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The market shaping of charges, trust and abuse: health care transactions in Tanzania

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Abstract

Effective health care is a relational activity, that is, it requires social relationships of trust and mutual understanding between providers and those needing and seeking care. The breakdown of these relationships is therefore impoverishing, cutting people off from a basic human capability, that of accessing of decent health care in time of need. In Tanzania as in much of Africa, health care relationships are generally also market transactions requiring out-of-pocket payment. This paper analyses the active constitution and destruction of trust within Tanzanian health care transactions, demonstrating systematic patterns both of exclusion and abuse and also of inclusion and merited trust. We triangulate evidence on charges paid and payment methods with perceptions of the trustworthiness of providers and with the socio-economic status of patients and household interviewees, distinguishing calculative, value based and personalised forms of trust. We draw on this interpretative analysis to argue that policy can support the construction of decent inclusive health care by constraining perverse market incentives that users understand to be a source of merited distrust; by assisting reputation-building and enlarging professional, managerial and public scrutiny; and by reinforcing value-based sources of trust.

Keywords: Trust; Health care transaction; Incentives; Capabilities; Exclusion; Tanzania

Introduction

Effective health care is a relational activity, that is, it requires social relationships of trust and mutual understanding between health care providers and those needing and seeking care (Gilson, 2003). Impoverishment too can be understood relationally, as involving loss of the capability to claim essential services such as health care and to participate in important social relationships (Sen, 2000). It follows that in a low-income context such as Tanzania, where access to health care generally requires out-of-pocket payment, ill health is a leading cause of long-term impoverishment. Illness brings the loss of income-earning capacity and forces the sale of productive assets in an often vain struggle to afford treatment (Tanzania Participatory Poverty Assessment Team, 2003). Furthermore, the poor and vulnerable find it hard to access decent care even when payment is made. The relational content of health care market transactions, the extent to which they are built on merited trust and communication or express the abusive exercise of power, is directly constitutive of impoverishment or conversely may be a force for combatting poverty.

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This article analyses the relational content of health care transactions in four districts of Tanzania in 1998–1999. We seek to show how patterns both of exclusion and abuse and also of inclusion and trust were actively and systematically constituted in these market environments. For some interviewees, exclusion and mistreatment at health care facilities were a core element of poverty as it was lived:

> If you have no money, nobody cares for you [in government health care facilities] and you may die.
> Given our poverty, we never seek treatment there [at a private dispensary] because of high charges.
> If you are not known [at a government hospital], you are treated with contempt.

Many experienced relations with the health care system not only as instrumental in generating poverty, by using up resources and leaving them in bad health, but also as constitutive of impoverishment in the broader sense of contributing to the creation of social groups living with the expectation of exclusion and abuse when at their most vulnerable.

Conversely, however, some very poor people experienced inclusion and decent treatment from health care facilities:

> They [a government dispensary] receive people warmly. If drugs are in stock we just get them, and services are free.
> Generally services [at a religious-owned dispensary] are good, in terms of drug availability, low costs, prompt service, and staff are polite and attentive.
> The facility [a government hospital] provides good and free services for small children.

Health care systems thus can and sometimes do help to counter impoverishment by providing decent and accessible health care. Furthermore, for facilities to deliver a decent trustworthy service in a low income fee-for-service environment, staff must resist market incentives to cheat and exclude. We explore here the interactive shaping in low income health care markets of the capability to claim decent health care in time of illness, including the construction and destruction of trust.

Methods: analysing health care market transactions

Tanzanian health care provides a good case study for this purpose. The government legalised private clinical practice in 1991 (reversing a 1977 prohibition of all but certain religious providers) in the wake of the 'battering' taken by government-provided social services during Tanzania's severe 1980's economic crisis (Kaijage & Tibaijuka, 1996). Liberalisation generated a rapid increase in private facilities mainly in urban areas, and was accompanied after 1993 by the progressive imposition of official fees, first in hospitals and then in urban and peri-urban dispensaries (Dyauli, 2000; Munishi, Yazbeek, & Lioneth, 1995; Tibandebage, 1999; Upunda, 2000).

We draw our evidence from a study undertaken in 1998–1999 of health care markets in Tanzania. Two distinct urban markets were studied plus part of the rural hinterland of each: the capital city market (a district of Dar es Salaam and a contiguous district of predominantly rural Coast region) and the market in a smaller town distant from the capital yet with sufficient income to support private providers (Mbeya Urban and Mbeya Rural districts in the Southern Highlands). Our methods were contextual in the precise sense defined by Hentschel (1999); that is, the collection of qualitative and quantitative data about specified aspects of behaviour, from a variety of points of view, in specific localities, followed by the triangulation of that evidence, with the objective of interpretative understanding of behaviour in context. Our research topics were care-seeking decisions, knowledge and reputation of facilities, pricing, and accessibility and quality of service (in terms of services available and patient handling, not clinical care).

