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U4 BRIEF

Informal pay and the quality of health care: lessons from Tanzania

Informal payments for health services are common in many transitional and developing countries. Informal payments are often claimed to reduce access to health services, especially among the poorest. Impacts on the quality of care are, however, less obvious. Both positive and negative consequences are conceivable.

This Brief draws on a qualitative study among health workers in Tanzania to describe the nature of informal payments that are taking place in the health sector, and their potential impacts on access to and the quality of health care. Particular attention is devoted to the policy implications. A more comprehensive report from this research can be found in CMI Working Paper 5/2007.

Background

Informal payments, defined as cash or in kind transfers to service providers in excess of official user fees, raise concerns both about access to health care and the quality of the services provided (Transparency International, 2006).

In order to gain a better understanding of the practice of informal payments in the Tanzanian health sector, and their potential impacts on health service provision, we conducted eight focus group discussions with 58 health workers from one rural and one urban district in Tanzania. In order

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to stimulate a free expression of experiences and views, separate group discussions were conducted for each cadre (doctors, nurses, clinical officers and medical assistants). Participants represented all the different levels of care (hospitals, health centres and dispensaries) and included staff from both government and private facilities.

Our findings suggest that patients are making informal payments in order to buy higher quality services, including shorter waiting times. Moreover, health workers are involved in 'rent seeking' activities, such as creating artificial shortages, in order to extract extra payments from patients. Gifts of appreciation are also common, but the distinction between gifts and bribes is often blurred because apparent gifts may be intended to buy better services in the future. Health workers may share the payments received, but only partially, and more rarely within their cadre than across cadres. The discussions revealed that many health workers think that the distribution of informal payments is grossly unfair.

How informal payments may affect access to health services

Informal payments, like formal ones, will increase the cost of seeking health services and may therefore induce patients to delay or forego health care. It is often therefore argued that informal payments will reduce access to health services, especially for the poor.

This conclusion may, however, be a bit too hasty because local health workers will often be able to differentiate their claims between patients with varying abilities to pay. When such "price" discrimination is possible, health workers may choose to ask poor people to pay only such small amounts as are compatible with their continuing to seek health care. With perfect price discrimination, informal payments do not necessarily lead to a reduction in the utilisation of health care. In fact, informal payments may be less detrimental to the poor than formal, and more rigid, user fees.

Our findings suggest, however, that even if health workers were able to discriminate the level of informal payments perfectly, they might not be interested in doing so. When patients have given a bribe, it seems to put them in a significantly stronger bargaining position vis-à-vis the health worker; even if the bribe is small, the patients may become quite demanding of the health workers. This may happen if there is a fixed cost of receiving a bribe. Such fixed costs may arise, for instance, if there are social norms that oblige health workers to give a certain minimum level of care to people who have paid, or if there is a positive probability of being charged with corruption, and the associated expected costs contain elements that are unrelated to the size of the bribe. For reasons such as these, health workers may be reluctant to accept small bribes. The result is that access to health services will be reduced for the poorest.

Another reason why health workers may not want to discriminate on price is that the workload may be too big. Many developing countries have a shortage of health workers, and the use of informal payments may then be a way to ration the demand. The poor are of course the most likely ones to reduce their demand. It is not obvious, however, that alternative rationing mechanisms would have been more favourable to the poor.

Finally, even if health workers know which patients are rich and poor, they may not be able to collect informal payments from the rich. People who are better educated are typically more able to claim their rights and thereby resist some of the attempts to collect informal payments. Hence, a system of informal payments may in some cases become more inequitable than formal user fees, because it is only the relatively poor who have to pay.

How informal payments may affect the quality of health services

Our research revealed a variety of mechanisms through which informal payments may impact on the quality of health care. A more profound understanding of these mechanisms is of interest because it may improve knowledge of how quality may be reduced or enhanced within a system where informal payments are common practice.

Positive impacts on quality

Induce higher worker effort

A positive impact of informal payments on the quality of care is not difficult to imagine when the payment has the character of a fee for service. To provide high quality services will normally involve some personal (non-pecuniary) costs for the service provider (effort costs). The provider may therefore reduce quality to a minimum unless there is some reward related to high quality service provision. Such rewards may take many different forms (e.g., satisfaction from helping the patient or from complying with professional quality standards), but for some health workers monetary rewards may be what is needed in order to persuade them to provide high quality. Informal payments may then induce higher quality of care.

