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# **Inequality and Distribution in Health Care**

*Analytical Issues for Developmental Social Policy*

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## **Social Policy, Health Care and Redistribution: An Introduction**

This chapter<sup>1</sup> contends that there is a need for more and better political economy of social policy in the development context, and seeks to contribute to its development. Specifically, the paper discusses the problem of achieving and sustaining redistributive health care in contexts of inequality and low incomes. Much of our evidence and specific argument are drawn from the health sector in Africa, and in particular from recent research<sup>2</sup> on health care markets in Tanzania. We believe however that our arguments have wider resonance for the effort to create effective, context-specific developmental social policy.

We employ a broad definition of ‘social policy’, to include governmental and non-governmental public action to shape social provisioning such as health and education, including influencing the distributive outcomes of social sector market processes. Indeed we argue that understanding the mutual interaction of public policy and market behaviour is key to designing effective developmental policy in health care as in other social sectors. We take for granted, as the basis for our argument here, some of the central propositions of Mkandawire (2000):

- That health and education are necessary for economic growth;
- That effective social policy can prevent developmentally dysfunctional inequality and conflict;
- And that we need to understand how these points can be moved onto the political agenda in both authoritarian and democratic regimes without such functionalist arguments undermining the intrinsic importance of social solidarity as an ethical objective.

We seek respond in particular to the challenge of the last point, by contributing to the development of political economy-based, policy-relevant analytical approaches to redistribution in the health sector.

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Our concept of ‘redistribution’ is intentionally broad. We define ‘redistributive’ action to encompass all social processes that create increasingly inclusive or egalitarian access to resources. In health care, this can include subsidy for access by those otherwise excluded; cross-subsidy within health care provider institutions; risk-pooling that increases inclusion of the moderately poor; and referral systems that increase the access of the poor to secondary care. More generally, it refers to shifts in health care systems in directions that sustain and legitimate access by those who can pay little or nothing, including processes that support redistributive commitments by governments and effective claims to access by the poor. This kind of shift is particularly difficult to achieve in contexts where health care reform based in marketisation is explicitly legitimating unequal access (Mackintosh 2001).

We argue in Section 2 that the health policy and development literature broadly lacks a theory of policy. Its prescriptions for allocation of public and donor funds emphasise redistributive intent, yet the research literature largely fails to tackle the problem of explaining persistent redistributive failure. Section 3 contrasts this methodological ‘thinness’ with elements of the European and African social policy literature that develops an empirically based political economy of policy. Note that aim here is *not* to argue that the European literature offers models of health care systems for emulation, but rather to identify relevant methodological avenues that are paralleled in work by scholars in lower income contexts.

Section 4 then discusses some key issues in the political economy of redistributive health policy in low income contexts. We explore some of the implications of understanding redistributiveness as a health care *system* characteristic. Distributive outcomes of health care emerge from interactions among policy makers, institutions in all sectors, and health care users and would-be users. Hence institutional behaviour, institutional legitimacy and response to market and non-market incentives are key variables in explaining redistributive success and failure. The argument in this section draws on institutional and game theoretic economics and the sociology and anthropology of institutional change. Section 5 explores some of these issues in the Tanzanian context, drawing on our own research. We identify partial social polarisation in this recently liberalised low income health care system, and discuss the scope for combating the resultant exclusion and impoverishment. Section 6 draws the threads together into an argument for a ‘thicker’ methodology of health care research and policy, aimed at rooting redistributive health care policy in local knowledge and locally feasible institutional design.

## **Health and Development: Thick Prescription, Thin Explanation**

In the development context, the health policy literature is strongly characterised by an emphasis on egalitarian objectives and by repeated demonstration of redistributive failure. There is strikingly less effort expended in researching explanations of the observed regressive distributional behaviour (Mackintosh and Gilson forthcoming).

We can illustrate this privileging of prescription and evaluation over explanation with reference to two major categories of health policy writing. One is the large and expanding literature on allocation of government and donor funds in health care. World Bank policy prescription in health care has repeatedly taken as its starting point a demonstration that ‘public spending on education and health is not progressive but is frequently regressive’ (WB 2001, See also 1993, 1996, 1997) (see also 1993; 1996; 1997; World Bank 2001: 80). The research literature includes repeated demonstration that the better-off generally benefit disproportionately from the allocation of government funding to health care, notably because of social inequity in access to government hospitals as compared to primary and preventative care (Barnum and Kutzin 1993; Peters et al. 1999).

The predominant response has been more elaborate prescription. As a recent report on African poverty published by the Bank puts it (White and Killick 2001): ‘The current trend is to identify the most cost-effective way of reducing the burden of disease as measured by DALYs (disability-adjusted life years).’ In the mid-1990s, a report from the World Bank’s regional office in East Africa took this approach, making strong recommendations for a reallocation of government spending in five countries including Tanzania towards ‘community and preventative interventions’ supplemented by only limited subsidy for curative care ‘carefully targeted’ to the poor (World Bank 1996: I). A prescriptive emphasis on targeting public sector funds to the poor has been consistent, though the emphasis of Bank policy documents has shifted, notably in the recognition that ‘subsidies to the non-poor cannot be fully avoided’ because of the need to garner political support for pro-poor measures (World Bank 2001: 81). Allocative failure is implicitly attributed to lack of political will and/or skill in fostering ‘pro-poor’ political coalitions (World Bank 2001: 108-112).

This policy mindset in health care is both source and product of the market liberalisation process itself in social sectors such as health care. Liberalisation of market supply is founded on the proposition – unsafe in health care – that private supply, charging and market access can sustain market-based provision with reasonable efficiency. Market liberalisation in practice furthermore tends to expose and drive out cross-subsidy. As a result, the marketisation process exposes the problem of access for those who cannot pay.

Marketisation thus simultaneously establishes a policy benchmark of sustaining competitive markets (the popular formulation of the ‘level playing field’ for competition refers to this idealised benchmark), while creating highly visible inequity and exclusion. There has as a result been a recent explosion of published evidence on the exclusion of those unable to pay health care user fees, in Africa and other development contexts<sup>3</sup>. The associated evolution in World Bank commentary can be illustrated:

‘The finding that many curative interventions are cheap and cost effective reinforces the economic principle that they should be left to the private market.’ (World Bank 1996: 22)

‘Most curative health care is a (nearly) pure private good – if government does not foot the bill, all but the poorest will find ways to pay for care themselves.’ (World Bank 1997: 53)

‘Several studies have shown that many households in developing countries cannot insure against major illness or disability’. (World Bank 2001: 152).

Behind each of these statements is the assumption that where health care ‘goods’ – services or insurance – can be constructed to be ‘private’<sup>4</sup> they should be supplied on private markets. These arguments both downplay the well-known scale of market failure in supply of health care (Barr 1998; Leonard 2000b), and imply that the proper sphere for redistribution is the institutionally separate one of the government budget. Policy proposals therefore continue to focus on elaborating prescriptions for ‘targetting’ government and aid funding to the poor, rather than on shaping the distributive outcomes of the mixed public-private health care sector as a whole. The more or less explicit objective becomes a health care system segmented into public and private sectors for the poor and better-off respectively (Bloom 2000; Mackintosh 2001).

The second category of health policy literature refocuses on the health care system as a whole. The WHO has recently put forward a particular version of this approach (WHO 2000), constructing summary measures of distributional aspects of health systems: inequality in health outcomes, distribution of ‘responsiveness’ of the system, and regressiveness of financing of the system as a whole. The report uses the burden of disease approach as a basis for recommendations for increased risk pooling as the primary financial method of tackling distributional inequity in health outcomes.

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<sup>3</sup> Tibandebage and Mackintosh (2001) provides detailed references. On Tanzania, see particularly (Asenso-Okyere et al. 1998; Cooksey and Mmuya 1997; Msamanga et al. 1996; Walraven 1996).

<sup>4</sup> In the technical economic sense: to be both fully rival (more for me is less for you) and excludable.

