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9 Do health care systems contribute to inequalities?

Maureen Mackintosh

This chapter considers the implications for health care policy—and specifically for models and processes of health sector reform—of the role that health care systems play in generating poverty and inequality.¹ That exclusionary and inequitable health care systems form an element of wider social inequality, and reinforce other sources of poverty, is well understood.² However, this aspect of health care systems is curiously underplayed in the current health policy literature. Current debate in the literature focuses on the impact of health care systems on health outcomes (arrow A in Fig. 9.1) and on the impact of social inequality on health outcomes (B). It does not pay anything like the same attention to the direct interaction between social inequality and health care systems themselves (C).

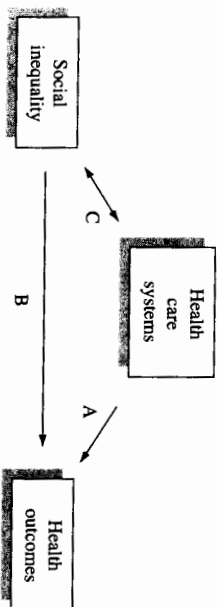


Fig. 9.1 Health/Inequality interactions

This chapter seeks to contribute to redressing this situation. It analyses health care systems as a core element of social inequality in any society, in the sense that unequal legitimate claims upon a health care system, and unequal experiences of seeking care, are important elements of poverty and social inequality in people's experience. It argues that health care systems, as social institutions, are built out of the existing social structure, and carry its inequalities within them. However, health care systems are *also*, and at the same time, a key site for

contestation of existing inequality: they offer a representation back to us of our societies' capacities for care, and a public space for reworking those capacities.

Effective health sector reform, that seeks to revise the social institutions of health care in more equitable directions, needs to draw on an effective theory of health care system/inequality interaction. At present health sector reform models tend to be prescriptive in content, which implies, as argued below, that they tend to disguise or mis-specify the links between the reforms and inequality. Building on more adequate concepts of institutions and of the nature of claims (outlined later), it is possible to rework health sector reform proposals to address the need for greater institutional inclusiveness and more spaces for public contestation of inequality and exclusion.

Prescriptive health sector reform models

If the health care system were widely understood among health care policy makers as a core element and institutional expression of social inequality, then one would expect the policy literature, including the large literature on health sector reform models, to address this problem conceptually as well as prescriptively. That is, it would analyse health care systems as embedded social and cultural institutions, changes to which interact with wider social, economic, and institutional change.

In practice, however, the health policy and management literature of the 1980s and 1990s on health sector reform displays—with exceptions—a prescriptive cast.³ It has three predominant characteristics. First, it has a technocratic bent. That is, it proposes structural change in pursuit of aims that are cast as self-evidently desirable and technical (as opposed to political) in nature, such as more efficient use of capped resources and better allocative efficiency or 'responsiveness'. Second, the structural proposals mix market mechanisms (including privatization) with decentralization of public management and regulation of health care. And third, reform is also given an equity objective, stated usually in terms of more progressive targeting of public funding on the poor.

This literature treats the government as the decision maker. The health care system itself often seems oddly 'transparent': a set of rules and formal organizations that can be rewritten, reorganized, and redirected, given the political will. To the extent that social inequality enters directly into these models, it is chiefly in terms of the difficulties of building a political coalition for reform at government level.⁴ The health sector reform documents of the World Bank, notably the 1993 *World Development Report: investing in health* (World Bank, 1993), display a characteristic mix of technocratic prescription and equity theme, often propounding health sector reform in low-income countries as an application of (a particular interpretation of) reform in high income contexts:

Probably the most important [OECD health care] reforms of the 1980s involved the introduction of improved incentives and regulations for providers and

insurers, with the aim of raising the productivity of rationed resources... the United Kingdom has moved away from its integrated National Health Service and toward more autonomous and competitive physicians and hospitals. (World Bank, 1993.)

The Bank goes on to specify an aim of reform in low income contexts as '... freeing resources to target the poor' (World Bank, 1993).

