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Informal Payments and the Quality of Health Care in Tanzania: Results from Qualitative Research

Ottar Mæstad
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1. Introduction¹

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

A growing number of studies have documented the nature, the extent and the causes of informal payments in transitional economies (Vian et al., 2006; Gaal et al., 2006; Belli et al. 2004; Falkingham, 2004; Ensor, 2004; Balabanova & McKee, 2002; Thompson & Witter, 2000; Lewis, 2000; Chawla et al. 1998; Delcheva et al., 1997). Informal payments are also common in developing countries (Nahar & Costella, 1998; McPake et al., 1999; Di Tella & Savedoff, 2001; Lindelow & Seernels, 2006; Lewis, 2006). No studies have been published on the extent of informal payments in the health sector in Tanzania, but a grey literature exists with numerous reports of informal payments for health services (Mamdani & Bangser, 2004).²

There is little evidence on the impact of informal payments on the utilisation of health services and the quality of clinical care. It is obvious, however, that informal payments, like all other payments, *ceteris paribus* will increase patients' costs and thus deter access and reduce their demand for care. Informal payments may thus induce patients to forego or delay care (Nahar & Costella, 1998; Lewis, 2000; Falkingham, 2004). The demand-reducing effect of informal payments may, however, be smaller than the demand-reducing effect of formal user fees, because informal payments give greater opportunities for price discrimination, typically leading to lower payments for people with less ability to pay (Belli et al., 2004; Falkingham, 2004).

If informal charges increase the quality of health services, their net effect on demand is not necessarily negative (McPake et al. 1999). The idea that user charges may improve service quality has been a rationale for the implementation of health sector user fees in many developing countries. In theory, therefore, charges may increase utilisation of the health services despite the increase in the price. The limited evidence available suggests, however, that user fees have reduced utilisation (Palmer et al., 2004). It is still possible, though, that user fees have had a positive impact on the quality of care.

The effects of informal payments on the quality of care are likely to differ from the effect of user charges for a number of reasons. On the one hand, informal payments tend to a larger extent to find their way into the pockets of health workers rather than to the facility as such, and are thus less likely to improve infrastructure or the availability of supplies. On the other hand, this fact also implies that informal payments may give health workers stronger incentives to stay at their duty posts, thus improving the availability of staff (Chawla et al., 1998). Some have also noted that informal payments may have a negative impact on the quality of care, through artificial lowering of service standards, delays of treatment, or through giving "too much" service (Gaal & McKee, 2005; Balabanova and McKee, 2002; McPake et al. 1999).

¹ Address of correspondence: ottar.mestad@cmi.no. For their useful comments, we are grateful to Astrid Blystad, Gaute Torsvik and to seminar participants at the iHEA conference, Copenhagen, and the NFU conference, Bergen.

² Two surveys from Tanzania have reported that, respectively, 6% and 22% of the population have paid bribes to health workers over the last 12 months (ESRF & FACEIT, 2002; REPOA, 2003) and that the health sector, together with the police, are the sectors where people most often encounter corrupt practices. As this paper will show, however, many Tanzanians classify informal payments in the health sector as "gifts of appreciation", even though these payments are expected to buy additional services, at present or in the future.

This paper adds to the existing literature by discussing in greater detail how a system of informal payments may affect quality of care through the interactions that are taking place among workers in the health facilities. We provide examples of various types of informal payment that occur in the health sector in Tanzania, explore the ways in which these payments are allocated among workers, and their effect of health worker behaviours and the quality of health services. We will obviously not be able to establish facts with statistical significance. Rather, our aim is to increase our understanding of behavioural dynamics at work in relation to informal payments in the health sector and to generate hypotheses that can be rigorously tested in future research.

2. Methodology

Mainland Tanzania is administratively divided into 124 districts. Around 200 hospitals, 500 health centres and 4500 dispensaries make up the backbone of the health services. The population of 38 million is served by less than 50,000 health workers, more than 35% of whom are medical assistants with little or no formal training. Tanzania has the world's lowest number of physicians per capita and most of the clinical work is performed by clinical officers. More than 40% of the health services are provided by NGOs, in the rural areas mainly by church-based organisations and in the big cities mainly by private for-profit organisations (Mæstad 2006).