We examined these topics through interviews with selected facilities' staff, patients on exit from facilities, and members of households in the facilities' catchment areas. Ten hospitals selected included all the government hospitals in the districts, all the non-government hospitals serving the population of the Mbeya districts, and four of the non-government hospitals in the Dar es Salaam district, spanning religious and commercial ownership and larger and smaller size. Thirty-six health centres and dispensaries were selected from government, private and religious/non-profit sectors in the four districts; selection was initially random, and facilities closed or (in one case) unwilling were replaced.

Staff interviewed in each facility included hospital director, administrator and matron, and owner or in-charge in lower level facilities. A total of 272 patients were interviewed on exit from facilities, selected to include a range of ages and where appropriate both men and women; 108 households, in wards selected randomly from those close to selected facilities, were purposively chosen to represent a range of income levels, and one household member in each gave an in-depth interview.

Data on prices paid included informal charges, and most health care transactions required payment. Of 367 visits to health facilities recorded in exit and household interviews, less than 9% were free of charge to patient or employer, almost all at a sub-set of the rural government dispensaries studied (42% of all visits were to government-owned facilities). The predominance of out-of-pocket payment is consistent with other evidence on

African health care (Fabricant, Kamara, & Mills, 1999; Stierle, Kaddar, Tchicaya, & Schmidt-Ehry, 1999). We investigated both the level of charges and the conditions for continuing provision of free treatment—against apparent market pressures and norms—in some facilities.

Interviews examined aspects of specified health care transactions including perceptions of the service provided, the payment made and the behaviour experienced when providing or receiving (or refusing or being refused) specified care or treatment. In addition to providing access to or blocking treatment, these transactional relationships *are* to some extent themselves the service being claimed, in terms of care and respect in time of need.

Our conceptual approach to the analysis of our data is interpretative, based in systematically cross-referencing all data relating to each facility, setting this in the context of the socio-economic status of informants (using questions drawn from the national census) and comparing evidence across different markets. In this paper we divide household interviewees into socio-economic groups as follows:

- 'urban poor': post-primary or primary education and below, *and* primary source of income petty trade or farming, *and* living in a predominantly urban district outside a few high income wards;
- 'rural poor': post-primary or primary education or below, *and* primary source of income farming or petty trade, *and* living in a predominantly rural district;
- 'better off': secondary education or above *or* in formal employment, retired from formal employment or engaging in formal or large scale business *or* living in a well-off urban wards.

Exit interviewees are similarly classified by education and employment status, but identified as urban/rural by location of facility where encountered.

Our analysis here focuses on the social and institutional patterning of market behaviour and its interactive evolution. Health care market transactions are everywhere peculiarly subject to asymmetry of power and information between staff and those who seek care, and fee-for-service provision of the Tanzanian kind therefore faces facilities and staff with perverse incentives to over-prescribe, reduce quality and cheat patients, as well as incentives to exclude those who cannot pay (Barr, 1998). We identify in our data systematically differentiated responses to these incentives, drawing on institutional economic analysis that understands transactions as shaped by reputation, trust, strategy and experience (Ben-Ner & Putterman, 1998) and also on 'the anthropological view of economies as cultural systems' including the 'ideas, values and visions' of the transactors (Humphrey & Hugh-Jones, 1990, pp. 3, 13). We show that the patterning of trustworthy or abusive behaviour was shaped not only by social inequality—poor people in urban areas being particularly subject to abusive, exclusionary and untrustworthy services—but also by the active constitution of trust and distrust by facilities and users over time.

Each transaction is thus understood, not as a one-off market event, but rather as shaped by information, expectations, levels of trust, norms of behaviour and incentives, all of which evolve over time through market and other social interaction. In conceptualising trust, we distinguish between calculative trust, which is based upon an explicit understanding of the incentives facing other transactors, and trust that is explained by interviewees as based in shared values or personal relationships. Calculative trust is hard to sustain in health care markets precisely because of people's understanding, clearly articulated in our interviews, of facilities' market incentives to cheat. Interviewees therefore placed great importance on other sources of value-based trust in the probity of providers, such as religious commitment, and on personal trust of known and related individuals.

In linking health care transactions to a capability-based view of poverty, we distinguish (drawing on Sen, 1997) between health care access as an input to a valued functioning, being as healthy as possible, and as a valued capability in its own right: to be someone with the ability to claim decent care and treatment when needed. People's capability sets are the active options they have, to be and to do; it follows that exclusion from access to health care is a severe form of social marginalisation as well as a route to loss of valued functionings.

