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Inequality and Distribution in Health Care

Analytical Issues for Developmental Social Policy

Maureen Mackintosh and Paula Tinbandebage

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UNRISD, Palais des Nations
1211 Geneva 10, Switzerland

Tel: (41 22) 9173020
Fax: (41 22) 9170650
E-mail: info@unrisd.org
Web: http://www.unrisd.org

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Social Policy, Health Care and Redistribution: An Introduction

This chapter[1] 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[2] 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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2 The fieldwork in 1998 and 1999 was supported by the DFID, see footnote 1. We thank A.D. Kiwara, P. Mujinja, P. Ngowi, G. Nyange, V. Mushi, J. Andrew, F. Meena, and J. Kajiba for their contribution to the design and undertaking of the research; Marc Wuyts for discussion, encouragement and help with data analysis; and everyone in the four fieldwork districts in Tanzania who gave their time to facilitate our research. The same disclaimer applies.

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 also1993; 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[3]. 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'[4] 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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[3] 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).

[4] 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[5]. This literature has the great strength that it recognises interactions within health care