This paper is based on a study carried out in June-July 2006 in the districts of Temeke in Dar es Salaam region and Kisarawe in Pwani region. Background statistics on the districts are summarised in Table 1.

Table 1. Background statistics from research districts

	Population	Infant mortality (per 1,000)	Under five mortality (per 1,000)	Population below poverty line (%)	Female literacy (%)	Hospitals	Health centres	Dispensaries
Kisarawe	95,614	94	152	51	51	1	2	16
Temeke	771,500	84	134	29	83	3	4	94
<i>Tanzania</i>	-	95*	162*	36	62	-	-	-

Source: Government of Tanzania (GoT, 2005) and Ministry of Health.

*Data are based on the 2002 Census. The Demographic and Health Survey from 2004 reports lower levels but does not provide data at the district level.

We used focus group discussions (FGDs) with health workers in order to generate data on informal payments in health facilities and how these practices may affect the quality of care through the dynamics of health worker interactions. We also asked questions about the reasons why informal payments are made and what the respondents considered to be effective measures against these practices. The study was designed to collect data on several other performance variables in addition to informal payments, such as the quality of care, patient courtesy, and absenteeism. Additional time was set aside for the health workers to express their general views and frustrations about their working situation. Placing the discussion of informal payments within a broader context of inquiry may have made health workers more willing to share their experiences on this sensitive issue. Data from the FGDs were supplemented by in-depth interviews with health workers from a couple of the facilities represented in the FGDs.

We held eight FGDs, four in each district, with a total of 58 participants. The groups were divided by cadre (doctors, clinical officers, nurses, medical assistants in different groups).³ Participants confirmed that this division was crucial in order to allow them to talk freely, both about issues specific to their own cadre and about their relationships with other cadres. Moreover, as there was a tendency to talk more openly about what other cadres were doing than about their own practices, having the views of all different groups emerged as helpful in validating the statements made.

Selection of health workers was administered by the district medical officer under the supervision of the research team. The officers were asked to pick eight health facilities, including both government and non-government facilities, at three levels of care (district hospital, health centres and dispensaries). From each of the eight facilities we asked them to randomly select four persons, one to each of the four FGDs.⁴ However, since not all facilities employed workers from all four cadres, this rule could not be followed consistently. For instance, in our sample doctors will typically be employed at a hospital, sometimes at a health centre, but never at a dispensary. Most facilities were nevertheless represented in more than one of the FGDs. Participation was based on voluntary informed consent.

Each participant was asked to fill in a questionnaire with essential background information. Key characteristics of the participants are summarised in Table 2. Note that rural church-based facilities are not represented in our sample. There are few such facilities in the coastal areas where we carried out our study.

Table 2. Background information on participants

	Total	Urban	Rural
Number of participants	58	28	30
Age (mean)	42 yrs	43 yrs	40 yrs
Female share	60 %	71 %	50 %
Level of care			
Hospital	48 %	41 %	63 %
Health centre	22 %	22 %	17 %
Dispensary	28 %	37 %	20 %
Years in health sector (mean)	19 yrs	19 yrs	19 yrs
Years in current position (mean)	10 yrs	9 yrs	10 yrs
Employer			
Government	74 %	46 %	100 %
Private for profit	21 %	43 %	0 %
Church based	5 %	11 %	0 %

FGDs were conducted at a conference centre (in Temeke) and at a conference room at the district health office and a waiting room at a remote health centre (in Kisarawe). Discussions were conducted in Swahili, recorded, transcribed and then translated to English. The identities of the speakers were recorded throughout, thus making it possible, for instance, to compare statements of people belonging to the same facility. In general, the participants were eager to share their experiences during the discussions, despite the sensitive nature of the subject.

³ In a few cases, a few lower cadre workers were admitted into the group of a higher cadre, but never the other way around. For instance, some clinical officers participated in the doctor's group in Kisarawe, because there were not enough doctors to make up a functioning focus group.

⁴ We are not sure that the random selection procedure was followed in practice in each and every case, but we were reassured that there was no reason to believe that the participants were selected strategically.

Data were analysed by deriving broad categories of themes on the basis of the information from the FDGs. These categories were further refined as the analysis developed. Statements were contrasted and compared across cadres, across the urban/rural dichotomy and across health workers belonging to different types of health facility.