Findings: charging, trust and abuse

Effective claims on the formal health-care system were highly valued by interviewees, and people of all levels of education and income engaged actively with the health-care market. Most interviewees displayed considerable knowledge of the charges, staff attitudes and particular strengths and failings of a number of local health facilities, and many actively sought information. Evidence of widespread effort to make informed choices, and a ready response to questions about value for money, belied the expectations of some policy makers interviewed who viewed users as generally inactive and uninformed.

In this context of active search, interviewees were eloquent about the difficulty of finding care they regarded as trustworthy at an affordable price. Some had despaired, saying 'wherever the quality of care is

low, the costs also tend to be low', and vice versa. This section sets out our findings on four aspects of this often frightening dilemma: experience of exclusion from care; sources of distrust in experiences of bribery and abuse; sources of trust against market odds; and the particular vulnerability of the poor in urban areas.

Exclusion and self-exclusion from care and treatment

People's capability to claim decent health care was highly income- and price-constrained. Among household interviewees, 24% of the rural poor and 34% of the urban poor said that they or a close relative had had an illness in the last 6 months for which no consultation at a health facility was sought, all blaming lack of funds. Of the rural poor, one had been excluded (i.e. turned away) at a facility for lack of money; one knew the fee for treating a child's ailment and could not pay, so stayed home; another had 'despaired' because a government facility never had drugs and a prescription was unaffordable; one felt that money could not be found to treat someone as elderly as his father. In the urban poor group, two had been excluded at a facility, and five had self-excluded for inability to pay; one untreated eye problem had led to blindness.

These findings support the huge body of evidence that health care fees in Africa generate exclusion of and self-exclusion by the poor from formal health care (Asenso-Okyere, Anum, Osei-Akotot, & Adukonu, 1998; Cooksey & Mmuya, 1997; Gilson, 1997; Karanja, Bloom, & Segall, 1995; Mwabu, Mwanzia, & Liambila, 1995; Sauerborn, Nougtara, & Latimer, 1994). They contradict the view expressed by a clinical officer, and echoed by other staff and policy makers, that 'if they [users] have to [pay], they can afford it' with the help of relatives.

The better-off had not been excluded at facilities. Two had self-excluded from consultation or treatment for lack of funds: one had bought medicine in a shop for a child's malaria because the private dispensary charged too much; one had run out of money for treatment for a heart condition that had stopped him working. This group had more scope to manage funds, but were mainly the better off among the poor rather than the comfortably off.

Half of the poor, and 38% of the better off said that they or someone they knew had been excluded at a facility for inability to pay. The percentages were higher in Mbeya where charges were higher. Over half the reported exclusions were at government hospitals, and the interview detail suggests this reflects a role of these facilities as last resort for the seriously ill poor. Some experiences recounted of exclusion from government hospital treatment had led to death: a pregnant woman who died because she was unable to pay for a Caesarian section; an elderly man who died because he had no money to buy drugs at a government hospital; and the deaths of a number of children from inability to pay bribes. Government hospitals were funded to treat TB free of charge but some who could not bribe had been excluded, putting the lives of others at risk from transmissable disease.

Interviews with patients on exit from facilities support these accounts. Of 272 interviewees, 207 (76%) had to pay on the spot from their own or their relatives' pockets (12% received free treatment and 11% were paid for by employers). Of those asked to pay, 40 (22%) were unable to pay all they were asked. Eight were excluded, mainly at government hospitals, while 24 managed to defer all or part of the payment, generally at private and religious-owned facilities, and often by accepting part treatment, a medically dangerous practice. Deferred payments could generate self-exclusion later, if people could not pay debts, and the prospect of painful negotiations around payment was one more deterrent to use of health care.

Abusive transactions and the destruction of trust

Patients cannot judge the clinical quality of their care directly, but must seek signals of trustworthy treatment. Claiming decent health care when needed therefore requires more than finding some money. Equally painful can be the struggle to identify and claim the 'appropriate service' (as several interviewees put it) paid for, and this struggle too was structured by socio-economic status as well as market incentives. Capabilities, both health and access to care, are undermined by poor *terms of inclusion* in health care markets as well as by exclusion (Sen, 2000).

The main recourse of the poor was the cheaper primary care facilities, plus government hospitals and some, particularly rural, religious-owned hospitals. In the urban areas, and particularly in Dar es Salaam, this translated into widespread reliance on private dispensaries since government and low-charging religious dispensaries and health centres were too few, while in rural areas people relied overwhelmingly on government and religious dispensaries. Many health care users faced abusive transactions, notably in those government facilities (mainly hospitals) where bribery was prevalent and in small private dispensaries where the incentives to cheat were very strong because of highly price-competitive markets (Mackintosh & Tibandebage, 2002).