Increase the effective supply of health workers

When informal payments constitute a large share of the income of health workers, these payments may prevent the workers from taking up alternative or second jobs. Hence, informal payments may increase the total number of health workers and/or increase the total time that each worker is available for service delivery. In a situation with a shortage of health workers, this is likely to improve the quality of the service, both through a reduction of waiting times and through an increase in the time available for each patient. We did not systematically collect data on the amount of informal payments received by the health workers in Tanzania, but examples were reported where clinical officers received more from informal charges than what was on their ordinary salary slip. We have no reason to believe that this is a general pattern, nor can we deny that it is. But there is clearly a possibility that informal payments in Tanzania contribute significantly to keeping up the effective labour supply in the health sector.

Induce quality competition among health workers

Although the receivers of informal payments may choose to share what they get with other health workers, our informants suggested that sharing is only partial and does not benefit all. Sharing between workers at different levels of care (doctors and nurses, for

instance) appears to be more common than sharing among workers within the same cadre.

Limited sharing of informal payments may in fact have a positive impact on the quality of care, because it creates competition among health workers about becoming the receiver of payments. In essence, the health workers bid for payment by raising service quality, as perceived by the patients.

We would expect the magnitude of this competition effect to depend on the number of care takers available. A single provider will be in a monopoly situation and no competition will take place. If more workers arrive, the competitive pressure will increase. Hence, in a system where informal payments take place an additional positive effect on quality may derive from increasing the number of health workers, due to increased competition among the workers for payments.

A quality competition race may lead to a kind of collectively irrational behaviour, as seen from the perspective of the health workers. In the extreme case, the health workers may simply be exerting higher effort without being able to extract higher total revenues from their patients. In such cases, norms may develop that induce health workers to compete less aggressively. Statements about health workers who talk condescendingly about colleagues who provide high quality suggest that such norms may have developed in some facilities in Tanzania. In the presence of such norms, the potentially positive effect of competition on service quality is obviously reduced.

Negative impacts on quality

Create artificial shortages

If there are prospects of receiving informal payments, health workers may be induced to create artificial shortages and thus reduce the quality of the service. For example, if doctors think that patients are willing to pay bribes in order to bypass a queue, there will be an incentive for the doctors to create a queue, for instance by working more slowly. Such rent-creating / rent-seeking activity will increase waiting times, which represents a reduction in the quality of the service.

Another example: imagine a ward with few health workers relative to the number of patients, implying that patients may be "competing" for the scarce time of the health workers. By reducing the time available for patient care (e.g., by having longer breaks), the patients' willingness to pay for the providers' time may increase at the margin. The "market clearing" price will then increase, which possibly may increase total incomes for the providers, in the same way that a monopolist may benefit from supplying a low quantity since the price per unit then will be higher.

In a system where high quality service is taken as a signal that bribes have been received, non-corrupt health workers may be induced to reduce their quality of care.

A common strategy, as reported by our informants, is to pretend shortages of drugs and supplies and ask for money from the patients in order to "buy" the missing supplies in the private market. Having received the money, the health worker simply picks the supplies from the available stock at the facility. Obviously, these embezzlement strategies can work only because patients think that being "out-of-stock" is common. Quality reductions in this case will be related to the wastage of time in convincing patients of the need to pay.

Bargain for a higher share of payment

Health workers may reduce the level of quality in order to bargain for a larger share of what their colleagues have received. One example is when nurses withhold quality in order to put pressure on a doctor to share the bribes that s/he has received. Doctors will often depend on nurses in providing the services required to the satisfaction of the patient. A nurse who suspects that the doctor has received a bribe, without sharing with the nurse, may then start to withdraw care from the patient. A doctor who feels obliged to satisfy the patient will then be forced to reveal that he has been bribed.

Signal that the threshold quality is low

When informal payments can be extracted, there may be incentives for health workers to reduce the quality of care in order to signal that there is much to gain from paying. Health workers will normally be guided by some professional or ethical standards to provide a certain "threshold" level of services even without any payments. Patients will then be willing to pay only for the value of services beyond the threshold. The problem, of course, is that patients have limited information about the actual threshold. Therefore, if a health worker is able to convince the patients that the threshold is low, the patients may become willing to pay more in order to receive a given level of service. One way of signalling that the threshold is low is to provide low quality in the initial stages of a consultation (e.g., to receive the patient in an unfriendly manner, to proceed very slowly with the work, etc.).