Ethical clearance was received from the National Institute of Medical Research (NIMR) and the Ministry of Health, Tanzania. A research permit was granted by the Tanzania Commission for Science and Technology (COSTECH).

3. Findings

3.1 How informal payments are obtained

Informal payments are obtained in a number of different ways and in different contexts: when patients want to bypass a queue, when drugs and other medical supplies are needed, when small services are requested, as well as in the case of major surgery. Informal payments sometimes take the form of gifts of appreciation and in some cases they are obtained even from clients who are not sick but request other types of service.

Reducing waiting times

Many participants said that bribes are paid for helping patients to bypass a queue:

Suppose there's a queue and there are some patients who do not want to stand on the queue, as a result ... they can bribe them in order to let them in before their legal time arrives.

[Medical assistant, urban]

A common tactic appears to be for the lower cadres to help patients bypass the queue by presenting the patient to the doctor as a relative:

S/he takes the patient ... and tells her/him that "I understand this doctor very well and I am sure s/he will help you, do you have money?", and then that staff comes and tells me that "excuse me doctor, I have a relative outside, can you please help me?" By knowing that the patient is a relative of my colleague I will attend her/him ... That person has already taken the money from the patient and when s/he went outside to call the patient s/he might have told the patient "I've already given the doctor his money so there's no problem" and so the patient come to me knowing that I took her/his money. *[Clinical officer, urban]*

...they [the medical assistants] just come and say that the patient is a relative while the truth is they have taken a bribe. *[Doctor, rural]*

Charging for "free" services

In some cases, health workers may bluntly ask patients for a payment for the service provided:

One of my young sisters was admitted at ... [name of health facility] and every day when she wanted the bedpan the nurse demanded Tsh 1,000. [Medical assistant, urban]

Patients may also be asked to pay for drugs that are supposed to be free:

...and the patient may not be able to refuse, and in the end s/he will agree to pay. [Doctor, urban].

Pretending a shortage of drugs and supplies

A more sophisticated strategy 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:

...they pretend that there are drugs that are missing... Because the patient wants the service s/he will end up asking “for how much are they sold?” and s/he can say they are sold for 3,000 or 4,000, so if you give me this money I can get them. Once s/he gets the money, s/he just takes the drugs and sends them to the patients ...S/he does not buy them, the drugs are there. [Nurses, urban]

When the pregnant women come from the clinic, they come even without some of the very key supplies needed. If such women go to the maternity ward, it becomes the happiest moments to the nurse, because she knows that that client is her source of income...It doesn't mean that the supplies are not there, but this is just a strategy of the health workers to gain an income. [Medical assistants, urban]

Running a private pharmacy within the clinic

Some clinicians explained that they were running private pharmacies within the consultation room, despite the fact that there was a separate pharmacy outlet at the facility. The clinicians would then try to convince patients to buy directly from their store rather than from the facility's outlet, for instance by claiming to have better medication than in the facility outlet. A more indirect strategy mentioned is to send patients to search for drugs that do not exist:

There's another strategy where the doctor prescribes drugs that are not in the facility or ... sometimes s/he might even use names that do not exist in order to make sure that the patient does not get the drug anywhere. And when the patient comes back, he ... gives them medication that is just ordinary drugs. [Clinical officer, urban]

Reducing “baseline” quality

Participants also indicated that health workers may reduce the quality of service in order to create a situation where the client becomes (more) willing to pay. One example is when waiting times for operations are deliberately increased in order to induce patients to pay for more timely treatment, either within the public facility or by visiting the doctor's private facility:⁵

⁵ Informal payments are not necessarily involved if patients visit the doctor's private facility. However, the consequences for the patients will be the same as if informal payments were made in order to get a more timely operation in a public

The tendency to postpone the dates for taking the patients to the operation theatre might be influenced by the goals of the doctors, the goals aimed at inducing the relatives of the patient to start thinking: “For how long should we wait for it,... we are at risk of losing our patient. It is better to raise the money that will enable us to take our patient to the private hospital of this doctor”. [Nurses, urban]

A similar strategy is to provide extremely low quality in order to signal to the patient that unless you pay, the quality will be very low:

...if you go at the health facility you’ll find a nurse with an angry look, who is just singing without showing any sense of care. ... Without giving something to this nurse you won’t be assisted. [Nurse, urban]

Receiving gifts

Informal payments are also made in the form of gifts of appreciation:

The most she can do is to say thank you sister for helping me get safe delivery, and she is to give you something. It might be 2,000 and not more than 4,000 Tsh. [Nurse, urban]

Although there is a strong element of gift-giving in such transfers, they may still be contested as corruption. A nurse would say: “*It’s a pity that the doctors regard it as corruption*” [Nurse, urban]. Moreover, payments presented as gifts may involve expectations of better treatment in the future: “*However, apart from paying it as his/her way of thanking, what gets into his/her mind is that next time when s/he comes s/he should be the first to be attended*” [Doctor, rural]. Hence, what is presented as a gift may in reality contain an element of bribery.

Providing gender-related services

Some peculiar, but quite interesting, examples were reported about clinicians who received informal payments from women who used the clinician as a lever in order to improve her bargaining position vis-à-vis her husband in the allocation of household resources. The strategy was for the women to ask for fake diagnosis and treatment:

...others might tell you please write me the most expensive drugs so that my husband can give me the money, I’ll give you 1,000 Tsh. [Clinical officer, urban]

Some women have been cheating their husbands saying that they were pregnant but unfortunately they got miscarriage... That woman might tell you “I am not sick, I don’t have a pregnancy ... what I want is to make money from this man ... You pretend that you’ve handled my case and that it costs 50,000. After that you and I take 25,000 each”. [Clinical officer, urban]

facility. Participants gave several examples of doctors asking for bribes in order to reduce waiting times for operations in public hospitals.

3.2 Who gets what?

Health workers at all levels are involved in informal economic activities, but they do not agree about which groups are getting the most out of it. As we might expect, there is a tendency to blame cadres other than their own for receiving most of the payments. While some point to the doctors as the main beneficiaries of the system, others point to the lower cadres, such as the assistants:

They offer bribes, ... but it only reaches a few crafty ones, mostly doctors ...
[Medical assistants, rural]

...there are so many people who might be involved in the corruption. It might be the clinical officer or it may be the attendant. [Doctor, urban]

[Nurse assistants] are the main players involved with the corruption, and in fact they are the ones responsible for associating health staff with corruption. [Nurses, urban]

It appears from the discussions that the amounts paid vary substantially from place to place, also depending on the type of service that is provided. Participants indicated that there is less corruption in non-government than in government facilities. Moreover, participants in the rural district noted that payments are smaller in the rural areas. In general, the amounts mentioned in the discussions ranged from five hundred up to a few thousand shillings for typical nurse-related work, while amounts up to 50,000 Tsh were mentioned in connection with surgery and other time-demanding work carried out by doctors (1,000 Tsh = 0.8 USD). This suggests that doctors typically are involved in the largest transactions, but since the lower cadres encounter the patients on many more occasions, they may be able to extract a larger number of smaller bribes. This is not to say that nurses never get the big money, though. Several examples were given of nurses pretending that a corrupt doctor wanted money (either for services or for drugs) and then putting big money into their own pockets.

3.3 Fighting for a higher share of informal payments

Processes related to the distribution of informal payments amongst health workers can have important implications for the quality of the services, in particular if what each person gets depends on what he delivers. A key question is therefore what an individual health worker can do in order to increase his share of the payments.

On this issue, several participants reported that health workers usually do not share what they have received from the patients:

If s/he gets it, it's his/hers and if you get it, it's yours. We don't distribute amongst ourselves what we get from bribery ... That is why we lack companionship.
[Medical assistant, rural]

A limited degree of sharing implies that there will be competition among health workers about being the one who receives payments. This may affect health worker behaviour, because "*... the patient will decide to give money to the one who has a good heart and who can help you rather than the one who has a difficult heart.*" [Nurse, urban] Hence, in a situation where there is competition for informal payments from patients, health workers may be induced to improve the quality of the service.