In relation to these abusive transactions a discourse about trust and distrust appears without prompting in our interviews. The Swahili terms used are *imani*, meaning 'faith' or 'trust', and related terms such as *kuaminika*, to be trustworthy and *uaminifu*, trustworthi-

ness. The terms capture the same implication of considered belief in conditions of uncertainty as in the English concept of trust.

Interviewees were eloquent and coherent about the difficulty of obtaining a fair return for their money. The only weapons of the urban poor were information and exit, and both were used, but with little cumulative effect. Interviewees understood very well the dangers of the profit motive in private dispensaries, and gave detailed examples of resultant abusive behaviour: use of unqualified staff such as 'Red Cross medical aides', prescribing expired drugs, unwillingness to refer complicated cases, false test results, prescribing expensive, unnecessary or fake drugs. Incidents recounted included two children paralysed by improperly administered injections by unqualified staff, and a death because a private facility referred too late. Thus calculative distrust was widespread:

> Private facilities are not trustworthy because their intention is to sell their drugs for profit.

Particular private facilities could rapidly acquire poor reputations through the circulation of such stories. Of one private dispensary an interviewee said:

> Some of the staff are not trustworthy. For example, they may inject a patient with water instead of chloroquine.

People did abandon facilities that became particularly distrusted: we observed one bankruptcy hastened in this way. But choice of facility was not a route to more trustworthy care. Market pressures were tending to undermine probity: private facilities opened and closed rapidly (Tibandebage, Semboja, Mujinja, & Ngonyani, 2001), all were financially fragile, and as a result it was hard for facilities with higher standards to survive undercutting in areas of severe poverty, while 'moving among the facilities' used up people's tiny resources.

There were three main ways in which people tried to achieve a more trustworthy return for their money. One was value-based: to find facilities where there was some non-health-related reason to believe in the probity of the staff. Another was personal: to go where one knew a staff member: a relative or other connection who would have a personal reason not to cheat you. And a third was a form of calculation: to pay more, in the hope that higher charges correlated with more reliable care. These strategies could be effective, and people with relatively high incomes could and did employ them in combination, for example paying doctors at clinics to use their connections to assist in obtaining good quality care from a government referral hospital.

The most widely cited signals of probity and competence were ownership based. Religious facilities were widely regarded as more trustworthy because of an implied ethical commitment to service and resistance to profit-driven unethical behaviour:

> Facilities owned by religious organisations offer services worth the money paid because they are committed to their religious course, to offer service rather than making profits; the management controls the facilities' activities more closely; and the staff are trustworthy in their work.

This view was sustained by some (not all) religious-owned facilities' earned reputations for politeness, warm reception to patients, and moderate or low charges. One woman said she had moved to a religious dispensary because she 'had lost trust in the injection prescribed' without diagnosis in a private dispensary.

Conversely, the government sector was widely characterised as competent, and repeatedly said to have the best qualified staff whose advice was worth seeking even when drugs were unavailable. However, difficulties arose in those facilities where bribery intervened. A government hospital matron said:

> It is possible that staff ask for extra cash in addition to the set charges.... That creates an environment where a patient cannot trust any more. And it causes a burden because it increases the cost. If someone comes here to deliver, and they have prepared 3000/-, and then someone wants more, they are not prepared: that is bad.

Interviewees of all social classes repeatedly associated bribery with unpredictability, abuse and neglect. By no means all informal charges in health facilities were described as 'bribes' (*rushwa* or *hongo* in Swahili), and we discuss below another category with quite different implications for the trustworthiness of care.

Transactions described as 'bribes' involved the exercise of professional power for personal gain, often abusively. Here is one account:

> I went to seek treatment for my child. I knew that there is no service charge for children at the [government hospital], but the child was not attended to. Then came the nurse who examined the child and said, 'Lady, your child has caught fever'. 'Indeed, a high fever', I replied. Then the nurse asked, 'But do you have some money? No service is available without money here.' I told her that I did not have any money. The nurse left and never returned. I stayed at the hospital until 4.00 o'clock when I decided to go back home. During the same night, the fever persisted and the child passed away.

Aspects of this awful experience are reflected in other accounts: neglect, abandonment without care unless bribes are paid, powerlessness, arbitrary behaviour, fear, grief and loss. Tests were held up 'until one gives a little

something'; staff had to be 'talked to well', or 'seen' before service was obtained. Many experiences, involving doctors, nurses and technicians, led to persisting illness and recourse to traditional healers.

In some hospitals, bribery was described mainly as a way of improving the service:

> If you bribe a doctor the services are always good.