The strengths of this approach are the focus on health care as a system, and on promoting cross-subsidy within it, and the associated recognition of health care market failure. The approach rather obscures, however, structure and segmentation within health care systems. Furthermore, the WHO (2000) report shares with the targetting literature an absence of a satisfactory concept of policy. Indeed the report oddly ascribes actor status and benign objectives to the system as a whole, for example:

Health systems have three fundamental objectives. These are:

- Improving the health of the population they serve
- Responding to people's expectations
- Providing financial protection against the costs of ill health (WHO 2000: 8).
- Mixed public/private and private provider-dominated systems will however have no such unmixed objectives, as we explore for the case of Tanzania in Section 5. The WHO's approach to public sector funding allocation is also prescriptive:

(T)he health system should strive for both horizontal and vertical equity ...this generally requires spending public funds in favour of the poor. (WHO 2000: 55).

Multilateral organisations are constrained in putting forward explanations of policy decisions by member governments. However, policy-oriented health systems research literature in the development context also has a prescriptive methodological cast, tending to focus on evaluation of performance of elements of the system against specified objectives concerning cost, access or quality, and displaying a preference for sample survey methods and quantitative results. Research of this type has generated a large literature on aspects of health care systems in low and middle income contexts, including increasing documentation of the quality and cost failings of mixed public/private market-based health care<sup>5</sup>. This literature has the great strength that it recognises interactions within health care systems, and the scope for improving resources use by changing relationships within the system – for example by improving referral and increasing access by the poor to government hospitals. Increasingly, proposals include formal and informal insurance schemes. The research literature also pays much more attention than multilateral publications to context and history.

However health policy proposals drawn from this literature continue to be poorly rooted in contextual understanding of non-market behaviour and behavioural responses to

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<sup>5</sup> For example (Bennett et al. 1997; Bloom 1998; Leonard 2000a; Segall et al. 2000) out of a large literature.

market incentives in health systems. Such behaviour is rather rarely researched directly using qualitative techniques (Segall et al. 2000), and policy proposals are frequently based in poorly supported behavioural assumptions (Leonard 2000b; Mackintosh and Gilson forthcoming). The dominant policy mindset in the field, and the dominant conception of the policy process in the academic literature, remains a linear policy formulation-to-policy implementation model. There are exceptions and numerous critical voices, but a lack of a solid alternative health and development literature rooted in political economy and social theory.

### **The Social Roots of Social Policy: European and African Perspectives**

This methodological ‘thinness’ in analysis of policy contrasts quite sharply with some current European literature on social policy. European social policy analysis contains some ‘thicker’<sup>6</sup> methodologies, that is, analysis that relates social policy and process to social structure, and to broader political and economic processes, and that seeks to explain redistributive success or failure in context. This includes historical and comparative work on welfare regimes, that brings together an understanding of the historical evolution of national systems with analysis of their current outcomes<sup>7</sup>; more abstract theorising of social policy processes, applying formal models to understanding historical development of welfare provision<sup>8</sup>; and the literature on social exclusion that draws strong links between economic change and social policy.<sup>9</sup> Finally, there is a burgeoning literature on the social construction of social policy<sup>10</sup>. All of these include health policy as an element of social policy.

Though highly diverse, these literatures share several key methodological features. They all seek to integrate broader economic and social structures into the explanation of particular forms of social provision. They all treat policy as a largely endogenous variable: as something requiring explanation in context, not simply as extra-contextual proposition and argument. And, as a result, they all take seriously and integrate into their explanations of policy the particularity of the discursive construction of local welfare problems.

The welfare regime literature traces its roots to Titmuss’s (1958; 1974) writing on social policy. As the authors of a recent empirical study of the outcomes of different

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<sup>6</sup> We are using ‘thickened’ here in a way that is different to Geertz’ famous (1973) concept of ‘thick description’ but nevertheless invokes it: we mean an analysis that is methodologically rich in its explanatory tools, including interpretation alongside calculation.

<sup>7</sup> From a huge literature, see for example (Esping-Anderson 1990; Goodin et al. 1999; Lewis 1992).

<sup>8</sup> A good example is de Swaan (1988).

<sup>9</sup> See for example, Rogers (1995).

welfare regimes put it, particular welfare regimes ‘bundle together’ ‘particular values with particular programmes and policies’, and with particular patterns of organisation of the broader capitalist economy. ‘Different sorts of welfare regime pursue different policies and they do so for different sorts of reasons’ (Goodin et al. 1999: 5).

The European social exclusion literature was driven by a concern that in an era of high unemployment, increasing numbers of people were facing multiple forms of disadvantage, many without effective social protection from established welfare systems. Silver (1995) analyses the multiple concepts of ‘exclusion’ in that literature – the many answers to the question, ‘exclusion from what?’ – as expressions, not of confusion, but of attempts to rework, in specific contexts, shared understandings of society, polity and the need for social integration.

This concern to understand the social and political origins of policy intervention reappears in more formalist European work on welfare policy and history. De Swaan (1988), for example, investigates the circumstances in which public health interventions such as connecting slum areas of cities to the public water supply became politically possible and desirable. The main influences, he argues, were changes in medical information on the sources of epidemics, notably the transmission of cholera; changes in proximity and hence mutual knowledge, as the cities became dense, with poor areas in inner cities alongside wealthy quarters; and changes in marginal costs of public hygiene for the poor, such as clean water supplies, once most of the city was connected to pipes. The driving forces were a mix of self-interest and an affordable sense of responsibility by even the fairly poor towards the destitute:

‘the price of empathy has gone down so much that even the common people can afford it.’ (De Swaan 1988: 255).

At that point, municipalities effectively turned water supplies into a public good<sup>11</sup>, making it non-excludable by decision and providing sufficient infrastructure that consumption was not then in practice rival.

De Swaan’s analysis incorporates the discursive construction of social policy issues into its explanatory framework. This is also characteristic of the European social constructionist literature, which employs the concept of a ‘welfare settlement’ or ‘social settlement’: a stable (though temporary) ‘truce’ or compromise between embedded inequalities and redistributive social provision (Hughes and Lewis 1998; Williams et al.

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<sup>10</sup> See for example (Hughes and Lewis 1998; Lewis 2000; Mackintosh 1996)

<sup>11</sup> ‘Publicness’ is often considered an inherent characteristic of a good or service; the alternative view is that ‘publicness’ is in good part a social product.

1999). In this framework, social sectors such as health and education constitute arenas that both reflect and consolidate particular patterns of social inequality *and* offer an effective stage for challenging inequity. Such ‘settlements’ are periodically broken up and reworked as a result of social and political initiative.

These key methodological features are also identifiable in work of scholars in middle and low income countries on historical and sociological analysis of inequality and exclusion and of social policy. We illustrate the point from East Africa. Kaijage and Tibaijuka (1996) argue, for example, that the social exclusion framework is methodologically attractive because it combines an emphasis on understanding individuals’ experience of marginalisation through economic deprivation and social isolation with an understanding of the context of that marginalisation: the fragmentation of social relations, breakdown of social cohesion and the emergence of new economic and social divisions. The authors’ analysis of poverty and exclusion in Tanzania traces the cumulatively unequalising effects of economic crisis and decline to differential access to ‘economic assets, or allocative and decision making power, or favourable social connections’ (Kaijage and Tibaijuka 1996: 182). Health services, they argue, are mediating social institutions shaping marginalisation: the ‘battering’ taken by government- provided social support services during Tanzania’s severe economic crisis of the 1980s and early 1990s was a ‘motor’ of deprivation (Kaijage and Tibaijuka 1996: 186). Other scholars have also sought to develop more satisfactory conceptual frameworks for analysing social policy content and effects in East Africa, in the context of economic change, recognising in particular the blurred boundaries between state and non-state service providers and the ambiguities of ‘privatisation’ in the context of continuing dependence of non-governmental service providers on state support. Therkildsen and Semboja (1995) consider social policy as an aspect of broader economic policy shifts under the impact of external market and donor pressure and internal social differentiation and political struggles. Other papers in the same collection (Semboja and Therkildsen 1995) trace the historical trajectories of service provision in health and education, unpicking and reworking concepts such as ‘partnership’ ‘access’ and community action in the context of changing state behaviour.