Examples were also provided of informal payments being shared, but these examples all related to sharing across cadres. Some participants reported that workers from a lower cadre may approach a

doctor and share what they have received without being asked to do so. Lower cadres can also sometimes claim their share of what a doctor has received:

If you go and ask that doctor “doctor, I have heard that you have received something from the patient and that you have included us in this deal...”, then the doctor will tell you “don’t worry, I will give you something for soda”. [Nurse, rural]

The participants also reported cases of explicit cooperation across cadres in order to generate money:

Normally the doctors are in liaison with the lower cadres [on getting money from patients], though sometimes they may even make a deal with the nurse. [Nurses, urban]

Despite some sharing and cooperation, the main impression is that most health workers perceive the allocation of informal payments to be grossly unfair. Many participants reported strong disappointment because they were not receiving their due share:

Actually it hurts so much, especially in cases where you have noticed that your colleagues have got something while you are supposed to provide care without getting anything. [Nurse, rural]

This brings us to a couple of mechanisms through which the processes for allocating informal payments (or the lack of such) can reduce the quality of services. First, participants clearly stated that the unfair distribution of informal payments creates frustration and leads to a poor quality of service:

...you feel bad because you do the work and someone else benefits and satisfy her/his personal interests behind your back [by taking the bribe]. That affects our work, leads to poor service provision ... because you think that you’re just contributing in completing someone’s job. [Doctor, rural]

The effect of informal payments on service quality may be greater in a strongly hierarchical health system such as Tanzania’s, because frustrations among lower cadre workers are more easily channelled towards the patients rather upwards where they rightly belong:

...if I am not with good heart and have seen that a doctor has been bribed, but I have not received any share from it, I may, if supposed to give six tablets, give four... if angry I may even give two tablets. [Medical assistant, rural]

Secondly, due to the lack of formal and informal rules about how payments are to be shared health workers engage in “bargaining processes” in order to increase their share. One way in which the lower cadres can bargain for a higher share of the payments is to reduce the quality of care in a situation where the doctor feels committed to high quality because s/he has received a bribe:

...when you tell the nurse that this is an emergency case so you should hurry up, you can find the nurse moving from one place to the other, and what she is thinking is that you as the doctor might have got money from the patient. [Doctor, urban]

... if the nurses know that a certain doctor has already received a bribe then [they] start to avoid or give less attention to that patient. [Doctor, rural]

A doctor who has received a bribe will often depend on a nurse for delivering the quality that the patient has paid for. Knowing this, the nurse can attempt to extract a higher share of the payments by holding back quality care. A doctor who feels an obligation to that patient might then be forced to share what s/he has received.

3.4 High quality as a sign of corruption

Several participants mentioned that giving proper attention to the needs of patients may easily be taken as a signal that the patient has paid something: *“if you decide to take care of that patient to make sure that you get the proper diagnosis, then people will start to think that the doctor has received something”* [Clinical officer, rural]. For example, a doctor who comes and sees a patient in the ward outside the ordinary ward round would immediately be suspected of bribery. And a nurse would say: *“...when you devote time to take care of a patient, others think that you must have been bribed by that patient”* [Nurse, urban]. Suspicions were also directed at medical assistants who provided high quality service: *“...when a person like me tries to take care to the patient, others might give such remarks as ‘are you pretending to be a mother from the church, what do you expect to get from what you’re doing?’”* [Medical assistant, urban].

A similar situation may occur in the outpatient department. Clinicians explained that when there is a long queue outside, they simply have to rush in order to finish. It would not be possible to ask patients to come back the next day, one of the reasons being that patients might suspect the health workers of corruption:

...it’s better to rush than tell them come back tomorrow, they may end up saying that the doctor wants something, that’s why s/he has asked me to go back tomorrow.
[Nurses, rural]

Interestingly, where the provision of quality services has become a sign of corrupt behaviour and attitudes, it may have implications for the quality of services provided by non-corrupt health workers. Those who do not want to be associated with corruption may be induced to reduce the quality of the service.

3.5 Informal pay and the equity of quality health services

It is not difficult to conceive that the prospects of receiving informal payments can induce health workers to concentrate on patients with the highest willingness to pay, which is likely to divert attention towards richer patients. It is also possible that the prospects of having to make informal payments will altogether preclude the poorest segments from seeking some health services.