Create frustrations

When a system of informal payments becomes institutionalised to the degree that health workers feel they have a claim to a certain share of the payments, perceived unfairness in the actual allocation of the revenue may in itself impact on the quality of services. Our informants suggested that health workers in Tanzania may feel that they have such claims and that failures to meet their expectations is creating frustration and lower levels of motivation. It is not obvious that such frustration will lead to lower levels of care, but it is not unlikely, and our findings clearly point in this direction.

Signal of non-corrupt behaviour

In a system where high quality service is taken as a signal that bribes have been received, non-corrupt health workers may be induced to reduce their quality of care. Our results point in the direction that provision of high quality care may easily create suspicions about corruption. When this is the case, non-corrupt persons who also want to maintain a high level of self-respect will be discouraged from providing their "normal" level of care. At the same time, of course, the fact that high quality is associated with bribery indicates that it has a positive effect on the quality of services delivered by corrupt health workers. The net effect will in this case depend on the relative shares of

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corrupt and non-corrupt workers. Note that a non-corrupt health worker will experience lower welfare when working in an institution where corruption is prevalent, because he is bound to compromise in one way or another. We might therefore expect non-corrupt workers to seek to move away from these institutions. This might be one explanation why participants in the focus groups maintained that the level of corruption differs across facilities.

Policy implications

Our findings have potential implications both for policies aiming at a reduction or elimination of practices of informal payment and for policies with the more parsimonious goal of minimising the adverse effects of informal payments on access to and the quality of care. It is important to stress, though, that our limited data do not enable us to make any specific policy recommendations.

1. Compensate for loss of informal payments in order to keep up the health workforce

Since informal payments for some health workers may constitute a significant share of their total income, there is a risk that a sharp reduction in informal payments may reduce the availability of health workers, unless the removal of informal pay is compensated by higher salaries.

2. Inform communities about resource availability

While a general recommendation for reducing corrupt practices would be to increase the supply of scarce resources, our findings suggest that more may be needed. In particular, to increase the supply of drugs may only lead to more money going into the pockets of health workers unless patients are informed that supplies have been increased. Embezzlement related to drug supply can continue as long as patients believe that there is a shortage. Information to patients about resource availability may thus be a key component of anti-corruption campaigns.

3. Increase the number of health workers

To increase the number of health workers may have beneficial effects beyond what is normally accounted for, due to a general reduction in the length of queues and therefore reduced opportunities to extract rent, leading to fewer incentives for reallocating scarce resources towards patients with the highest willingness to pay. In addition, increasing the number of health workers may have positive effects on the quality of care via increased competition for informal payments.

4. Improve management systems

The observation that there are facilities with much lower levels of corruption than in others may or may not have interesting policy implications. It does not necessarily have policy implications if the reason for the observed pattern is that health workers who are non-corrupt seek to come together in facilities with other workers of the same type (self-selection). Nor does it necessarily have strong policy implications if the reason is that the institutions themselves have carefully selected their workers, because the pool of non-corrupt workers may be a fixed one. However, our participants also noted that part of the reason for there being less corruption in some facilities is better systems of supervision and management, which may imply that effective corruption control actually can be achieved in a Tanzanian context through systemic reform.

5. Make punishments for bribery sensitive to the size of the bribe

As for the debate about informal payments versus formal user fees, our analysis emphasises that there are inherent distributional problems with a system of informal payments, because 1) scarce resources may tend to be allocated to rich patients rather than to the most needy, and 2) because health workers may be unwilling to accept small bribes due to certain fixed costs in receiving bribes. One policy implication is that punishments of bribery should be made sensitive to the size of the bribe in order to minimise the fixed cost element involved in bribery. Moreover, to make the punishments over-proportional to the size of the bribe is likely to be to the advantage of those who are not able to make large informal payments.

6. Stimulate open discussion about the unfairness of the system

Given that a system of informal payments is in place, there may be reason for the personnel in charge of health facilities to initiate discussions with the employees about the perceived unfairness in the system. Our findings suggest that a reduction in the level of frustration due to unfair allocations of informal payments might lead to improved quality of care. On the other hand, increased openness around systems of informal payment might undesirably give increased legitimacy to these practices. Moreover, increased openness about the system might strengthen cooperation among health workers in extracting rents from patients, which may have a negative impact on quality.

Finally, it is important to stress that even if it could be shown that informal payments had a positive impact on the quality of care, this alone would not of course be a convincing argument that one should not fight corruption in patient-provider relationships. Corrupt behaviours in the health sector may impose costs on society far beyond the arena that we have been discussing here.

Photo by Ida Lindkvist, CMI