More research on social sectors in low income contexts, that combines detailed economic analysis of distributive processes and outcomes with historical and sociological analysis of institutional and policy evolution and the interaction of social policy with broader economic and political change, will strengthen the scope for social policy that draws on local institutional strengths. Furthermore, the stronger the dialogue between local policy makers and local researchers, the more effective the research is likely to be in feeding into context-relevant institutional design. Conversely, one reason for the treatment

of policy as a largely exogenous variable, and lack of analysis of local institutional design for redistributive policy, may be the relative dominance – far more marked in writing on Africa than elsewhere – of external prescription within the overall policy debate. We seek below to make an analytical argument for the benefits of localisation and context-specificity in policy analysis of the scope for redistribution.

### **Political Economy and Health Care Systems: Reciprocity and Redistribution**

‘...redistribution, by which we shall simply mean an unrequited transfer of resources from one person to another’ (Boadway and Keen 2000: 679)

Redistributive behaviour in unequal societies is likely to be hard to sustain, since those with higher incomes must pay twice, once for themselves, once for others. Even to state the point thus starkly suggests the limits of prescriptive injunctions in policy analysis. Rather we need to explore what processes of institutionalisation and legitimation might sustain in theory, and have historically sustained, such behaviour over time.

Institutional economics has had a considerable impact in recent years on the way economists theorise economic behaviour in communities and markets (Ben-Ner and Putterman 1998). However, the literature has focussed overwhelmingly on the problems of and incentives for co-operation, and this has underpinned, in theoretical terms, the policy shifts towards decentralisation, co-production and community involvement in the social policy and development literature. Much less explored are the conditions for effective redistributive behaviour by governments, service providers, funding institutions and communities. As a result the policy literature, while criticising redistributive failure, pays too little attention to designing relationships that can sustain redistributive commitment.

Economists typically theorise redistribution, as in the above quotation, as unrequited gifts between individuals. The further social sector ‘reform’ proceeds in the direction of marketisation of supply and targeted gap-filling, the closer the redistributive process moves to that economists’ model: the more redistribution is institutionally separated out and made visible, the more stark becomes its social and political identification as unreciprocated gift. This is a source of concern, since both economic and anthropological theories of gift giving suggest that unrequited gifts are problematic to receive and to sustain.

Standard economic theory, including game theoretic models, constructs gift giving from better-off individuals to poor people as altruism. Redistribution of this kind will only occur if the better off *choose* to provide for others as well as themselves. Altruistic

preferences may be ethically based – the better off may be dismayed by extreme poverty – or they may be based in fear of disorder. The defining feature is that people's perception of their welfare, and hence their behaviour, is influenced by the welfare of others as well as their own (Barr 1998; Collard 1978).

The implications is that altruistic behaviour is fragile because of the 'free rider' problem: even altruists may not behave altruistically if they cannot be assured that others will do so too. In these models, income redistribution has the qualities of a public good: it will be underprovided unless participation of all can be assured. Hence, coercion through the tax system may be acceptable: a situation that Barr (1998:87) calls 'voluntary compulsion'. This kind of model is used to explain voluntary acceptance of redistributive taxes by failures of voluntary co-ordination; it does not seek to explain the altruistic preferences themselves nor consider how they may be sustained.

Game theoretic economic analysis, and associated experimentation, has shown that mutually 'collaborative' behaviour – such as resisting incentives to free ride - can be sustained even when individual incentives to 'defect' are high (Gintis 2000; Kreps 1990). Furthermore, experimentation repeatedly demonstrates mutual generosity – or 'gift giving' – and reciprocal collaboration for mutual benefit, beyond that predicted by an assumption of pure self-interest. Gintis – an evolutionary game theorist – formulates from these experimental results the hypothesis of *homo reciprocans*: in contrast to *homo economicus* this is a representative person with a 'propensity to cooperate' (Gintis 2000: 251) but who retaliates against non-cooperative behaviour. This whole body of work is widely argued to imply that voluntary collaboration is likely to be particularly sustainable in small communities where people perceive mutual benefits, know a good deal about each other, can see the consequences of their actions and will continue to interact over time; in these conditions communities support the continuation of 'pro-social' norms (Bowles and Gintis 1998).

Many of these results depend on the key assumption of mutuality of benefit to sustain collaboration. It is inattention to this assumption that underlies the elision, in some of the literature on social capital and health care, between collaboration and redistribution:

'Social capitalists...champion the importance in public policy of co-operation, community, equality, and inclusiveness..' (Kunitz 2001: 160).

‘Communities’ however are typically far from egalitarian, and in unequal societies there is a need for a much sharper distinction between co-operation and altruism. Very little game theoretic work has considered the consequences of persistent inequality for optimism about collaboration<sup>12</sup>.

The implication that unreciprocated gift-giving – unlike reciprocal generosity – is problematic to sustain is supported by the analysis of gifts in anthropology and sociology. Part of the definition of the ‘gift’ in the anthropology literature since Mauss (1924) is the close association of the nature of the gift with the giver’s and receiver’s social locations: gifts create social relations of dependence and obligation, in contrast to alienable commodities (Gregory 1982). The sociological literature explores 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 discursively framed as unreciprocated. The common thread is the link between gifts and social relationships: whether discursively framed as ‘free gifts’, or whether given in the explicit expectation of the reciprocation, persistently unreciprocated gifts create problematic relationships of dependency and unfulfilled obligation for both giver and receiver.

The economic, anthropological and sociological analysis all thus suggests that redistributive gift-giving may work best when embedded in relationships that are socially constructed as reciprocal. In the rest of this section we draw out some implications of this suggestion for redistributive behaviour in unequal societies, with particular reference to health care. We distinguish two ‘ideal types’ of unequal community. In each case, the community can be divided on the basis of the primary distribution of income into two sets of people, ‘better off’ and ‘poor’. Then we can distinguish:

Case A: where the membership of the sets is stable, that is, the same people are very likely to be poor and better off year on year; and

Case B: where the membership of the sets is unstable, that is, the probability of individuals shifting from one group to another from year to year is high.

We assume that ‘redistribution’ means that the ‘poor’ set receive a subsidy from the ‘better off’. Then redistribution is likely to be a sustainable public good in Case B, so long as the community has stable membership and mutual knowledge is high – people know who is better off and who poor. People who are better off know they may slip into poverty, and those who are poor know it may be temporary. In those circumstances the self-interested among the better off have an insurance motive to contribute to redistribution

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<sup>12</sup> An exception is Bardhan (2000) who explore the conditions under which inequality can undermine maintenance of local common pool resources.

in addition to any altruistic motivation they may have. Redistribution will in principle be sustainable whether there is a fund with formal rules requiring contributions (no payment when better off implies no support when poor) or whether informal collaboration is the means to ensure that the fund does not disappear because of free riding.

Mutual health insurance can build effectively on this model in ‘Case B’-type contexts. Mutual insurance schemes are widespread in Africa, and while they display successful risk pooling on a reciprocal basis, tend to exclude the very poor (Atim 1999; Criel et al. 1999). The more formal mutual savings schemes that include health care appear to be strongest when they are both embedded in, and operate to strengthen, wider reciprocal social ties (Atim 1999). Some locally initiated mutual health insurance schemes (but apparently no donor-led schemes in Africa) have built on existing mutual organisations (Atim 1999; Kiwara 2000: 887). There is certainly a redistributive element in these schemes, since prepayment improves inclusiveness of health care by increasing the use of the formal health care system by the seriously ill on low incomes (Criel et al. 1999). Incorporating those who cannot pay is hard because it breaks the mutuality on which the schemes are based, though some donor-subsidised mutuals in Africa have successfully incorporated locally managed exemptions for the indigent (Kiwara 2000).

Indian evidence also suggests that voluntary mutual insurance is hard to establish or sustain in contexts of acute social and income inequality (Giridhar 1993). Which brings us to Case A. In an unequal community where poverty and relative wealth are persistent features of individuals, economics and anthropology (and common sense) suggest that sustaining redistributive behaviour is hard. The group of persistently better off lack mutual benefit motives for generosity and the requirement of persistent altruism by one group towards another puts a heavy weight on ‘benevolence’.<sup>13</sup> A *homo reciprocans* assumption will reinforce that conclusion, since the poor cannot reciprocate. We should not therefore expect much active redistribution within such highly stratified small communities.