This mix of technocratic presentation and equity theme characterizes the official, semi-official, health management-oriented, and economic literature on reform in the two areas used to develop the argument in the rest of this chapter. In the UK, often seen (as above) as a health sector reform pioneer among OECD countries, management academics, economists, and (in the 1980s and early 1990s) politicians have presented the reforms as an application of 'new public management' ideas to the search for better health care with rationed resources.⁵ In the UK, the purchaser/provider split instituted by the reforms was associated with an equity theme, in that the purchasers were given a duty to assess local needs.

In Eastern and Southern Africa, from which my other examples are drawn, the research literature confirms that health sector reform is strongly driven by donors' models of reform, not by reform proposals emanating from within the local health care systems, despite the leverage exercised by local Ministers of Health once the reform process is under way (Mogedal *et al.*, 1995).⁶ The reform models combine (a) a strong emphasis on cost-effectiveness analysis of allocational problems, pointing to a public sector focus on primary care; with (b) the introduction of market mechanisms in the form of public sector charging and privatization, plus decentralization of public sector provision and funding (Gilson and Mills, 1995; Leighton, 1996; World Bank, 1996; Gilson and Travis, 1998). In this context, the donors' objectives explicitly include targeting public sector resources to where they will most reduce the disease burden, and filling gaps in the primary and preventative care system for the poor in order to do this. Improving the allocation of health care resources and improving equity are both highly desirable objectives. However, the prescriptive approach—and a widespread willingness to accept the reformers' stated intentions at face value—have obscured both the mixed objectives being pursued in practice, and the problematic implications of context and institutional process for the outcomes of the reforms in the health sector.

Unequalizing reforms

There is a curious dissociation between the cast of thought in the health sector reform literature, and the social, economic, and political context of reform, as reflected in broader socio-economic research on social sector and welfare state issues. Both in the UK and in Eastern and Southern Africa—for example—the health sector reforms have formed part of broader 'unequalizing' social and

economic reform processes. In both areas, the broader reforms associated with economic liberalization have been widely understood, within government and in public debate, as intentionally promoting greater social and economic inequality.

The UK National Health Service (NHS) reforms

The UK NHS reforms were thought up, pursued, and fought over in an intensely unequalizing context: one of widening income inequality, rising poverty, unequalizing welfare regime changes, and cultural and ideological changes legitimating greater inequality. The 'Big Bang' in the City of London, privatization of the utilities, the emergence of mass structural unemployment associated with the collapse of much heavy manufacturing, mining, and shipbuilding, the rise in part-time employment and the decline in wages at the bottom of the scale: the interaction of all this drove an enormously sharp rise in inequality and poverty in the UK in the 1980s and the first half of the 1990s (Hills, 1995; Goodman *et al.*, 1997; Atkinson, 1999).

In the welfare system, the context was a sharp decline in the relative value of universal benefits (such as pensions), and a shift from universal towards means-tested benefits, bringing, in the UK context, social stigma and contested individualized decision making to many more people. Young people were very hard hit. In this unequalizing context, the shift to higher and more widespread individual fee payment—especially flat rate payment—that occurred in social care, nursing home and home nursing care, health care (higher prescription and dental charges), social and public housing (higher rents), and education (payment by parents for a wide range of activities and services and for uniforms) all exacerbated inequality.

The final aspect of the unequalizing context united a deliberate squeeze on public spending with an ideological and institutional emphasis on privatization and mixed public/private provision. The effects were to encourage and force some people out into private and non-profit provision in pensions, social and nursing care, education, social housing, dentistry, transport, and some aspects of health care (such as certain surgical interventions).

In this context the NHS reforms were not—and were not seen as—simply technical reforms to improve health care. They were *also* understood, with government encouragement, as ways of bringing private sector management, financial incentives, private funding, and competition into a health service the government perceived as monolithic and resistant to change (Timmins, 1995). The 'internal market' reforms opened up scope for privatization of parts of the system. The government floated proposals to provide tax incentives—even opt outs—for private medical insurance⁸ (Timmins, 1995). The government quite explicitly sought a more diverse—that is, more unequal—health service. As Margaret Thatcher put it in 1989: 'Those who can afford to pay for themselves should not take up beds from others' (Timmins, 1995).

This was a period of constant discursive emphasis on wealth generation and

individual self-support: of the politically-driven language of scrounging; of public denigration of the poor and of notions of care and solidarity. The 'short-lived and dishonourable' NHS management catch-phrase of 'treatment not care'⁹ is of a piece with the period's political emphasis on individual responsibility and competition as drivers of economic growth and social improvement.