Against the latter argument, it has been claimed that health workers may have the information needed in order to differentiate payments according to economic ability, and that informal payments therefore do not necessarily reduce access to health services for the poor. Our findings challenge this proposition. Notice first that when the patient has given a bribe, it seems to put him/her in a new bargaining position vis-à-vis the provider:

It is easy to tell [when there has been a bribe]. The patients will show over-confidence to the level of dictating to you that “you come and clean here, this is your responsibility. [Medical assistant, rural]

Secondly, participants suggested that patient demands can become so overwhelming that the provider even regrets having received the payments:

...it happens that the amount of money they gave you is very small, say it is 500/=, but the patient will say: "I gave that nurse my money". S/he will hang on you to the extent that you'll regret taking that money. [Medical assistant, urban]

In other words, health workers may be unwilling to accept small bribes. This may result in imperfect price discrimination at the lower end of the scale and thus in reduced access to quality services for the poor.

4. Discussion

Our data reveals a variety of mechanisms through which informal payments may impact on the quality of health care. A more profound understanding of these mechanisms may improve knowledge of how quality may be enhanced within a system where informal payments are common practice. In addition, this knowledge may shed further light on the overall effect of informal payments on the quality of health care.

Informal payments in the form of pure gifts, i.e., transactions with no element of payment for service, will not impact on health service provision, simply because pure gifts do not create incentives to change behaviour. We therefore confine our discussion to those cases where the payments involve an element of fee for service, and thus an element of bribery.

It is quite obvious that no patient will pay bribes to health workers without expecting that the payment will improve the chances of receiving (quality) care. It is less obvious that a system where bribery is common will deliver higher quality services on average than a system without such practices. In the corruption literature, there is an old controversy between those who maintain that corruption mainly "greases the wheels" and leads to more efficient outcomes (Leff, 1964; Nye, 1967; Huntington, 1968) and those who emphasise that corruption is "sand in the machinery" and can cause large inefficiencies (Myrdal, 1968; Rose-Ackerman, 1978). Our data points in both directions. The following mechanisms suggest that informal payments will reduce the quality of health services.

First, the prospects of receiving informal payments may induce health workers to engage in rent-seeking activities. When patients are willing to pay in order to bypass a queue, health workers will have an incentive to create a queue or to delay treatment (see also Balabanova & McKee, 2002). 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 may raise total incomes for the providers (in the same way as a monopolist may benefit from supplying a low quantity since the price per unit will then increase). While delayed treatment in itself represents a reduction in the quality of the service, it may also reduce the clinical quality, as timely treatment is often a precondition for effective cure.

Secondly, embezzlement strategies whereby health workers pretend shortages of drugs and supplies in order to extract money from patients are also likely to delay treatment. Moreover, the time and energy needed to convince patients about stock shortages will reduce the time available for other tasks, which may reduce the overall quality of the service. Note that these embezzlement strategies can work only when patients think that stock shortages are common, while at the same time a private market exists where the drugs and supplies are available.

Thirdly, 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. Two preconditions need to be present in order for this mechanism to work. First, the doctor must depend on the nurse for the provision of the services that the patient has paid for (“joint production”). Secondly, the doctor must feel that receiving a bribe creates a responsibility for delivering a certain level of quality. In addition, these practices are not likely to emerge unless bribery is partly hidden. If the health workers possessed full knowledge about the payments received, it would seem more rational for the doctor to share with the nurses right after receiving the payments, because quality would then be maintained at a higher level, which again could increase the patients’ willingness to pay. The reported pattern of behaviour therefore suggests that informal payments are partly hidden: the doctor does not know for sure whether the nurses know that he has received something, and s/he therefore holds back the money. The nurses, suspecting that the doctor has been paid, then start to withdraw care. This may, if the two preconditions above are met, force the doctor to reveal that he has been bribed.

Fourthly, when informal payments can be obtained 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 level of the threshold. Therefore, if a health worker is able to convince the patients that the threshold is low, these 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.). Health workers will normally experience a “moral cost” in deviating from professional norms in this way, but if the moral costs are small enough, they may be outweighed by the prospects of higher payments from the patient.