While the findings on the importance of insurance motives for mutual collaboration are conventional, what is less familiar is the drawing out of implications for the design of redistributive mechanisms in more stratified ‘communities’. If redistribution in such communities is necessarily based on altruism, or alternatively on some concept of duty, then these potentially fragile commitments may be more sustainable if they can be embedded in or supported by norms and expectations that contain some elements of reciprocity.

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<sup>13</sup> The phrase is from James Meade, who advised that policy should ‘economise on benevolence’; see Atkinson (1993).

Low incomes do not make redistributive health care impossible – as the Kerala example demonstrates – but in general they create severe dilemmas in confronting inequality. Case A is likely to be particularly relevant to many low income situations. So in Case A situations, is there scope nevertheless for embedding redistribution in reciprocity? We suggest that health care does offer particular opportunities to do so, in part because of the efficiency gains available from risk pooling and from constraining market incentives, and in part because of the ethical weight carried by the behaviour of health services in people's understanding of society and polity.

There are two ways of thinking about the embedding of 'gifts' in reciprocity. One, characteristic of institutional economics, formalises the idea that the 'return' that sustains duty-based redistributive behaviour by the better off may be standing, respect, legitimisation of relative wealth, or more generally, social 'regard' (Offer 1997). This suggests that recognition – professional or more personalised – may sustain persistent 'gift giving'.

Evidence of the difficulty of redistributive behaviour in small communities and of the relevance of this kind of personalised and professional reciprocity to addressing that difficulty can be drawn from research on local exemption schemes and local mutual insurance in health care. The introduction of user fees at government health care facilities, as part of health sector reforms, has often been associated with a requirement that the facilities offer some free or reduced price care to specified groups, usually including very poor would-be patients (Gilson et al. 1995; Russell and Gilson 1997). These cross-subsidised exemptions are thus unreciprocated local 'free gifts' from those who can pay to those who cannot. Research demonstrates that the poorest rarely benefit, and that those with status and power within communities frequently obtain free treatment (1999; Gilson et al. 1995; 1998; Russell and Gilson 1997; Tibandebage and Mackintosh 2001; forthcoming).

A case study of a genuinely effective exemption scheme in Thailand, however (Gilson et al. 1998) suggests that the conditions for its success included: clear, nationally set and openly applied criteria, adapted by agreement to local experience; information campaigns targetted at beneficiaries promoting their use of exemptions and generally of public health care; and *also* the embedding of redistributive action within local reciprocal relationships and meanings. For example, in Thai communities, a (small) observed 'leakage' of exemptions to some non-poor with close connections to village leaders and those held in high regard within the community was socially construed in this way: "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 would mean to make them proud and honoured?" (Gilson et al. 1998: 41-2). This type of cultural reworking of the

exemption schemes in terms of the duties of the better off and their due recognition may help to give them their observed legitimacy and sustainability.

We offer in the next section some evidence from our own research that personalised recognition is relevant to redistributiveness in small communities. Nevertheless, there is thus no reason to assume that small communities are more redistributive than national systems. Decentralisation – widely recommended – may have redistributive effects, but only if shaped by an appropriate combination of clear central guidelines, and openness to local adaptation and review, including review of central government practice; allocation criteria based on formulae further open the process to public scrutiny (Gilson and Travis 1998). To the extent that personalised redistribution is unstable, larger scale, more impersonal rules, legitimated through national social and political organising, appear to be central to redistributive success. National public action can also establish concepts of entitlements or minimum rights that can legitimise voluntary collective action to attain them.

The question of legitimation brings us to the second way of thinking about embedding ‘gifts’ in reciprocity. Drawn from anthropology and the ‘cognitive’ end of institutional economics (Scott 1995), this approach is less individualist in its modelling of norms of behaviour. Institutions here are not ‘rules’ of a game, and ‘norms’ are not observed regularities of behaviour; rather, norms are more like ‘scripts’ for sense-making, and institutions are things we ‘think within’, or that ‘think’ for us: parts of ourselves as social beings (Douglas 1987: 124; Scott 1995). These theorists argue that legitimate institutions are those that come (for a time) to appear in a carefully defined sense as ‘natural’: part of the world we take for granted, often expressed through metaphors associating them with the natural world. Douglas (1987) argues that such legitimate institutions ‘make’ big, difficult decisions such as some that arise in health care get made; we do not rethink each decision from first principles. This locates the shaping of institutions as a key policy issue, and also implies that policies are themselves influenced by existing institutions.

There is some evidence that successful redistributive behaviour in existing health care systems is sustained by embedding it in taken-for-granted reciprocal relationships and meanings. At the national level, high income countries are generally in the happier Case B situation. Longitudinal research suggests that a high proportion of severe poverty in these countries is transient: people move in and out of poverty over time, and persistent poverty – which is a serious concern – is focused in a small segment of the populations (Goodin et al. 1999). This suggests that the insurance motive for support of redistribution is likely to be strong. *Capacity* to redistribute is also strong (this was De Swaan’s point, above.) If we

add that the risk of severe illness affects the better off too, we have an explanation of the observed strong support in most such countries for highly redistributive universalist health care systems that does not depend on institutional legitimation.

However not in all: the USA is an outlier, with a much less redistributive welfare and health care system, despite conforming to the conditions just set out (Barr 1998; Goodin et al. 1999). Furthermore, citizens' preferences are observed to differ according to the system they live with. Europeans, for example, are found to have stronger commitments to health care equity of access than do citizens of the United States: as Besley and Gouveia (1994: 249) put it:

The US social equilibrium has traditionally taken it for granted that the poor deserve less health care than the middle classes.

By contrast, the standard of evaluation in European debate tends to be equal access in response to equal need. Social insurance for health care, once established, appears to reinforce the norms and values that support it<sup>14</sup>.

These reflections in turn suggest path dependency: norms and values interact with institutional development. How does policy intervene? There is evidence that redistributive action – including in health care – has historically become institutionalised where it was been closely involved in nation-building and the construction of concepts of citizenship. For example, Chiang (1995: 228) recounts how in Taiwan national health insurance was politically constructed as ‘a critical indicator of ‘good’ government in a modernising nation’ by the Kuomintang’s electoral platform, accelerating the acceptance of universalisation of access through tax subsidy.

Similarly Indian research shows that political commitment and ideology in favour of redistribution can influence health care tax allocation behaviour, especially when associated with active political pressure. In Kerala, for example, collective political organising 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). In contrast, in the large northern states with the worst health care record, these issues do not figure in party programmes and electoral politics are overwhelmingly dominated by élite concerns (Drèze and Sen 1995: 103).

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<sup>14</sup> Where the ‘insurance’ functions work poorly – as for cold surgery in the British NHS – the redistributive function ceases to be taken for granted, as in current UK public debate.

Health care, because of its ethical weight, is thus an important arena for political organising. Health systems, like welfare systems more broadly, once they enter the political arena, form part of the process of construction of who is a full citizen. Hence, they also exclude and stratify (in the UK notably, by ‘race’ and gender as well as social class<sup>15</sup>). The systems *both* reflect broader social inequality *and* form a political ‘stage’ for the contestation of inequality; they are thus important building blocks of legitimate democratic states. Critics of the limitations of coverage of the Korean national health insurance system, for example (Yang 1996) argue that resolving exclusion involves constructing ‘shared understandings’ and positive public meanings around the concept of social insurance perhaps through a ‘citizen’s movement backed by formal consumers’ organisations’ (Yang 1996: 251). Londono and Frenk (1997) argue that overcoming the blockage on health care redistribution in Latin American countries represented by institutionally polarised health care systems involves governments’ taking responsibility for ‘social mobilisation’ and ‘advocacy’ to create the social basis for universalisation. The difficulty of creating greater redistribution across established polarised systems, even in wealthy countries, is illustrated by the failure of health care reform in the United States.