However, at the government hospital with by far the worst reputation for abuse, people were constantly afraid of bribing the wrong person, running out of money ('How many staff can a patient bribe? every shift?'), or being neglected despite paying a bribe:

> You can give a lot of money as a bribe and still not receive good services or drugs.

In these latter circumstances, trust in the transactional relationship has completely broken down, and the risks of private transactions look a better bet:

> Private facilities are better than the government sector because one pays some money and gets the appropriate service.

Over time, facilities had established norms around informal payment supported by mutual expectations, reflected in consistency in the sums mentioned in relation to particular facilities. Several interviewees said users were part of the problem:

> Corruption has now been adopted as a normal procedure [in the government sector]. Whenever one person happens to bribe a doctor word spreads around, so whoever goes for treatment necessarily prepares money for a bribe.

Norms of this kind shaped the terms of inclusion and exclusion, widening economic and social inequality.

What influenced these terms of exchange? Knowing a staff member could help to avoid both informal and formal charges in government facilities:

> I had free treatment at the [government] hospital, so I think if one has a relative there, especially a doctor, medical service can be free.

At a government hospital in a predominantly rural district, where reports of bribery were fewer and balanced by accounts of good treatment, a few interviewees, uniquely, recounted success in individual resistance to demands for bribes. Tellingly, in this hospital a threat to go to the hospital management appeared to work. Elsewhere, no one reported resisting a demand for a bribe, indeed to complain was seen as dangerous:

> We never complain anywhere. We are afraid that if they know who has complained, they may poison the patient.

We met not one person who had ever trusted a facility's management sufficiently to actually make a formal complaint.

Many users blamed abuse and bribery on low wages and poor conditions of staff, and expressed understanding of their situation. Liberalisation allowed low-paid hospital doctors to go into private practice—a motive for neglect of hospital duties. Hospital nurses were caught between many of the worst pressures in the system: very low wages, long hours in often dangerous conditions, responsibility for severely ill patients without the necessary resources, often unsupported by doctors. The more abused they felt, the more likely a culture of abuse of patients; this was felt to be particularly destructive of trust in health facilities since nurses were expected to care:

> A patient relies on the nurse's love and trustworthiness. S/he puts him/herself in the nurse's hands for help.

However, reported behaviour varied greatly between institutions where staff had similar pay suggesting that important as pay levels are, the broader culture of support, or lack of it, to lower level staff, and the behaviour and level of probity of management were key determinants of patients' experience (Tibandebage & Mackintosh, 2002).

Sustaining access: trust and informal 'contributions' in rural areas

At the primary-care level, rural government facilities continued to constitute a partial safety net for the rural poor. None imposed formal charges, and while donor-supplied drug kits were limited, and regularly ran out, people emphasised that in many facilities they continued to exercise effective claims to these drugs:

> When drugs are available, we just get them.

Most rural government dispensaries (not all) imposed small informal charges, called a 'contribution' (*mchango*), but these, strikingly, were not associated with abusive behaviour. They were characterised as 'for kerosene' or 'for syringes':

> If one is prescribed an injection [at a rural government health centre] one must contribute Tshs 100 for kerosene for the sterilising stove.

People drew a sharp distinction between these contributions and demands for bribes (for example, to assist with delivery or worse, for access to drugs that should have been free), which also occurred at certain rural facilities. Describing one facility, someone said:

> You are not made to pay bribes…for an injection you pay Tshs 100 for kerosene.

People debated, and generally appeared to trust, the stated purpose of these contributions. One village chairman had publicly asserted that the money indeed went to kerosene. An interviewee who pointed out that the charges were not according to government guidelines nevertheless complained, not about paying, but about some others not having paid and the failure to issue receipts. The acceptability of this category of informal paid transaction appeared to rest on the small size of the charge (relative for example to bribes, which seemed to be larger even in rural areas); on belief that the payments went to support essential items, not into individual pockets; on their visibility; and on the lack of association with abuse and arbitrary exercise of power. In this case informal charging did not undermine trust.

Charging and impoverishment: the particular vulnerability of the urban poor

Government sector transactions at low charges thus sustained successful claims to some primary care by the rural poor; that provision in turn was sustained by donor-provided drugs. Virtually all the low-charge transactions recorded, charges of zero or below Tshs 500 (already a large sum in rural areas), were in the government sector (Table 1), mainly at primary level and 88% in rural areas. Of those rural government sector transactions, in turn, 95% were by the poor.

The urban poor, however, had no such recourse. The few government dispensaries and health centres in urban areas were charging user fees by 1998, improving the drugs supply but excluding those without funds. Among poor urban household interviewees, 80% of health centre and dispensary visits were to non-government facilities (a higher proportion than among the better off); and exit interviews confirm the use of these facilities by the poor.