The 'market-like' NHS reforms of the 1980s and early 1990s were thus not a separate category of public action, somehow outside the general drive towards greater inequality. The potential and actual unequalizing effects of the NHS reforms were deeply contested in the UK, and are being partly reversed; furthermore, the reforms themselves have opened up new possibilities and spaces for contestation (see below). However, the lessons drawn from the UK experience in, particularly, the World Bank's health sector reform literature largely ignore the contestation, seeking instead to associate the proposed structural changes with socially equitable purposes the original reformers did not share.

This is the more curious in that resistance to health care commercialization has been in no way special to the UK. The World Bank (1993) noted rather disappointingly that in the (non-US) OECD countries, 'Despite widespread calls for privatization of finance, no country has reduced its commitment to public coverage.'

Eastern and Southern African health sector reforms

The context of reforms elsewhere has been comparably unequalizing. In Eastern and Southern Africa (ESA) the context of broader social sector reform has included colonial and military misrule and war, as in Mozambique, Zimbabwe, and Uganda, and severe economic crisis in most of the region, also including Zambia, Malawi, Tanzania, and Kenya. The crises have brought declining formal sector employment, widening income distributions, increasing poverty, and fiscal deficits. The timing of economic crisis has varied greatly between countries, but in much of the region¹⁰ the 1980s and early 1990s were a time of crisis associated with 'adjustment' measures including privatization, fiscal squeeze, and economic liberalization. (Cornia *et al.*, 1987; Hanton, 1991; Sombaja and Thirkildsen, 1995; Gibbons, 1996; Raikes and Gibbons, 1996; Kalumba, 1997).

This economic context was experienced locally as a crisis of extended family support systems, a crisis to which social sectors were unable to respond.¹¹ Education and health care deteriorated in quality and availability throughout the region as public expenditure on services fell (Dodge and Wiebe, 1985; Hanton, 1991; Woelk, 1994; Sombaja and Thirkildsen, 1995; Kalumba, 1997; Thandage, 1999). There was a rise in informal charging in the public sector, encouraged by a dramatic decline in public sector wages and salaries in those countries worst affected (Dorje, 1992; McPake *et al.*, 1999). The effect was to exacerbate social division between those who could pay and those who were

increasingly excluded because they could not. Morbidity and mortality worsened in many countries (Mogedal *et al.*, 1995).

In this context, the effect of the social sector reform programmes on inequality is much debated. The ESA structural reforms of health care systems have had three main elements, though details and processes differ: liberalization and privatization (including increasing NGO provision), the charging of user fees for public services, and decentralized public sector management (Gilson and Mills, 1995; Mogedal *et al.*, 1995; Leighton, 1996; Beattie *et al.*, 1998). Behind these structural prescriptions lie models of reform strongly propounded by donor governments and the World Bank: the privatization of secondary and tertiary care perceived as primarily serving the middle class; the separation of regulation (and some funding) from management of remaining public sector provision; and a mix of user fees and decentralized accountability to make primary provision more locally responsive. The reforms are locally managed, and driven in many countries by fiscal crisis: but their form—and especially the emphasis on decentralization—owes a great deal to donor pressure (Mogedal *et al.*, 1995; Gilson and Travis, 1998).

These reforms are widely seen by local commentators and professionals, and by field researchers, as unequalizing in content and effect, despite the prior (if patchy) experience of informal charges. There are three main reasons for that perception. One is that formal charges *legitimate* exclusion and unequal access. Fees for public sector primary and secondary education, and for different levels of health care, impact most severely on the poor, and research shows them to have exclusionary effects. Exemption mechanisms work poorly (Gilson *et al.*, 1995; Oyugi, 1995; McPake *et al.*, 1999; Tibandebage, 1999).

Second, the reform models entrench unequalizing processes, intentionally, within the institutions of the system. The *aim* is separate systems for the middle classes and those in formal employment, through the privatization of such provision; public primary provision for the poor is intentionally gap-filling, notably primary care in rural areas. Decentralization in this economic context also generally means—initially at least—better-off districts doing better, since many countries do not have equalizing grant systems (Gilson and Travis, 1998).