### **Polarisation and the Problem of Health Care Redistribution in Tanzania**

The previous section has argued that redistributive commitment within a health care system appears to be an endogenous variable: that is, it is deeply influenced by the general patterns of social class and inequality in society, and also by the particular institutions of the system and the norms of behaviour established within them. For a health care system to operate redistributively requires not only government commitment to redistributive behaviour in allocation of funds, but commitment at the institutional level to operate in an inclusionary manner, and within communities to sustain inclusion of the poor. This is possible, though difficult, in ‘Case A’ situations, and easier, but not inevitable, in ‘Case B’.

In this section we draw briefly on recent research in Tanzania to illustrate what some of the implications of this argument might be for health care research and policy in a low income context. Liberalisation of formal private provision of health care in Tanzania and in many African (and other) countries, has reshaped existing health care markets, and created implicit choices about the direction of private health care market development. Social polarisation in some systems is limited but appears to be consolidating, facing governments with clear choices of policy framework. If we are correct that redistributive

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<sup>15</sup> See (Lewis 1996; Williams 1989)

commitment is interactive and path dependent, then early directions of institutional change will shape not only later options but also later decision making frameworks.

We start by providing some evidence for social polarisation in health care provision and access, using data on pricing and access by social group from recent research in Tanzania<sup>16</sup>. Tanzania is one of the world's poorest countries. GDP in 1999 was estimated at US\$240 per head (World Bank 2001); donor funding accounted in the early 1990s for more than half of non-private health care finance (World Bank 1996), and official development aid – which fell sharply in the 1990s – was estimated at 12.5% of GDP in 1998 (World Bank 2001). Spending on health care by government plus donors, estimated at less than US\$5 per head per year in 1992/3, or about US\$7.3 in total including private spending (World Bank 1996) was a long way below the US\$12 minimum the World Bank estimated was needed to provide basic preventative and clinical care, or the later estimate of \$35 by the Commission on Macroeconomics and Health (CMH 2001; Tibandebage 1995). Allocation of very limited public funding for health care therefore involves very invidious choices.

A period of rapid expansion of government health care provision in Tanzania in the 1960s and 1970s, and the abolition of private for-profit practice in 1977 (Upunda 2000) was followed by severe economic crisis and decline in quality of provision (Kiwara 2000). The subsequent liberalisation of individual private clinical practice by the 1991 Amendment Act no. 26 formed part of a wider process of economic and political liberalisation (Wangwe et al. 1998). In a context of severe and widespread poverty, the result has been a rapid rise in for-profit private practice only in the urban areas (Tibandebage 1999; 2001). Also in the 1990s, user fees were introduced in government facilities, first hospitals and later urban dispensaries and health centres. At the time of our study, in 1998 and 1999, only rural government dispensaries were not charging formal fees.

We studied two health care markets, in the capital Dar es Salaam and a contiguous area of Coast Region, and in Mbeya, a town in the Southern Highlands and an adjoining rural district. Most of the fieldwork was undertaken in mid- to late-1998, and included interviewing and data collection in facilities, and interviews with patients on exit and with household members in the facilities' catchment areas. At that time, most patients paid for consultations and treatment out of pocket, whether they attended government, religious-owned or private facilities (Table 1): in that sense this was truly a market system of health care, and our aim was particularly to understand the market interaction of types of facility

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<sup>16</sup> See acknowledgements in note 2 above; this section draws on Tibandebage and Mackintosh (2001).

and patients in local markets and their consequences for users and for those excluded. We were studying a moment in an evolving market system.

Table 1: transactions by payment category, exit and household interviewees, by market  
(number of facility visits)

Transaction type	Region		Total
	Mbeya	DSM/Coast	
Zero payment: government or donor funded*	27	5	32
Paid out of pocket by self or relative	141	161	302
Paid by employer	14	19	33
Total	182	185	367

\*Excludes visits with free consultation where a prescription was written and then filled at a private drug shop or pharmacy; includes visits where the question concerning prescriptions was not answered, hence may still overestimate free transactions.

In this context, Figures 1 and 2 provide images of what appears to be emerging market segmentation. The circles are primary care providers (dispensaries and health centres) in all sectors in Dar es Salaam; the size of the circles is weighted by activity level; the two axes show two independent measures of charging levels, mean stated facility prices and mean charges to patients leaving the facility. Two poles of activity with different charging levels emerge: these are small sample data, but the qualitative evidence supports emerging, but still incomplete social segmentation of the market.

Figure 1 Segmentation in the Dar es Salaam /Coast region health care market (Tshs)

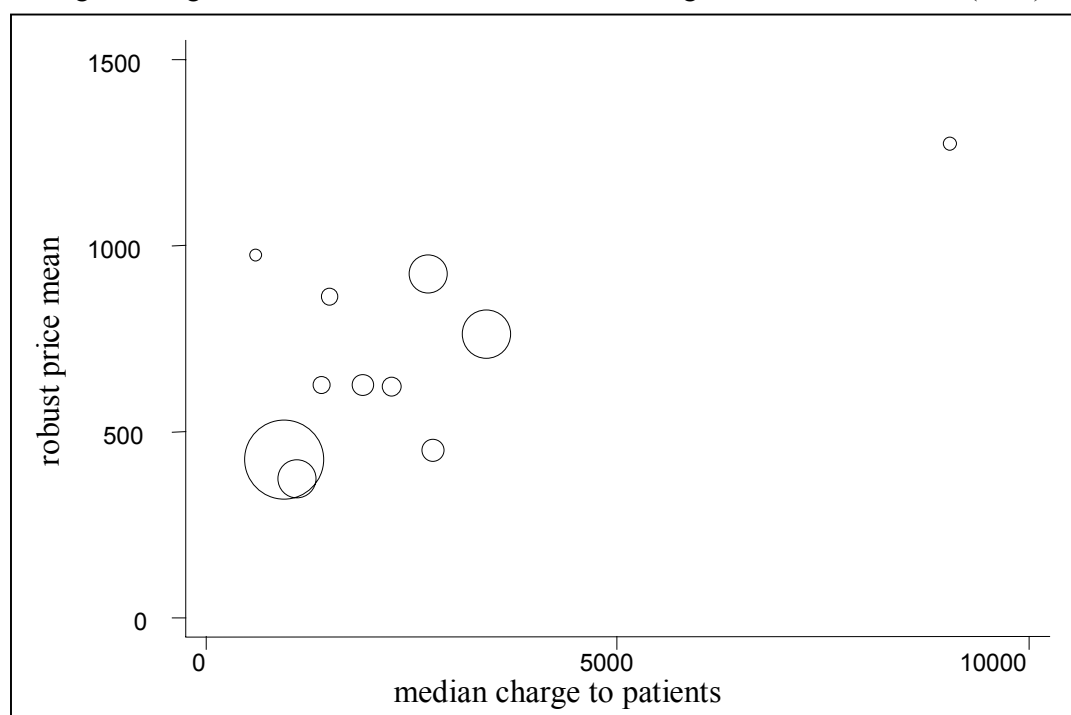
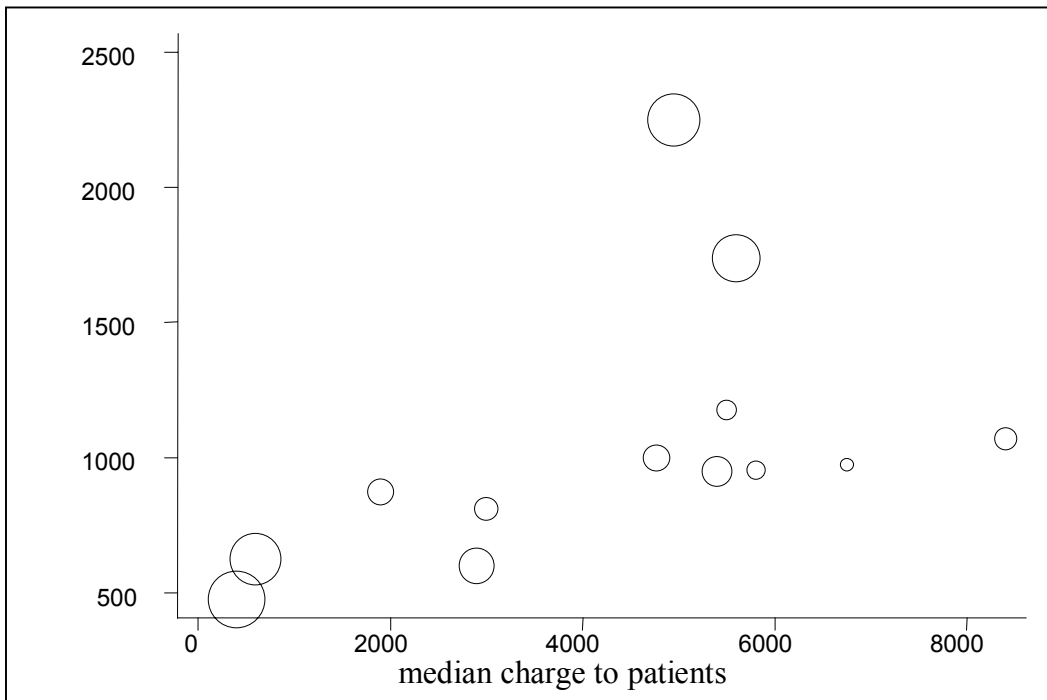


