced intermittent risk - there are good reasons why such gifts are likely to be hard for institutions and communities to legitimate and sustain. The anthropological literature on gifts stresses the obligations and reciprocity involved in gifts, and the problematic nature of 'free gifts': the theoretical economic literature concerned with equity tends to stress the need to economise on such 'benevolence'21, as being a scarce and easily depleted resource. The demand, as in the

21 This concept of the redistributive - unreciprocated - gift as 'benevolence' is from James Meade, see several papers in Atkinson (1993).
exemptions care, for pure 'benevolence' puts a considerable strain on low income and socially divided communities, where local elites are able to exercise power and influence. The literature also however suggests several ways in which the commitment of communities and institutions to sustain their poorest members and patients could be strengthened.

First, minimise conflict of incentives. The deliberate creation of financing norms and rules that undermine exemption mechanisms puts an enormous strain on communities' commitment to redistribute. Creating funds to support exemptions that are separate from the revenue generated by a fee system may enable the giving of exemptions by allowing two separate norms to be established and supported: one, a commitment to revenue generation and institutional sustainability, and the other a commitment to protection of the poorest.

The successes of the Thai low income care suggest other ways in which local redistribution can be eased. A local norm of protection for the poorest can be strengthened in various ways within local understandings and procedures. Involving community representatives and health workers in decision-making, and regularly revising frameworks guiding decision-making in response to experience of success in protecting the poorest, may generate local social capital, in the sense of building trust between these groups, and working towards establishing a common norm of protecting the poorest. Information campaigns targeted at beneficiaries to promote and aid their use of exemptions, as well as promote their use of public health care, can also generate broader shared understanding and commitment to exemptions as a proper use of funds. Monitoring, too, needs to focus on the local legitimacy of policy guidelines, and how they translate into norms and patterns of behaviour: not simply on outcomes, but on why outcomes emerge from practice.

Finally, giving the poorest a voice in divided communities is hard and may even be dangerous (see Section 6). The way may be eased if the meaning of the redistributive 'gift' can be rewritten in more reciprocal terms. The Thai voices quoted in Section 3 illustrate the point. Local power and relative wealth are often locally understood - in culturally specific ways - as bringing duties in their train. So local cultural norms may allow space for reworking exemption schemes in terms of the duties of the better off and also some scope for reciprocity upwards, to help to give the schemes legitimacy and sustainability. The current health policy frame of thought on exemptions obscures these issues.

**Shaping commitment in low income communities and making it sustainable**

One benefit of treating duty or commitment - 'free gifts' - as a separate analytical category from exchange is that it brings to the foreground the importance for health care policy of attention to supporting and encouraging the development of ethical norms. The last example included ways of supporting an ethic of commitment 'downwards'. But, as Section 6 argued, much recent health policy has been framed as a demand for free gifts 'upwards': from poor or relatively poor people to 'communities' that may be socially very unequal, or even to the state. As a result, CHW programmes have tended to be unsustainable, their aspirations unfulfilled.
A case study of a successful CHW programme implemented in Ceara state in Brazil suggests however that recognising the power and conflict involved in specific contexts may allow participation to be designed in ways that allow low income participants to pursue mixed objectives. The study (Tendler 1997) points to the diversity of factors contributing to CHW motivations. Tendler identifies five critical elements of the programme that promoted a good morale among its CHWs (known as health agents):

- a transparent hiring process based on merit which accorded newly hired workers considerable prestige;
- a public information and education campaign which emphasised the ‘noble mission’ of the programme to reduce infant mortality and disease;
- encouragement to those who were not appointed as health agents to work as informal monitors of the programme as a whole;
- giving those who were appointed opportunities for further training which could be transported to other jobs;
- promoting job satisfaction by allowing health agents to take on extra tasks as they saw necessary (e.g. taking on some basic curative tasks or doing general chores to help mothers, rather than limiting their services only to preventive care, and so gaining the trust and support of the community being served).

This evidence shows that personal motivations of CHWs often combine some form of individualised material exchange (financial reward, or access to opportunities for such rewards) with other non-market behaviours - including non-market rewards (such as job satisfaction) and duty or commitment. There is little evidence of the factors explaining commitment - but hints at the importance of cultural norms, as well as a combined package of material and non-material rewards. The Brazilian experience also specifically suggests that such programmes can be designed and implemented in ways that promote committed non-market behaviour, by marrying material and non material incentives with ethical motivations. If a context can be created where commitment is protected and can flourish, then individuals can build the pursuit of other rewards upon it, including personal standing and future prospects. Commitment can certainly be generated and sustained by low income communities: but not as an externally demanded 'pure' free gift.

**Embedding health care initiatives in existing mutual support networks**

Can health care initiatives designed to be inclusive both draw upon and strengthen existing non-market behaviour in the form of mutual support networks - and also avoid weakening those networks? Section 7 documented the reciprocity involved in 'home care' and mutual support, and the stress poverty puts on this reciprocity. Section 6 demonstrated the gap between mutual health care finance programmes and existing informal savings reciprocity.