Fifthly, perceived unfairness in the allocation of informal payments amongst health workers may in itself influence the quality of health services. The existing literature suggests a strong link between worker efforts and the fairness of payment structures (see Fehr and Schmidt, 2003). Our results suggest that health workers in Tanzania feel that they have a claim to receiving a certain share of the informal income, and that failures to meet their expectations create frustrations, envy and reduced motivation. It is not obvious that such frustrations will lead to reduce service quality, but it is not unlikely, and our results clearly point in this direction.

Sixthly, 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 high quality care easily creates suspicions about corruption. When this is the case, non-corrupt persons wanting to maintain a high level of esteem can be discouraged from providing their “normal” level of care (see Ellingsen and Johannesson (2007) for a discussion of the importance of social esteem for worker performance). At the same time, of course, the fact that high quality is associated with bribery indicates that bribery has a positive effect on the quality of services delivered by corrupt health workers. The net effect will in this case depend on the share of the corrupt relative to the share of non-corrupt workers. Note that a non-corrupt health worker will experience lower welfare by working in an institution where corruption is prevalent, because he is bound to compromise in one way or the other. We might therefore expect non-corrupt workers to seek to move away from these institutions. This might be one explanation why the participants maintained that the level of corruption differs across facilities.

Seventhly, with regard to equity in the provision of quality health services our findings suggest that a system of informal payments may disproportionately reduce access to quality services for the

poor, even if health workers are able to discriminate prices perfectly. 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 the health workers to give a certain minimum 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.

Two additional arguments which support this conclusion are 1) that poor people will often be in a relatively weak position to claim their rights (e.g., due to less education) and thus resist attempts to charge informal payments, and 2) that as long as quality care is a scarce resource, health workers will be tempted to reallocate quality care towards patients who are willing to pay more. While willingness to pay may to some extent reflect underlying health needs, it will of course also reflect the patients' ability to pay. Hence, informal payments may reallocate quality care from those who are in need to those who are in a position to pay, thus generating larger health inequities.

Informal payments can also have positive impacts on the quality of health services. First, informal payments can give health workers an incentive to increase their efforts by compensating for the personal costs involved in making the effort required to provide high quality service. Consider the following example. Assume there is one health worker and that it is costly for the health worker to deliver quality services. If the provider cares only about his own benefits and costs and not about professional standards, he will not deliver quality services unless he is rewarded with a payment exceeding his costs. In such an instance, informal payments may induce higher quality of care.

Secondly, when there is more than one health worker present the prospects of receiving informal payments can create a competition among the workers about receiving the payments. Under certain circumstances, such competition may induce a higher level of quality. Our data suggests that although the receiver of informal payments may choose to share what s/he gets with other health workers, the sharing is only partial and does not benefit all. Furthermore, sharing appears to be more common between workers at different levels of care rather than among workers within the same cadre. The limited sharing of received payments can easily create a situation where health workers, especially those who belong to the same cadre, compete in order to get the bribe.

Whether this competition induces high quality is a more open question, though. In any case, we are talking only about quality as observed and perceived by the patients, which may or may not conform to accepted professional quality standards. Our data point in the direction that patients, if they have a choice, prefer to make payments to health workers who are relatively friendly. Competition to receive informal payments can therefore induce higher quality in the form of improved courtesy to patients. On the other hand, since provision of high quality services often requires a considerable degree of cooperation amongst staff, a competitive attitude amongst the health workers may undermine the cooperation that is needed for delivering high quality care.

We would expect the magnitude of the 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 there may be an additional positive – or a negative – effect on quality from increasing the number of health workers, due to increased competition among the workers in order to receive the payments.

Note that from the perspective of the health workers, a quality competition race leads to a kind of collectively irrational behaviour. The competition is clearly collectively irrational if it does not lead to larger total payments from the patients. But even if it causes the total payments to increase, due to a higher level of quality, the competition can still lead to “too high” quality in equilibrium in the sense that the additional amounts extracted do not compensate for the additional costs of exerting

higher effort. In such cases, norms may develop that lead 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 the level of quality is obviously reduced.