Figure 2 Segmentation in the Mbeya health care market (Tshs)

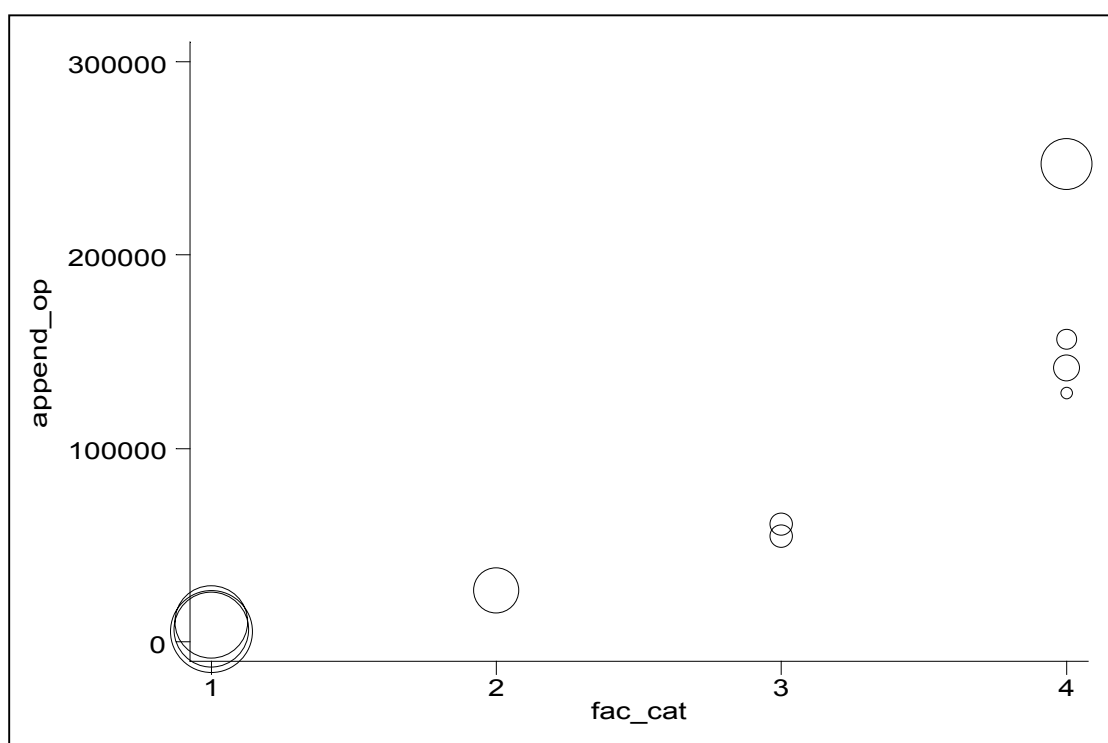


The two emerging poles are patterned by ownership. In the Dar es Salaam study, the large high-charging facilities are religious and private-owned facilities generally unaffordable by the poor; the large low charging facilities are religious and government-owned, and their quality is crucial to the access and experience of the poor. The scatter of small facilities in between are mainly private-owned, and the qualitative evidence suggests that they are also of considerable aggregate importance to the urban poor. The Mbeya data generate a recognisably similar pattern, though with more small relative to large facilities. Here, the large high charging facilities are both religious-owned; the two large low charging facilities are one government, and one religious-owned. The rest of the scatter is of mainly private small facilities, some patently over-charging relative to their declared prices. One of the most striking findings of this study is the polarisation of the religious-owned sector between low charging, genuinely charitable facilities, and facilities who were applying their subsidies and energies to serving the better-off (Tibandabage and Mackintosh 2001).

This image of polarisation is reinforced at hospital level. Figure 3 illustrates this point. It shows the facilities' stated prices for a basic inpatient stay in a hospital, not including the cost of drugs<sup>17</sup>. Again, the facilities are weighted by activity. The categories on the lower axis are (1) government (2) a rural religious-owned hospital (3) two small private hospitals in Mbeya (4) Dar es Salaam non-government hospitals, private and

religious. Categories (1) and (2) are markedly cheaper on all the available evidence, including interviews with patients, except for one of the government hospitals where informal charges and the requirements on the patients to buy all supplies and drugs from commercial suppliers had pushed up observed payments dramatically. The two Mbeya private hospitals, though much cheaper than *all* non-government hospitals in Dar es Salaam, were still out of reach of most of the population. Perhaps most dramatic however is the lack of hospital care options available in Dar es Salaam to those on even moderate incomes: if government hospitals fail the poor in the city, there is little recourse.

Figure 3. Hospitals, price of an operation (OPD consultation, appendectomy, inpatient charge), by facility category, scatterplot weighted by inpatient activity (Tshs)



The image of polarisation suggested by these facility-level data is strongly reinforced by the qualitative interviewing of patients on exit from facilities and household members in the catchment areas of selected facilities (Tibandabage and Mackintosh 2001). The health care system both reflects and reinforces social division and exclusion, most strikingly in the urban areas. There is evidence that the burden of impoverishment via the health care system was falling most heavily on the urban poor. The rural poor, and indeed most people in rural areas, continued to rely primarily on the government sector, and at the

<sup>17</sup> This is because the most expensive hospital (and only that facility, a religious-owned hospital) refused to provide drugs prices.

primary care level, the rural government facilities continued to constitute a partial safety net for this group. None imposed formal charges; informal charges were prevalent but very low compared with those in urban areas; and donor-supplied drugs kits, though limited, provided much needed free access to basic drugs.

Virtually all the low charge transactions recorded – zero or below Tshs 500 (already a large sum in rural areas) – were therefore in the government sector, mainly at primary level, and 88% of those were in rural areas. Of those rural government sector transactions, in turn, 95% were made by the poor: that is, by people who were small farmers or petty traders or dependent on them and who had primary education and below. Thus government sector transactions at low charges sustained access to some primary care by the rural poor; the provision in turn was sustained by donor-provided drugs<sup>18</sup>.

The urban poor lacked this limited recourse. The few government dispensaries and health centres in urban areas<sup>19</sup> were charging user fees by 1998, improving the drugs supply but implying exclusion of those without funds; only one in the study was widely said to ask for bribes, the others appeared to be charging only the formal fees. However they were few, and the urban poor relied strikingly on non-government facilities, including private for-profit, at the dispensary and health centre level (80% of visits by the urban poor), while turning almost solely to the government sector for hospital care; indeed they relied proportionately more than the somewhat better off on small local private dispensaries.

The quantitative and qualitative evidence is consistent. Over 80% of people classified as urban poor said they had never so much as heard of a case of free treatment. ‘There is no service without money’ was a repeated view; and we met no-one in this study who had benefited from, or could recount an example of, exemption from fees for inability to pay. In addition, the data show a pattern of abusive behaviour and informal charging at some (not all) government hospitals, and of abusive mistreatment at some private dispensaries. Both types of mistreatment fell most heavily on the urban poor, and were associated with high levels of exclusion and self-exclusion. Taken together, these data show a pattern of high charges, lack of free options, and reliance on abusive facilities that is worst for the poor in urban areas (though not limited to them).