Figs. 1–3 show the distribution of reported charges for health facility visits by social group. Each dot plot shows the logarithm of (charge + 1): this use of 'started logs' displays zero payments as zero on each figure and allows inspection of the distribution of low payments; the horizontal lines are labelled with Tanzanian shilling (Tshs) values. Among household interviewees (Fig. 1),

Table 1
Categories of charges paid at facilities (health centres, dispensaries and hospital outpatients), exit and household interviewees 1998, Tanzanian shillings (Tshs)

Charge	Ownership			
	Government	Religious/NGO	Private	Total
Zero	49	2	2	53
Low (Tshs 0–499)	29	4	6	39
Tshs 500+	71	85	84	240
Total	149	91	92	332

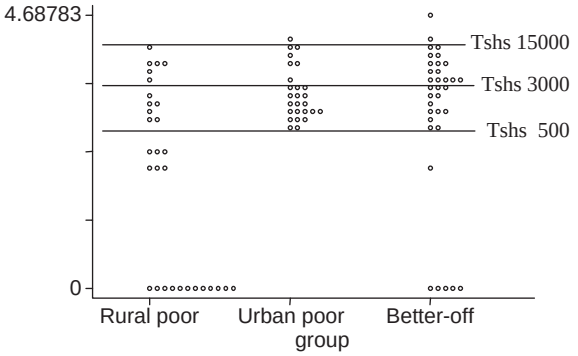

Fig. 1. Dotplot: charges paid by household interviewees, by socio-economic group 1998 (log (charge + 1)).

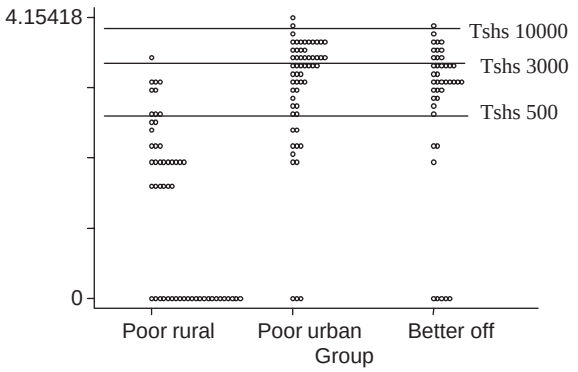

Fig. 2. Dotplot: charges paid by patients interviewed on exit from health centres and dispensaries, by socio-economic group, 1998 (log (charge + 1)).

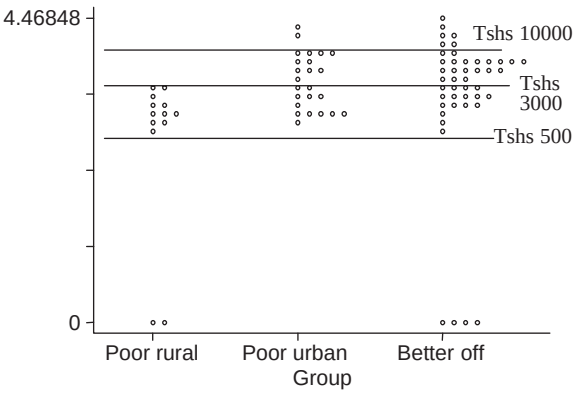

Fig. 3. Charges paid by patients interviewed on exit from hospital OPD, by socio-economic group, 1998 (log (charge + 1)).

no free or 'cheap' (less than Tshs 500) services were obtained by the urban poor at primary facilities or hospitals. Among those exit interviewees at primary facilities classified as 'poor urban', only four out of 102 interviewees had obtained services without payment, while in rural areas the proportion was 40% of 67 interviewees (Fig. 2). Strikingly, the urban poor were paying relatively more high charges than the better off and obtained fewer free services (Fig. 2). No poor patients at urban government, religious or private hospital outpatients ('poor urban' on Fig. 3) obtained free services, and their payments were substantially higher than those of the poor at rural (government and religious-owned) hospitals. The better off obtained more free service, and paid a range of charges similar to the poor at urban hospitals.

These levels of payment observed appeared unsustainable for the poor. Mean non-zero charges reported by exit interviewees (Table 2) are consistent with mean charges reported by household interviewees for a facility visit (including hospital OPD) of Tshs 4090 in Mbeya, and Tshs 5495 in Dar es Salaam and Coast. The pain represented by these sums can be inferred by comparison with a rural and peri-urban poverty line of Tshs 12,100 per adult-equivalent per month in 1998, with over half of the population living below it (Semboja & Rutasitara, 1999). In Tanzania as across much of Africa and low-income Asia the poor are more susceptible to illness, often find themselves excluded from care, and pay a larger proportion of their incomes for care with more severe consequences (Bloom & Lucas, 2000; Fabricant et al., 1999; Pannarunothai & Mills, 1997).