Finally, many local commentators worry about the thin conception of the public sector in health care in these reforms. One doctor and academic recently summarized the reforms as privatizing middle class provision so that there will be more public funds available for the poor,¹² and wondered why reformers expect the public sector suddenly to become more progressive in an increasingly unequal context? Doctors and health planners share the fears expressed in the UK that legitimating commercialism and dividing the system will simply increase unequalizing pressures within the state itself.

In summary, health sector reform models, in the UK and Eastern and Southern Africa, have been presented in policy documents as equalizing in intent. Yet they have also been locally understood, for good reason, as deliberately unequalizing in health system terms: as reforms that seek to embed and

legitimize existing and emerging structural market-based inequity within the health care institutions. This contradiction has bred, in both areas, some new spaces for contestation of inequality and exclusion. The rest of this paper outlines a conceptual framework for health sector reform that grasps this contradiction, with the aim of assisting better institutional design.

Health care institutions and 'social settlements'

A more adequate characterization of health care systems for policy purposes would not disguise unequalizing processes, but would build an understanding of inequality into the framework of policies designed to combat it. To achieve this requires a 'thicker' and more culturally rooted concept of health care institutions that understands them as always embodying inequality within unequal societies.

Conceptualizing 'institutions'

A relevant definition of 'institution' can be drawn from the anthropological literature. Mary Douglas's (1987) analysis of institutions starts from the idea that an institution is, 'minimally ... a convention'. This resembles the economic institutionalists' definitions of institutions (North, 1990) in terms of norms, habits, and conventions of behaviour. It locates formal rules and organizations as just one element of the full institutional context, along with informal understandings, including norms of market behaviour.

Douglas is particularly interested in the *legitimation* of institutions: the way in which patterns of behaviour come to seem natural and proper. So a deeper definition of institution in her work is a 'legitimised social grouping' such as 'a family, a game, or a ceremony'. Legitimation, in Douglas' view, typically involves both reasoned justifications of patterns of behaviour and the invoking for this purpose of 'naturalising' analogies. An example of the latter can be drawn from the writings of economic institutionalists. Oliver Williamson (1975), justifying his use of markets as a standard of comparison for other institutional forms, writes: 'In the beginning was the market.' He invokes by this phrase—how ironically it is hard to tell—existence before sin, natural creation and evolution without human intervention. Similar comparisons between the assumed normality of market exchange and the process of administrative (bureaucratic) service delivery—the latter a last resort when markets 'fail'—carry motivational weight in the social sector reform policy documents.

In Douglas's view of institutions, naturalizing cognitive conventions arise and stabilize (or not) over time through the interaction of discourse and experience. 'Discourse' here refers to shared meanings and ideas that form the basis of communication. Mutual feedback between behaviour, experience, and ideas can create an institution that in a recognizable sense 'works'.¹³ Once an institution

has become 'naturalized' and legitimate, it 'makes' big decisions for us. People think and act 'within the scope of institutions they build' (Douglas, 1987).

'Social settlements' in health care systems

This type of institutional analysis leads us to consider health care, not as an integrated system in the functional sense, but as an overlapping group of social institutions that are cross-cut by institutions wider than health care, such as kinship and gender. The patterns of inequality in any society are framed by strong legitimizing conventions of thought: from caste-based social distinctions carrying religious significance, via deeply embedded assumptions of gender inequality, to shared expectations that the more educated should receive higher incomes. Major social institutions such as health care systems build on many of these shared assumptions, and are themselves bearers of broader social inequality and privilege.

The health care systems of both the UK and Eastern and Southern Africa illustrate the point. The design of the UK NHS embodied an explicit compromise with the organized medical professions. Internal inequalities established from the beginning included steep status hierarchies and strong privileges for consultants in terms of earnings from private practice (Timmins, 1995). Professional hierarchies initially strongly reflected inequalities in the wider society, with consultants largely male and from the upper middle classes, and nursing being a largely working-class female profession including increasing numbers of Afro-Caribbean nurses; this social hierarchy has been changing, but only slowly (Langan, 1998). Funding has long favoured hospital treatment and curative care over home-based and chronic care, in ways that respond to medical hierarchy and that disadvantage in particular the poor elderly and their carers. There is strong though debated evidence that variability in access and quality of curative care favours the middle classes.¹⁴