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<sup>18</sup> Our findings accord with other recent research that shows that in many rural contexts, free drugs kits are distributed free of charge, indeed the ‘gift’ of the drugs appears to have a positive ethical impact on facility behaviour (personal communication from A. Raikes); these findings contradict the commonly held assumption by many donors, policy makers and academics that such drugs are generally resold.

<sup>19</sup> In the Dar es Salaam district studied, the 1999 Health Statistics Abstract shows 17 government dispensaries, and 39 government facilities in all (health centres, clinics and hospitals) out of a total of 339 health facilities. Mbeya

What are the implications for redistributive policy of this type of polarisation, and the associated impoverishment of the already poor who are struggling to pay fees?<sup>20</sup> In methodological terms, health policy cannot be conceived solely in terms of allocational processes for public funds. Allocation matters greatly, but resources are made effective through the operation of the health care system as a whole, and where markets dominate, public resources are employed, diverted, invested and recirculated through them. The distributional outcomes depend on the interactions within the system, and between system and users. The Tanzanian government has furthermore, by regional standards, been allocating a relatively high proportion of its funds to primary and preventative care; however in the context of the almost exclusive concentration of official donors on support of preventative and primary care, the hospitals remain heavily dependent on government funding support (World Bank 1996).

Furthermore, allocational processes respond to month to month fiscal and political pressures: as one government interviewee put it, in a situation of acute financial constraint, non-government providers promised subsidy ‘can only have one thigh of the duck!’. In other words, there are competing pressures and also bargaining processes that operate between formal and effective allocational decisions, and effective allocational commitment will depend on such processes.

We found that all health care sectors currently relied on funding from non-fee sources. Not only government but also religious, NGO and private providers depended on government funds and assets (not least, in the private sector, on government-trained personnel (Tibandabage et al. 2001). Some religious sector facilities were directly subsidised by government and many received donations. Official donor funds went into all three sectors. And private providers – finding it very hard to raise investment funds – also subsidised facilities from profits of other commercial ventures.

Finally, there are strong market interactions between health care facilities, and this should affect government policy on pricing and other aspects of policy (Tibandabage 1999). In this overall context, the right question to ask about the allocation of government funds, if the concern is to encourage redistributive behaviour, is surely: what would be the best use of these limited funds to influence the quality and improve the accessibility of the system as a whole?<sup>21</sup> While the government has, for example, few resources for inspecting

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Urban recorded 11 government facilities in all out of a greatly underestimated recorded total of 27 facilities (Dyauli 2000; URT 1999).

<sup>20</sup> The next few paragraphs draw on Mackintosh and Tibandabage (2000).

<sup>21</sup> We tried asking this question directly in our first round of interviews with policy makers in government and with other key stakeholders in the health care system, but found that it was not at the time understood.

the private sector, the overall (competitive) *weight* of government-funded activity in the system is very large – and even larger if donor spending is added to tax funding. It should be possible to use this weight to influence the evolution of the system – but to do so involves some rethinking of policy processes of type now very much underway in Tanzania<sup>22</sup>.

We summarise here some implications for thinking about policy approaches, based on our research and drawing on discussion at a health policy workshop in Dar es Salaam in 2000<sup>23</sup>, and link them to the theoretical arguments put forward above.

### *1. Build on Redistributive Success.*

This sounds obvious, but it is not. There were some real success stories in this study in providing some elements of a safety net for the poor but policy processes did not necessarily identify or ensure support for them. They included good government facilities in both urban and rural areas and some truly ‘charitable’ religious-owned facilities. Lack of recognition meant that they could be undermined, and the success not built upon. How can such successes be sustained against the counter-pressures of falling subsidy, and against individual and facility incentives to generate income from patients? Here, the discussion of reciprocity and institutionalisation offer ideas. To strengthen probity and ‘charitable’ cultures requires their embedding in a framework of local and national recognition, beneficial incentives, and greater policy leverage: recognised achievement is a considerable incentive for continued probity. One way to do this may be:

### *2. Strengthen desirable self-regulation*

Self-regulation has considerable dangers<sup>24</sup>. But collaborative self-managed associations of genuinely accessible providers of reasonable quality also offer considerable potential benefits<sup>25</sup>. In the religious sector they can help to develop, and can publicise, ‘benchmark’ fees and standards of accessibility and care; they can strengthen the existing

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<sup>22</sup> Some of the local policy rethinking is described in Mackintosh and Tibandebage (2000)

<sup>23</sup> The workshop proceedings are summarised in ESRF (2000).

<sup>24</sup> If poorly designed it can raise prices and increase exclusion.

<sup>25</sup> See Brugha (1998: 116); there is now widespread interest in accreditation and social marketing schemes among health policy analysts and donors, but Tanzanian policy makers in 1999 and 2000 found accreditation an unfamiliar idea.

networks of collaboration (such as those in the religious-owned sector<sup>26</sup>) by developing self-management capacity; in return, such publicity can raise activity in facilities and help good facilities to undercut poor ones. And membership can act as a ‘signal’ to donors of effective use of subsidy. The more visible, the more such associations can influence public expectations and debate and create pressure on those allocating funds: one among a number of possible ways of endogenising redistributive pressure on allocation of funds. This in turn (see Boadway and Keen 2000) might be aided by:

### *3. Involve the public in identifying success*

In the rural government sector, there was some evidence that community involvement played a role in sustaining probity and inclusion. Reciprocity between facilities and the public create beneficial reputation effects, but users have limited information. A benchmarking scheme that involved local communities in developing and publicising good practice could add to their knowledge and build on existing involvement. A district might identify a benchmark group of good rural facilities, that could be encouraged to develop higher levels of community scrutiny. The ‘label’ could constitute much needed recognition of existing probity and good practice, and encourage continuing donor support. This implies a fourth principle:

### *4. Abandon the ‘level playing field’ – differentiate providers*

Some facilities that serve the poor are dangerous and abusive, notably some but *not* all private dispensaries. Others offer competent basic care and cross-subsidise preventative care as a strategy to attract patients: their sustainability needs support, including help in surviving undercutting by poor quality competitors (which we found to be a serious issue, not merely an inevitable complaint). Some donors are already working on schemes to assist them. For-profit providers play an important role in determining quality of urban primary care. Self organisation can play a useful role, but it is hard for private providers’ organisations to police quality.<sup>27</sup> Particularly promising are schemes of accreditation to

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<sup>26</sup> The churches in Tanzania are actively developing collaborative policy and supervision, under the umbrella of the Christian Social Services Council; schemes such as this, if ‘owned’ by the sector, might also create new cross-faith networks between charitable Muslim and Christian facilities.

<sup>27</sup> There are emerging private sector associations: one represents particularly the private and elite religious hospitals (Kaushik 2000); one local association brings together smaller independent providers (Dyauli 2000). These organisations share information, are developing a role in policy-making, and try to identify opportunities for professional collaboration.

mutual and social insurance schemes, especially if this can be done collaboratively. This suggests:

#### *5. Develop mutual schemes that link users' organisation and clinical audit*

Mutual health care schemes that build on existing users' organisations in urban areas can also influence quality of care through clinical audit. One scheme that has done this successfully in Tanzania is UMASIDA (Kiwara 2000), an urban informal sector mutual insurance scheme. This builds on existing co-operative organisation, is largely self-financing, and has used clinical audit to influence the practices of accredited private dispensaries. This provides private providers with incentives for probity. Mutual schemes can also increase redistributiveness in another way:

#### *6. Embed exemptions in mutuality*

Exemption schemes require collaboration between communities and facilities and, for very impoverished communities, external funding. Some donor-subsidised mutual community health funds have successfully encouraged and required communities to identify candidates for exemptions (Kiwara 2000). Embedding redistributive obligations within schemes of broad community benefit - and publicly valuing the fulfilment of those obligations - appears to be a route to sustainability. We met a clinical officer in a government dispensary who had asked village leaders to help identify candidates for exemptions and met a flat refusal; closer involvement in facility management could change that attitude. This implies:

#### *7. Stabilise links between facilities and groups of users, to increase 'voice'*

Health care users and would be users were found to be far from passive<sup>28</sup>. Rather, they actively sought and circulated information, and discussions with household members of value for money from different facilities were well informed. However, users faced the system as individuals, and people feared complaining. To strengthen users' voices requires some forms of collective action and representation, which were most likely to work where they could build on stable links between groups of users and particular sets of facilities: in

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<sup>28</sup> Contrary to expectations of many policy makers but in line with a good deal of recent research on health seeking behaviour (Leonard 2000a; Segall et al. 2000).

addition to pre-payment schemes, the possibilities include building on existing village and urban local structures' initiatives; formalisation of lay involvement in facilities management; and local collaboration with primary providers to try to create effective referral and a stronger primary providers' role in representing patients' interests. Which brings us to:

## *8. Blur the boundaries*

We share the view, expressed by one of our interviewees, that 'privatising middle class care' is most unlikely to make the health care system as a whole more redistributive. Rather, the more the system can be prevented from polarising in terms of both finance and providing institutions, the more it is likely to be possible to sustain and increase redistributive and inclusive behaviour. If we are right that separating out redistribution in institutional terms makes it fragile, then blurring boundaries makes it easier to extract cross-subsidy through reciprocal benefits: efficiency improvements for redistributive action.