Section 6 argued that mutual insurance in health care is a valuable form of solidarity, but needs to be rooted in - as well as to contribute to - supportive social relationships. Commentators in Africa are now suggesting that mutual health insurance schemes would be greatly strengthened if they were more closely integrated with existing mutual savings and assistance schemes, that draw in their turn sources of solidarity from ethnicity, neighbourhood and workplace. So far, the literature does not seem to be considering the
follow up question: to what extent can formal sector schemes also draw on those experiences to sustain their probity, for example by improving their accountability to members?

Here van den Brink and Chavas' warning is relevant: they argue that governments should not try to incorporate local savings schemes into formal structures, since governments are not part of the local 'moral economy' and will almost inevitably undermine the schemes. However governments can encourage them, and create suitably enabling legal frameworks. Such a caution fits with a policy approach that takes non-market relationships seriously, as having a life of their own not easily amenable to being reorganised by policy makers. And the shift of mindset from setting up structures to encouraging independent institutional development illustrates the general argument about policy frameworks at the beginning of this section.

Another potential example, not developed in this paper at present, is the scope for health system support of home care and self care. The evidence in Section 7 suggests a lack of integration, and indeed active undermining by health care reforms that cut back services during recession of communities' scope for reciprocal home care support. Resources need to be targeted to support critical non-market behaviour, such as ethical health worker behaviour to patients. Resource use decisions, focused on contributing to health gain for the population, need to pay attention not just to what is provided but to how it is provided. The emphasis on health gain as sole outcome also needs to be qualified by a recognition that goals such as 'inclusiveness', that do not have a quantifiable immediate health gain, also need resource support.

Attention to meanings: rebuilding trust and communication

Section 7 documents examples of failures of communication, contested meanings, and the (well founded) collapse of trust. Recurrent problems in health care systems of professionals' assumptions of monopoly of knowledge; of contempt for patients' experience when it does not fit predetermined models; of failure to communicate and listen; and of the privileging of treatment over care are all long standing. We documented examples of these problems tipping over into misinformation and abuse. Section 7 offers two examples of the different meanings constructed around particular forms of treatment by patients and health care staff, in response to breakdown of trust.

This section thus demonstrates our general point about the role of discursive construction of actions in shaping non-market behaviour. Health policy needs to pay attention to meanings, since mutual understanding of the meanings put on treatment, and the understandings of risk, are a precondition for creating trust, improving quality and reducing risk. The authors cited make some suggestions for how that might be done.

Birungi (1998: 1458), having documented the 'domestication' of risk management and its dangers, draws the conclusion that needles and syringes can only be drawn out of the home through opening up the sterilisation process and its rationale to public scrutiny and participation: '... trust relations seem to be built on personal relations and confidence tends to be influenced by what people get exposed to, see and hear about institutions'.

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22This gap is because of a lack of examples of success; however a gap in our literature review at present is literature on, for example, support for home care of AIDS sufferers, which may offer relevant lessons.
This policy mixture of altering health care provider behaviour and also changing the terms of communication is echoed by Nichter (1990) who proposes a move away from military campaign metaphors for vaccinations, associated with an emphasis on 'take up', towards a process aimed at generating mutual understanding, greater trust and sustainable demand for vaccination.

**Tackling power and hierarchy, legitimating claims**

We have argued in Sections 2 and 4 that the prescriptive emphasis on equity in health policy tends to obscure the exercise of power and the operation of hierarchy. The evidence on non-market behaviour in tax allocation demonstrated both the role of self-interested exercise of power by elites, and also the importance of different forms of non-market exchange. Indian research (Section 4) compares non-redistributive outcomes of closed, elite-centred allocation and personalised political barter with the more redistributive outcomes - however incomplete - of more open national and local political processes focused around social demands backed by political organising.

This literature suggests that a range of policies can help to push allocation mechanisms in more redistributive directions, by identifying and strengthening mechanisms that constrain self-allocation by elites. Greater public information, by a variety of means, including information campaigns, and public and media access to health care system information, is probably the most important. Information is never enough to ensure implementation of redistributive policies, but it can enhance understanding of practice and give disadvantaged groups a 'tool' with which to question practice. It thus strengthens the capacity of disadvantaged groups to make claims through both the political and the health care system. Establishing legal rights and norms, and working with groups who can challenge the elite, can also contain their influence.

Much more explicit attention also needs to be paid to 'exchange' or bargaining within unequal state structures. Decentralisation *can* support redistributive policy ends - but it needs a design that is shaped by understanding of power structures, of sticking points, and of the 'deals' to be done, and an appropriate combination of clear central guidelines, genuine audited central government commitment to redistributive allocation, and openness to local adaptation and review, including review of central practice. Allocation criteria based on formulae assist public scrutiny.