A single private dispensary or hospital OPD visit could therefore use up savings and also borrowing capacity from low-income kin who are struggling too. A hospital medical officer said people were 'finishing things up at home' by selling goods. Once households sell assets their capabilities shrink and they are permanently impoverished. Here is one account: most of the charges are informal.

> My wife had a miscarriage so I took her to the [government] hospital. First I paid Tshs 3,500 and was given a receipt for Tshs 500 for registration only. When she was admitted, I paid Tshs 3000 for tests and gloves. After that, I was asked for Tshs 3000 for a womb cleaning procedure. At that point I had no more money … So I went to sell my pig and brought the money, and on the third day the procedure was done. However, she had already lost a lot of blood. A nurse at the theatre was given Tshs 1000, a nurse at the ward Tshs 1000. The total cost was 11,500 but I was given only the Tshs 500 receipt for registration.

A safety net for the poor in the form of free or cheap care of perceived reliability was thus largely absent in urban areas and at hospital level. Over 80% of household interviewees classified as urban poor said they had never so much as heard of a case of free treatment. 'There is no service without money' was a repeated view. The introduction of government sector user fees was accompanied by a formal system of exemption for those unable to pay; however, we found no-one who could recount an example of exemption on grounds of poverty. These results accord with other studies in Africa (Nyonator & Kutzin, 1999; Stierle et al., 1999).

Furthermore, methods of accessing treatment without charge that did sometimes work, such as exemptions from fees in government facilities for small children and (in one case) the elderly, and for categories of illness such as HIV and TB, and deferral (or occasionally waiving) of payment in the private sector, all functioned less reliably in urban contexts. Relations between population and facilities were unstable, so the mutual knowledge and trust that are the basis of judgements and claims could not be built up. One private dispensary owner working in a small town in a rural area put it this way:

> When patients find prices unaffordable they ask for deferral and agree to pay at a later date…. There is very strong good will and trust because I have been living and practising medicine in this area for many years [interviewer's note: since 1970s].

Similarly, rural government facilities that were operating reasonably well were the only facilities sometimes referred to by interviewees as 'our' dispensary or health centre.

In Dar es Salaam, the high-charging religious hospitals had welfare schemes, run by some better off religious groups, that paid fees for poorer community members; one such facility noted that they also permitted deferred payment by patients known to staff members and 'regular patients who are trustworthy'. One large Muslim dispensary in Dar es Salaam had a charitable account, funded by a number of local mosques, used for 'the elderly and destitute', particularly

Table 2
Mean payments by patients interviewed on exit from facilities, by ownership of facility and region 1998 (Tsh)

Ownership	Dispensaries and health centres		Hospital OPD	
	Mbeya	DSM/ Coast	Mbeya	DSM/ Coast
Government	224	903	2492	1714
Religious/ NGO	4301	2420	2520	7729
Private	4931	1923	6180	10209

Notes: dispensaries and health centres: non-zero charges only; hospitals: OPD charges to be paid by self or relatives only.

those recommended by the Imams, and to cover bad debts.

These personal networks of support were biased towards the better off and stable residents, and outside of them the poor found it hard to obtain care and treatment in Dar es Salaam. The poor in urban areas faced barriers to the use of both value-based trust such as reliance on the values of religious organisations, who ran few urban facilities and personalised trust based in being known and part of communities to access care in time of need. These barriers reinforced the consequences of high charges, lack of free options, and reliance on abusive facilities that were worst for the urban poor and for those who travelled without funds to urban hospitals. The free drugs and very cheap or free consultations that constituted the core of the fragile rural safety net were unavailable in urban areas. Exclusion and abuse were rooted in social inequality and disadvantage, and health care market experiences fed back into strengthening poverty and marginalisation.

Discussion: reputation and trust in the shaping of health care transactions

We return now to the dilemma posed by an interviewee in the last section: how to access cheap but good quality care? We have traced the roots of trust within health care market transactions to three sources: community scrutiny (e.g. the 'contributions' in rural areas), signals of trustworthiness (e.g. the reputation of religious facilities for probity or government staff for competence) and individual knowledge and networks. These are largely value-based and personalised sources of trust, developed to combat the calculative distrust of personal profit-seeking behaviour, especially the abusive manipulation of a culture of bribery.

Can policy reinforce existing sources of trust within a market-based health-care system in ways that increase the capability of the poor to access decent care? We suggest three broad approaches: supporting transactional behaviour that unites calculative with other sources of trust via reputation-building; constraining individual profit-seeking through professional and managerial scrutiny and institutional design; and reinforcing value-based sources of trust through public appreciation and information.