Keeping poor and better off in the same institutions also reduces middle class ignorance of, and distancing from, the problems. Blurred boundaries make experiment easier, and potentially allow desirable institutional cultures to help to break bad ones. They allow more efficient sharing of scarce resources; can reduce stigmatising of the government sector; and permit independent providers access to government resources. Tanzania already has some successful examples of cross-subsidy from private wards in government facilities helping to ensure that lower paying patients also have access to equipment and specialists. Opportunities for private income can help to retain good staff, and can if well managed help to sustain a culture of high quality care for lower income patients. In addition to mixed institutions:

## *9. Negotiate explicit returns for government support*

Elite hospitals given non-profit status can also reasonably be asked in return for explicit contributions to the capacity, quality and inclusiveness of the health care system as a whole: expanded contributions to training, including support of trainees and collaboration with other institutions; allowing lower charging institutions access to scarce equipment at low prices; exchanging staff with other institutions to assist with updating skills, including management skills; and providing specified services to patients referred from government facilities free or at low cost. Creative negotiating can create more efficient use of scarce

resources through cross-boundary collaboration: cross-boundary contracts for staff with explicit and monitored government sector commitments; joint equipment purchase and maintenance schemes between institutions. Even in a country as poor as Tanzania, expensive assets are being underused. Given the financial fragility of the private and religious owned elite sectors, there is considerable scope for the joint creation of public goods and shared assets for mutual benefit.

### **Conclusion: Redistribution in Conditions of Path Dependency and Policy Endogeneity**

The ideas that market systems are path dependent in their distributive behaviour and that policy itself is in good part endogenous are both increasingly accepted in economics (Atkinson 1999; Hoff 2000; Kanbur and Lustig 2000). Much analysis of European social welfare systems takes the same view: the institutions evolve in path-dependent form influencing policy development in the process (Section 3). The health policy and more generally, the social policy literature in the development context, needs to follow suit: its methodology at present is insufficiently 'social' in content and insufficiently dynamic in its economic analysis.

To improve policy analysis, a shift is needed towards more space for localism in social policy work, in the sense of the building up of local literatures on social security and social provisioning. Countries where donors' prescriptive fashions have operated with less force than in much of Africa, such as some East Asian countries, have built up distinct literatures and traditions in social policy<sup>29</sup>. There is a considerable body of research on African social security and social policy by local scholars including historians and sociologists, and a lot of individual involvement of local researchers in policy, but it has been hard for African researchers to build up the networks and visibility needed for the further development of distinct policy traditions.

There needs, relatedly, to be space for methodological as well as prescriptive debate. The models of health care funding allocation emphasised by the multilaterals are one important contribution to those debates in health care. The policy debate would be enriched by more space also to debate issues of the type discussed above: the compromises between inequality and redistribution required to sustain redistributive behaviour in particular contexts; the existing local patterns of reciprocity that can be built on to support redistributive action; the particular pattern of market behaviour emerging in health care and its implications; the scope for focussing on health care as an 'arena' for public action to

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<sup>29</sup> For example, Japan, Taiwan, South Korea; from a large literature see for example (Campbell and Ikegami 1998; White et al. 1998)

increase social inclusiveness; and the consequences of a recognition that behavioural influences run in both directions, from social provisioning systems to government distributive behaviour and back.

Health care markets – like other social markets – are very internationally diverse. Some are more polarised and more exclusionary than others. There has not been enough research on the reasons for the differences and their implications for policy. In principle, we would expect that the market differences relate to a mixture of the broader patterns of inequality in society; the inequality of resultant endowments that people bring to market; the market culture itself; the level of political activism around market organisation and behaviour; and the cumulative feedback between those seeking care and facilities' development, including the impoverishing effects of charges on the already poor and the consequences of price-based competition for very poor users. There has recently been an increase in market studies in health care; they need bringing together in locally appropriate ways with the work on allocation of subsidy.

Theoretical and empirical research in health policy and development thus needs to pay more attention to the social, political and institutional conditions for sustained redistribution, indeed to bring that problem back to centre stage. The general implication of our arguments is a search for policies that work with *some* of the grain of existing health care institutional behaviour while creating active blocks on undesirable directions of institutional development. The early stages of emergent market development offer particularly crucial opportunities for influencing the later path of development. Policy intervention, if well thought out, can push the system towards increasing redistributiveness and probity in the medium term, rather than exacerbating inequality and poverty. In circumstances such as these, government action within partly polarised systems will help to shape the scope for future integration. Governments do not only fund care; they also influence – and are influenced by – the institutions that emerge in the market. Donor policies that try to *exclude* governments from such involvement, by pushing for a polarisation between private provision for the better off and public provision for the poor, are likely to have strong negative effects on government redistributive capacity and commitment.

Health policy would also benefit from more research on and policy attention to legitimacy: to the ways in which redistributive action is legitimated in unequal societies. We need more research and debate on how to value and sustain in low income contexts cross-subsidy, charitable provision, and competent provision free at the point of use. There are good examples of all of these in African contexts, but their legitimacy has been

challenged and their achievements denigrated, and the questions have been squeezed out of the research literature by the ‘polarising’ policy mindset discussed above.

Our general argument is simply for a closer focus in the social policy literature on the political economy of redistribution, including the process of legitimating and strengthening claims to redistributive behaviour, the influences on the distributive outcomes of private/public systems, and the scope for sustaining redistributive behaviour by embedding it in forms of reciprocity. Such a research programme needs to pay close attention – it follows from many of the arguments above – to the discursive construction of social policy; the currently dominant social policy discourse and mindset is a real roadblock for policy makers with redistributive intentions.

The two alternative policy ‘visions’ of the state as gap-filler and the state as a major player in the shaping of the system as a whole, thus need revisiting and debating explicitly in current development contexts. The economic literature on redistribution documents what Lindert (2000) calls the ‘Robin Hood paradox’: the more unequal pre-tax/benefit incomes, the less redistribution there tends to be on both cross-section and longitudinal evidence. Lindert regards this as a ‘paradox’ since high levels of inequality generate an *efficiency* case for redistribution. From the political economy perspective, far from paradoxical, the evidence further supports a hypothesis of path dependency and endogenous policy development.

Health policy is a particularly promising field for redistributive action and agitation, because redistributive mechanisms can be designed to have strong efficiency properties, given the extent of private health care market failure. Where these joint benefits can be allied to political processes that legitimate access by the poor and value success, redistribution can be sustained. This is, in essence, the argument of the ‘social settlement’ literature (Section 3): that explicitly accepting within health and welfare systems some forms of social inequality has been historically an important element in for stabilising redistributive success. This argument does *not* suggest that some forms of inequality are fine. Rather, it focuses attention on the culturally specific processes whereby redistribution has been actively fought for in different countries, and on the way in which associating rights to social provision with the construction of citizenship can be both effective and double-edged. Redistribution through social provisioning has never been just a ‘technical’ matter; rather it has been a crucial element in the fight for democratic governance.

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