In Eastern and Southern Africa, parallel inequalities structure health care institutions. The demands and costs of medical training—as well as the financial rewards—imply that doctors tend to be drawn from more privileged social groups. Nursing is a problematic profession for its members. In many countries, nursing was one of the few professions open to African people before Independence. Caught between doctors and patients within a deteriorating health care system, nurses have seen their working conditions, pay, and social status decline sharply since Independence, reflecting the general decline in public services.¹⁵ Despite major efforts by governments to develop primary care, big differences remained before reform between urban and rural access and service quality. Subsidy patterns that focused on treatment for public servants and the military and supported urban secondary and tertiary care tended to favour the better off. Once economic deterioration set in, informal charging and falling quality in primary care reinforced the existing inequalities.

The pre-reform health services in both areas carried these inequalities while

at the same time, they also embodied 'universalist' principles that explicitly sought to redress other existing inequalities, notably exclusion of would-be patients from health care through inability to pay. In the UK after 1945, the NHS expressed a commitment to universal access in time of need. This universalism was rooted in a process of post-war reconstruction that rejected certain aspects of social inequity and created new rights of citizenship (Timmins, 1995; Hughes, 1998).

The ESA post-Independence governments saw their health services, in parallel fashion, as key elements of the construction of new states and of new relations between states and citizens, and all attempted greatly to expand access. The Frelimo government in Mozambique in the late 1970s was particularly explicit about this aspect of health services: 'It is often in the hospital that the people see reflected the organisation of our state.'¹⁶ In Tanzania, the 1970s saw a big shift in policy away from hospital building towards construction of rural health centres and dispensaries, and the training of suitable staff; Mozambique was notably successful in making the same shift soon after independence (Hanton, 1991; Tibandebage, 1999). The self-help movement in post-Independence Kenya generated health facilities that were taken over by the state in the 1970s (Oyugi, 1995). Comparable policies and initiatives can be documented across the region.

This mix of embedded inequalities, shaped by unequal citizenship, and redistributive attack on specific forms of exclusion, has been labelled in the UK social policy literature a 'social settlement' (Williams, 1989; Hughes, 1998). The 'settlement' has proved remarkably stable because it has offered—like other Western European health care systems—insurance against the risk of needing health care (and against the risk of being unable to pay for it), plus perceived opportunities for relative privilege for the better off, combined with substantial redistribution towards those on low incomes. Institutional inequality can, in this way, actually *stabilize* highly redistributive health care provision (Barr, 1994; Besley *et al.*, 1994).

Health care reform, in this framework, should thus be understood as a breaking up and reworking of the compromises between inequality and redistribution embedded in the health care system (Mackintosh, 1996; Hughes, 1998). In Douglas's framework, people think and act for themselves, but work inevitably with the ideas and experiences they share with others. The remaking of those shared meanings recreates institutional culture in new forms. This analytical framework thus internalizes the point frequently made in the literature that health care systems are embedded within distinct cultural contexts, and not 'transferable' in any simple way.¹⁷

During the reform process, we would expect to find competing discourses, seeking to legitimate and contest the new inequalities embedded within reformed systems. These discourses embody competing notions of right and wrong, of priorities and principles, of who can do what, what can be discussed and what will be suppressed.¹⁸ The UK reforms were marked by such contested discursive change, as public service was reworked in market language (Mackintosh, 1997).

In health in particular, this change was much resented.¹⁹ The market language sought to 'naturalise' the commodification of health services, including higher regressive charges for previously low-priced or free care and treatment, by invoking familiar and powerful images of customers and consumer rights. The 'contracting' language also operated to obscure the re-embedding of social class hierarchy within the new managerial forms of organization (Mackintosh, 1999; Towers *et al.*, 1999).

Presentation of the reforms in Eastern and Southern Africa has also sought to legitimize market-based inequalities, with considerable emphasis on 'willingness to pay' for health care. Institutional processes in public sector institutions that charge fees tend in practice to prioritize financial stability over access, and hence to legitimize exclusion of those who cannot pay (Mackintosh and Gilson, 1999; Tibandebage and Mackintosh, 1999). Reform models also present market segmentation as a rational response to restricted public funding, despite the evidence that excluding the poor from out-patient public hospital care at a time when urban primary care is becoming predominantly private (and only the formally employed have insurance) can be highly regressive.