Where reputation building worked to the advantage of the poor it involved signalling mechanisms that elicited commitment from users in return. Religious facilities that capped prices, treated small children very cheaply and would treat in emergencies before asking for payment said (and interviews independently confirmed) that they elicited a commitment to return with deferred payment. Private dispensaries that waived fees in emergencies and vaccinated without payment were using probity in part to market themselves. Policy can build on this complex mix of calculation and professional or religious values to increase trust: for example rewarding non-government facilities for preventative care; involving them in pre-payment schemes that undermine the distrust inherent in fee-for-service provision; learning from good charitable facilities' charge-capping systems.

Abusive transactions can be constrained by effective management, by community scrutiny and by clinical audit. For example, a mutual insurance scheme for about 5000 urban households working in the informal sector (UMASIDA) incorporated clinical audit by doctors giving their time unpaid; results appeared to include upward pressure on quality, formal representation for users with problems, and an improvement in affordability because of predictable capped payments (Kiwara, 2000). In addition to valuing and learning from success, for example in the better hospitals, policy can legitimate community leadership and scrutiny, for example through provision for formal representation of the interests of users in facility management or District Health Management Team meetings.

There are other ways in which policy could reduce perverse market behaviour. There was no functioning referral system, and patients of private providers were often 'reprimanded and denied service' at government hospitals. Patients often refused to go, saying they 'did not trust the hospital services'. Creating hospital working practices that rewarded proper referral by responding to primary practitioners' paperwork and reducing fees for patients, and encouraging and facilitating primary practitioners to act as patients' advocates could reduce the impoverishing impact of hospitals.

Finally, sustained probity and commitment against market odds too often went unrecognised by policy makers. For example, our findings imply that donor and government support for free rural dispensaries was working relatively well: drugs were limited, but distributed free of charge much more often than we had expected in the light of national and international policy commentary of the time. Yet that success was underestimated and hence vulnerable to marketisation.

Conclusion: trust and impoverishment in low-income health care

The Tanzanian Poverty Reduction Strategy Paper (United Republic of Tanzania (URT), 2000) argued that improving human capabilities is key to poverty eradication, hence, 'the government will place special emphasis on reducing morbidity, improving nutrition and

strengthening access to health services and safe water' (United Republic of Tanzania (URT), 2000, p. 24) The earlier National Poverty Eradication Strategy (United Republic of Tanzania (URT), 1998) identified inadequate access to social services, geographical and social exclusion, and limited capacity to influence events as key aspects of poverty. We have taken the relational concept of poverty implicit in these policy statements as a starting point to explore some of the determinants of merited trust and the sources of distrust, exclusion and abuse within health care transactional relationships.

Our findings support the now widespread understanding that unaffordable fees exclude many of the poor from access to health care. In addition, we have shown that the roots of merited distrust in health care provision, notably distrust and anger at provision by many (particularly small scale) private providers and government hospitals, lie in the perverse incentives for cheating and abuse generated within a competitive, low income fee-for-service system. These incentives were well understood by users, and the worst experiences recounted were those of the many interviewees who had faced arbitrary behaviour associated with bribery in some government hospitals. Exclusion and impoverishment were generated not only by difficulty in paying, but also by difficulty in achieving access to decent, appropriate care in return for cash expended.

We have gone on to show, however, that the Tanzanian health care also contains examples of merited trust and the avoidance of abuse. These arose from individual probity and examples of good management (for example, in one government hospital studied) but also, importantly, were found systematically in certain sectors of the health care system. These included those religious facilities that had sustained their charitable objectives, and a majority of rural government dispensaries studied, where informal charging, though present, was of a form not associated with abuse, exclusion and individual profit. The active construction and sustaining of trust in these contexts worked to the benefit of the poor as well as the better off.

It follows that a better understanding of the roots of trust, in calculation, in ethical and religious values, in institutionalised scrutiny and in personalised relationships can help to formulate policy that combats some of the worst effects of the calculative distrust inherent in fee-for-service health care. Public action can work to reinforce trustworthy signals of decent, respectful, qualified treatment, and can strengthen people's collective voice as both citizens and users; such policies need to be underpinned by ensuring that government facilities (hospitals in particular) expel the worst abuses associated with informal marketisation.

Health care market relationships are both instrumental means to, and directly constitutive of impoverishment and relative privilege understood in a capabilities framework. Failures of trust in the health care system, and broader social marginalisation, interact to 'put people in their place'. To take a sick child home without attention is truly to know just how poor you are. Conversely, policies that value probity where it is found and which help to sustain and rebuild trustworthy relationships greatly enhance the effectiveness and cost-effectiveness of money spent for health care both by poor people and by government and donors.

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