Thirdly, informal payments can prevent health workers from taking up alternative or second jobs and thus increase the availability of health workers. This will enable health workers in already understaffed facilities to spend more time with each patient, which might improve the quality of the service. This argument only makes sense if informal payments constitute a significant share of health workers' incomes. We did not systematically collect data on the amount of informal payments received by the health workers, but examples were reported where clinical officers received more from informal charges than what was on their ordinary salary slip. We do not have reason to conclude that this pattern is a general one, nor can we deny that it is. But there is clearly a possibility that informal payments contribute to retaining health workers in the Tanzanian public health sector.

As this discussion clearly shows, it is impossible to draw general conclusions about the aggregate impact of informal payments on the quality of care. There are payments that may induce extra efforts by health workers and thus contribute to higher quality, but there are other types of payment that are mainly transfers of surplus from patients to providers. In some cases, the amounts to be transferred may be increased if the health provider reduces the level of quality (even though this is likely to reduce the total surplus available).

Policy implications

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

Firstly, 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 economic attractiveness of health sector jobs and ultimately induce some workers to move to other sectors unless the removal of informal pay is compensated by higher salaries.

Secondly, while a general recommendation aimed at reducing corrupt practices would be to increase the supply of scarce resources, our findings suggest that more may be needed. In particular, increasing 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 may thus be a key component of anti-corruption campaigns.

Thirdly, 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 possibilities to extract rents, leading to lower incentives to reallocate scarce resources towards patients with the highest willingness to pay. In addition, to increase the number of health workers may have positive or negative effects on the quality of health services via increased competition for informal payments (although this effect may be counteracted by a general reduction in rents in cases where the rents are created by a shortage of health workers).

Fourthly, 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 punishment 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.

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

5. Concluding remarks

Our study has generated a set of hypotheses about how informal payments are affecting the quality of health services, both through direct effects on the patient-provider relationship and through indirect effects on the interpersonal dynamics among health workers. Further research, both qualitative and quantitative, is needed in order to substantiate these hypotheses. A limitation of our approach is that we did not talk to patients either about the magnitude of informal payments or about their perceptions of impacts on the quality of health services. Of course, health workers will naturally also encounter the health system from a patient's perspective when they seek health care for themselves or for their relatives. And in our discussions, health workers clearly took the patient perspective from time to time. Future research will have to incorporate this perspective in a more systematic way, however, preferably by incorporating quantitative approaches.

On a final note, we would like to stress that even if it could be shown that informal payments had a positive impact on the quality of care, this alone would of course not 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.

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SUMMARY

Informal payments for health services are common in many countries, especially in transitional and developing countries. As part of a larger study focusing on health worker performance in Tanzania, one objective was to investigate the nature of informal payments in the health sector, and to identify mechanisms through which informal payments are affecting the quality of health services. A more profound understanding of these mechanisms is of interest because it may improve knowledge of how quality may be enhanced within a system where informal payments are common practice. In addition, this knowledge may shed further light on the overall effect of informal payments on the quality of health care.

We organised eight focus groups with 58 health workers representing different levels of care in one rural and one urban district. Focus groups were set up in order to facilitate learning about how informal payments affect health workers' behaviours, including their interaction at the workplace.

We found that health workers at all levels receive informal payments in a number of different contexts: for helping patients to bypass a queue, in return for drugs and supplies, for small services as well as for surgery, and even for purposes that are not related to health. Gifts of appreciation are also common, but the distinction between gifts and bribes is often blurred as apparent gifts may be intended to buy better services in the future. Health workers sometimes share the payments received, but only partially, and more rarely within the cadre than across cadres. Our findings indicate that health workers are involved in 'rent-seeking' activities, such as creating artificial shortages and deliberately lowering the quality of service, in order to extract extra payments from patients or to bargain for a higher share of the payments received by their colleagues. The discussions revealed that many health workers think that the distribution of informal payments is grossly unfair.

Our findings reveal a variety of mechanisms through which informal payments may impact on the quality of health care. Negative impacts occur due to rent-seeking behaviours and the frustrations created by the unfair allocation of payments. Interestingly, the presence of corruption may also induce non-corrupt workers to reduce the quality of care, because high quality care can be a signal that bribes have been received. Positive impacts can occur because informal payments may induce health workers to increase their efforts, and maybe more so if there is competition among health workers about receiving the payments. Moreover, informal payments add to health workers' incomes, thus contributing to the retention of workers in the health sector and to avoiding a further escalation of the current health worker shortage.

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