The policy literature implicitly sees political will as the central problem in tax allocation. Section 4, while qualifying this by attention to power and exchange within the state, also offers some supporting evidence. Communist governments' focus on widespread primary health care access can be seen as a mixture of ideology - in the sense of political commitment to redistribution - and the building political legitimacy. External organising, by trades unions and communities, is a force sustaining redistributive commitment when it exists. Social inequality within the state is compatible, in principle and practice, with redistributive behaviour in social sectors; case studies of how to support the creation of administrative systems for redistributive ends, and how to sustain them, in circumstances where the political will also exists, are important for policy (a point now recognised by the World Bank, 1999).
Aim to shape market relations (blur the private/public boundaries)

Our last point is implicit in much that has gone before. Policy that takes into account non-market behaviour and aims to support and shape it to increase the inclusiveness and effectiveness of health care for the poor, must see one of its tasks as shaping market behaviour. Health care free markets are riven with perverse incentives and generate high levels of exclusion (Barr 1993), but they also vary substantially. One dimension of variation is the extent to which ethical behaviour is also (at least reasonably) profitable. Another is the extent to which incentives for cost escalation operate. Both are strongly influenced by social insurance rules and purchasing practices.

In Section 4, the Korean study of the difficulties of universalising access shows that the early exercise of market power by providers can block later universalisation. It suggests that if systems are to be universalised, non-market relationships such as primary care gatekeeping and referral need to be built in at an early stage, as do constraints on fee-for-service payment systems that drive cost escalation. There is too little discussion in the literature about how non-market relationships such as effective referral can be built in mixed systems - and supported by social insurance - despite widespread agreement that referral is ineffective or non-existent in many systems and that by-passing of primary care facilities is common even in the public sector in most low income countries (e.g. Sanders et al 1998, Akin and Hutchison 1999, Yang 1996). The advantage of universal social insurance is that it sustains redistributive commitment by embedding it within an insurance system. To achieve that, the link between insurance and mutual commitment expressed through non-market behaviour needs to be built early.

These arguments suggest the importance of trying to create non-market relationships that shape market incentives at low levels of income. Effective social insurance needs the commitment of physicians. If they have strong competing incentives to concentrate on private patients, then the insurance system may deteriorate from within. If, on the contrary, the system is also to the financial advantage of physicians (for example, it stabilises income, and provides standing through registration) then duty and financial advantage may overlap to everyone's benefit. If social insurance is strongly developed early in any marketisation process, then it can shape the market relationships rather than being shaped by them. Blurring institutional boundaries may help with this, for example allowing private practice in public institutions, and developing a culture in them that can achieve cross-subsidy.

Compulsory social insurance mechanisms all require the exercise of some kind of administrative power. To work, that exercise of power needs to be accepted as legitimate, otherwise social insurance schemes will deteriorate and be sabotaged from within. Creating legitimacy appears to involve creating a coalition of interests among patients and providers and exercising an ethical public commitment to inclusiveness. The Korean case strongly emphasises the importance, in the political process of trying to improve inclusiveness, of building 'shared understanding' about the scope for linking insurance, redistribution and cost control in the construction of a public lobby for cost control and inclusiveness, and to construct positive public meanings around the 'social insurance' concept. Chiang (1995:228) effectively supports this argument, with an account of how in Taiwan national health insurance was politically constructed by the Kuomintang as 'a critical indicator of 'good' government in a modernising nation'.
Some recent work on Latin American social insurance systems for health care has also addressed these issues. Latin American countries seeking to extend social insurance coverage face their own country-specific problems of costs and organisational structures blocking redistributive schemes. Londono and Frenk (1997) argue that these blockages are rooted in social division: institutions with different financing and facilities for rich and poor need to be reformed by horizontal integration within a pluralist organisational context. This requires a reshaping of the non-market elements of the system through a political commitment to universal access built on a basic package of services, and by an active governmental responsibility for 'modulation', that is, for building the social base and responsiveness of the system including 'social mobilization' and 'advocacy' (Londono and Frenk 1997:20). This is, in the health policy and development literature, still an unusual article in its awareness of the importance for health care policy of social relationships and non-market linkages within a mixed system, and points to the kind of shift in policy framework of thought that we are proposing.
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<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Authors/Date</th>
</tr>
</thead>
<tbody>
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<tr>
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<td>Foreign Investment, Globalisation and International Economic Governance</td>
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Economics Research at The Open University

Throughout the 1990s, The Open University has been developing its research capacity in economics. Economists at the OU comprise a lively and expanding group with a wide set of interests ranging from development policy to decision theory, from Marxist theories of profit to libertarian foundations of environmental policy and from econometric analysis of large data sets through institutional economics to the use of case-studies in policy formation. Nearly 1000 students from around the world register each year to study economics courses and their needs, together with the multi-disciplinary nature of social science at the university, shape out research. Through a variety of personal and group research projects, our work makes a strong contribution to areas like business, public policy and even philosophy where sharply focused analysis can inform decision-making as well as contribute to scientific progress.

In 1999, approximately £250,000 million worth of externally funded grants (3 from the ESRC) were held by discipline members, some of whom also act as consultants to national and international bodies. Approximately half a dozen students are currently reading for doctorates with members of the discipline and we are always interested in proposals from colleagues or potential students who would like to do research with us.