Poverty, claims and representations in health care

If inequality is institutionally embedded in health care systems, then so is effective contestation and redistribution. If reformed health care systems are to be genuine new settlements, embodying new forms of redistribution, then the capacity and commitment to redistribute have to be built into the institutions of the system. This involves the creation of a legitimate basis for the poor to claim health care, and a strengthening of institutional capacities to make, and the commitment to respond to, such claims.

Poverty and health care claims

Health care systems that do not offer care—that take a narrow or an abusive view of their duties—thereby contribute profoundly to people's experience what it is to be poor. To face abuse or to have fear cumulated when at one's most vulnerable—to be denied care—is an element of what poverty is as it is experienced (Tibandebage and Mackintosh, 1999). The failure of care is a core element of social exclusion: Kaijage and Tibaijuka (1996) place exclusion in the failure of access to 'economic and cultural resources', including land and cash, education, and family, kinship, and community support systems, and also in the failure of government social sectors, including health care, to sustain and supplement such community support systems in times of crisis.

A growing literature on poverty and vulnerability focuses, not just on income, but on the tangible and intangible assets of the poor. However, these studies underplay the asset value of effective claims to health care. Moser (1998), for example, defines potential assets to include 'health status', skills and education,

and household relationships and networks of mutual support. Some networks, such as pooled savings schemes and reciprocal lending, assist access to health care. Relationships *with* the health care system are not considered assets, except for credit from private practitioners. Carter and May (1999), in a study of class and poverty in South Africa, treat claiming systems for cash (pensions and disability allowances) as assets—but not claims to health care or education. Comparably, both the 'capabilities' and the 'basic needs' approach to poverty centre on health status, and neither treat *care* as a need in itself (Dreze and Sen, 1989; Doyal and Gough, 1991). However, effective care in response to need and vulnerability strengthens people's agency and self respect, as well as increasing physical well-being.

Legitimate claims to health care should therefore be considered as social assets for the poor, and institutional design of health care reform should seek to strengthen effective legitimate claims.²⁰ A 'claim', in this analysis, is the duty owed to an individual that they should have a good or service (Broome, 1989; Mooney and Jan 1997). Claims may be of different strengths—they are not 'absolute' in the sense that rights are often considered to be. Concepts of fairness prescribe 'how far each person's claim should be satisfied *relative* to the satisfaction of other people's claims. Stronger claims require more satisfaction ...' (Broome, 1989).

Claims in health care are rooted in needs, and the formulation and agreement upon the strength of health care claims is necessarily an institutional process (Mooney, 1998). In unequal societies, some people's claims will be denied legitimacy, and some legitimated claims are likely to remain unfulfilled. Decision-making responds to institutionalized understandings of priorities and principles and also on institutional experiences of active claiming. Hence the culture and operation of the health care system (as a whole, public and private) *is* the way in which claims are established, legitimated, and denied or fulfilled by 'society'.

The implication is that health care claims are *relational*; they are shaped by the norms and experiences governing patients' relations to providers. The literature on sustainable primary care (e.g. LaFond, 1995) emphasizes its relational nature and its roots in trust and shared understandings; and studies of health system collapse demonstrate how people try to re-establish—sometimes in perverse ways—control over risk (for example, Birungi, 1998).

Claiming greater equality within unequal systems

The UK reform experience suggests two important elements that interact to sustain legitimate claims to care within unequal systems. The first is 'universals': shared and stated general commitments that form a principled basis for claims. The second is organized support for making claims.

The UK reforms opened up new spaces for claims by the disadvantaged and excluded. The shift to 'consumerist' notions of provision invited demands for more respect for and communication with patients. The 'purchasers' duty to

define local needs similarly opened up political spaces for interest groups to contest professional definitions of need, for example of the needs of people with disabilities. And individual needs-assessment for domiciliary and nursing care—intended by the reformers to assist rationing—gave campaigning groups a new handle for contesting failure to meet need. In this context, the 1970s and 1980s social movements' history of organizing could be put to good effect in establishing new effective claims (Harrison and Mort, 1998; Barnes, 1999). In sum, the consumerist orientation opened up, in some unforeseen ways, spaces for new *collective* definition of needs and collective and individual claims for resources.

This history suggests that more attention may need to be paid to strengthening the claiming process in the Eastern and Southern African health sector reforms. Those reforms too potentially create new spaces for contesting inequity and exclusion. Some donors and local officials see the entrenching of a culture of official payment not only as aimed at raising funds, but also as stimulating and legitimizing activism by patients around quality of care. They believe that people will more readily defend and contest services they pay for, and many user fee financing models build in community participation or community management. Officializing payment within a decentralized planning context can also stimulate experiments in pre-payment systems, and these in turn can provide a site for community organizing around health care issues, including exemptions for the indigent (Gilson *et al.*, 1995; Mackintosh and Gilson, 1999).

Furthermore, open and official payment in the public sector makes comparison with the NGO and private sectors in terms of value for money a natural progression.²¹ Best provision in each sector can be used as a benchmark to exert pressure on others. Private and NGO competition can provide alternative styles of care, and in some contexts offer an escape from punitive cultures in public sector health care, thus helping to force change. A regulatory duty on government, established by the reforms, can also force governmental providers to meet common quality standards and to provide information to patients.

But all this change requires a confident, well-informed, and indeed organized public. While many local health officials are eloquent about the importance of people developing confidence to complain and to express needs, the current health sector reform models pay little attention to such relational issues. While the reform models promote an essential package of care, this is as an aspiration, a package to be delivered. Londoño and Frenk (1997) point out, in a critique of segmented Latin American health care systems, that such a package should rather be institutionally and discursively constructed not as a 'minimum' but as a 'nucleus of universality'. The authors reconceptualize the package as a 'social commitment based on citizenship principles' and argue that it should be a key focus for social mobilization and participation, promoted and encouraged by the public sector. Most health sector reform models ignore this analytical link between 'universal' commitments and the promotion of activism in claiming care, a link which draws—like this chapter—on a conceptualization of health

systems in terms of the *relationships* between populations and institutions' (Londoño and Frenk, 1997).

Conclusion: poverty, inequality, and health care policy

This paper has argued that social inequality directly shapes inequitable health care systems, and that the failure of legitimate claims to health care is a core element of poverty as it is experienced. It follows that commitments to redistributive health care, and notions of the public good that sustain those commitments, have to be actively constituted and sustained within unequal health care institutions. Local policy debate on reform frequently recognizes this. A Zambian health policy maker, for example, writes of the need for a 'negotiated health order' (Kalumba, 1997), and discusses the tension in the reform process between 'needing popular legitimacy as a basis for authority' and 'meeting the state's need to make the administrative structures for resource allocation coincide with the social balance of power'.

The 'social settlement' approach to institutional design in health care, put forward here, is aimed not at accepting inequality for its own sake, but at employing particular inequalities to help to stabilize and sustain institutional commitment to particular forms of redistribution. The approach to conceptualizing health sector reform implied by this paper might be summarized as follows.

- Begin by accepting the relational nature of health care, and focus attention on strengthening the capacity of the poor to make claims. Seek to strengthen in particular effective interaction between non-state public action to support claims and responses from the health care system.
- Establish some principled universal commitments—such as an essential package of care—as a basis for claims, and focus institutional design around ensuring that all sectors of health care fulfil the commitments. Consider both medical treatments and also care and respect for patients, when formulating universal principles.
- Decide what inequalities to live with within the system and be open about them. Seek to associate middle-class reliance on privilege with middle-class acceptance of duty to others, drawing on their experience of health care institutions. Do not allow the better off to segregate themselves institutionally.
- Concentrate on improving information about health care in the public domain, including information about governmental facilities, and on strengthening the capacity of the public—better off and poor—to organize around health care.
- Seek to shape the private sector through negotiation and public pressure, as well as formal regulation. Influence the private sector institutional culture by blurring boundaries, using a mixture of incentives, demands, and professional pressure. Publicize bad practices, kite mark. Try to avoid the creation of

powerful private sector lobbies against socially inclusive institutions: try not to create active *enemies* of the poor.

- Take discourse seriously. The public representations of the health care system are important. Health care systems shape how we learn who we are in society, what we can expect, how we may behave.²² They help to create a more individualist or a more mutual society, they polarize or string links of solidarity across divides. Ethical and redistributive commitments in health care are *both* a set of principles *and* an institutional construction in the form of a set of working understandings. Such commitments have to be constantly reconstructed in a market-dominated or market-pressured system.

Notes

1. I owe a great deal of my understanding of these issues to research, writing, and discussion over the last two years with Paula Tibandebage and Lucy Gilson, and over a much longer period with Pam Smith. Continuing research with Paula Tibandebage is financed by the UK Department of International Development (DFID), whose support is gratefully acknowledged. However, the contents of this chapter are the sole responsibility of the author, and do not reflect the policies and practices of the DFID. This chapter began life as a talk, and the style (including the rather sweeping approach to a very large and necessarily less than fully referenced literature) continues to reflect that origin.
2. The understanding is implicit, of course, in the 'targeting' literature which proposes to concentrate public health care resources on primary care for the poor, and underlies government policies seeking to universalise health care access. The literature on 'safety nets' in the adjustment process is rooted in the 'basic needs' approach to poverty, including access to basic health care (Cornia *et al.*, 1987; Vivian, 1995), and the 'public action' literature, rooted in the capabilities approach to poverty, similarly sees health care as an important focus (for example, Drèze and Sen, 1989; 1995).
3. In place of a very long but necessarily incomplete set of references, this argument is *illustrated* below using the literature on two case study areas. Counter-examples from the literature are also considered below.
4. Political coalition building is important, but not my topic here; from an extensive literature see, for example, Jeffrey, 1988; Reich, 1995; Chiang, 1997. The World Bank (1993; 1997) tends to see political issues in terms of 'removing obstacles to reform'; for a research paper along the same lines, see Leighton, 1996.
5. Department of Health, 1989 and HMSO, 1990 are the key official documents. Much economic commentary has taken the objectives of the reforms at face value, and evaluated them in their own terms, for example, Robinson and Le Grand, 1994; Flynn and Williams, 1997. The classic 'new public management' text is Osborne and Gaebler, 1992; see also Pollitt, 1993; Clarke and Newman, 1997.
6. The discussion draws examples from Tanzania, Malawi, Kenya, Mozambique, Zambia, and Zimbabwe, and to a lesser extent from Botswana and South Africa, where the social, economic, and political pressures surrounding health care reform are each very different.

7. I am using 'unequalizing' throughout as shorthand for 'promoting or resulting in greater social and economic inequality', understanding inequality in a broad sense to include income inequality, rising social division and exclusion, and rising inequality in capabilities, access to services, and quality of life.
8. Only tax relief on premiums for the elderly was ever introduced—for a time.
9. Source: fieldwork; see Mackintosh and Smith, 1996.
10. Botswana went through a recession and severe drought in the early 1980s, but has escaped economic crisis of the severity faced by much of the rest of the region and has experienced substantial economic growth.
11. Kaijage and Tibaika (1996) and Tibaika (1997) make this argument for Tanzania.
12. The source for this paragraph is recent fieldwork in Tanzania—see Mackintosh and Tibandebage, 1998. The summary echoes Margaret Thatcher's formula quoted above—a formula that was resisted in the UK.
13. For an example of field research addressing these feedbacks during reform, see Mackintosh (1997; in press).
14. Le Grand, 1982; Goodin and Le Grand, 1987. For critiques see O'Donnell and Propper, 1991; Powell, 1995.
15. Jewkes *et al.*, 1998; the authors note that the situation of nurses and quality of nursing in the region is under-researched.
16. Speech by President Samora Machel, 1979, quoted in Walt and Mehlamed, 1983.
17. For example, Fuchs (1993) makes this point for Canada and the US.
18. Dryzek (1996) analyses competing discourses in the process of institutional design; Mackintosh (in press) uses the framework in more detail in the context of health care reform.
19. In 1989 William Waldegrave, then Secretary of State for Health, acknowledged this resentment and anxiety, noting that the public 'think we do not know the difference between a hospital and a supermarket' (quoted in Butler, 1994).
20. I owe my introduction to the 'claims' literature and its application to health care to Lucy Gilson.
21. In recent research in Tanzania (see Tibandebage and Mackintosh, 1999), a clear finding was that patients and would-be patients from all social backgrounds had no difficulty in understanding and responding to a question asking which type of facilities offered best value for money.
22. This is also of course an old argument; see for example Timmus, 1970.

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