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Unofficial Fees at Health Care Facilities in Bangladesh: Price, Equity, and Institutional Issues

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Nazmul Kawnine
Project Director

Stephen Thomas
Associate Economist

Yuwa Hedrick-wong
Horizon Pacific International

Azizur Rahman
Data International

Prof. James R. Killingsworth
Team Leader

Najmul Hossain
Data International

Tahmina Begum
Data International

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Executive Summary

At its District and Medical College Hospitals, Bangladesh has an extensive experience in the collection of official fees. Levied for outdoor (outpatient) and indoor (inpatient) services, these official fees generate about 12 percent and 3 percent of total annual expenditures at District and Medical College hospitals, respectively. At Thana Health Complexes (essentially, primary health care service points), official fees are only collected at selective pilot project centres. The revenue potential, though not great, represents an attractive potential contribution to the provision of health care in the country.

Resource constraints have forced decision-makers in the health sector to consider expansion of official user fee collections. The question of whether to do so is greatly affected by judgment about the ability to pay of those seeking health services. Many policy questions are only partly examined:

- Can the poor be protected comprehensively or even partly from excessive burdens placed upon them by user fee collections?
- If expanded to THC's will user fees further erode the already low utilisation levels that exist at these facilities?
- Will administration of these funds, particularly if they involve exemption schemes, consume the full amount of the funds collected?
- Can or should fees vary from area to areas and should the decision about fee levels be decentralised?
- Should fees operate on a self-selection basis for the non-poor or will self-selection result in still further inequities among health care consumers?
- If fees are collected, should they be used only at the central government level or should they be utilised at least in part at the local level?

But another area of questions regarding user fees concerns the matter of *unofficial fees*, the subject of this study. Unofficial fees at public facilities are defined as those not promulgated and formally sanctioned by official government policy. They can be contrasted with officially authorised user fees collected by public facilities for cost-sharing purposes and sanctioned public/private mix innovations. Information about such unofficial fees in developing countries is largely anecdotal, receiving only scant attention until official user fees are adopted to generate additional health service revenues. Conceptual exploration of unofficial fees has also been limited, leaving considerable ambiguity about the function and desirability of the practice and uncertainty about policy steps appropriate for dealing with their consequences.

This study provides additional systematic information about unofficial fees at three health care facility levels in Bangladesh: the Thana Health Complex (THC), the District Hospital (DH), and the Medical College Hospital (MCH)—roughly, primary, secondary, and tertiary levels. While not a comprehensive survey of the practice, the empirical findings of the report help to specify some major economic, equity and institutional effects of widespread unofficial fee collection, to advance to some degree the conceptual understanding of the practice by relating it to the economics of "rent seeking," and to suggest that successful health policy must take into account the impact of unofficial fee practices on health sector reform in developing countries.

The main findings of the article are:

- Unofficial fees are widespread and prevalent at public facilities, representing in some cases as much as 10-12 times the expected amount of official fees—a major proportion of the opportunity costs of health care in some developing countries.
- Unofficial fees involve the individual-by-individual capture by health facility employees of a significant "consumer's surplus," a "rent capture" with significant costs to society beyond the welfare loss of the consumer's surplus itself.
- Unofficial fee payments, including fee-for-services, fee-for-commodities, and fee-for-access charges, threaten patients with a near-dilemma: pay to avoid service of the lowest quality or accept the risk of deficient, sub-minimal care.
- By being levied on an individual basis, unofficial fee collectors ("monopolists") and patients ("consumers") approach "rent capture" through a complex pattern of price discrimination and institutional sanctions.
- When coupled with exemptions favoring the privileged, unofficial fees work to the disadvantage of the poorest and most vulnerable members of society and tend to cycle subsidies upward toward the non-poor.
- Once institutionalised and linked to specific employee groups, unofficial fees provide a type of built-in bias against the delivery of quality services and a likely impediment to reforms that may raise efficiency and quality at the facility level.

Section A: Introduction

Unofficial fees in developing country health systems must be clearly defined. They ought not to be confused with health sector reform experiments linking public and private health care practice—for example, government-approved health sector reforms such as after-hours use of public facilities for private practice. Where officially promulgated governmental policies sanction a mix of public and private health services, no unofficial fees exist. These fees co-exist with fees collected at private and NGO health facilities whose prices in at least some cases set an upper price boundary or relative price structure for unofficial fees charged at public health facilities.

Unofficial health care fees at government health facilities are un-authorised fee payments that co-exist with "free care" and formally approved "official" health service charges collected at public facilities under the sanction of public policy . They fall into three broad categories:

- *Fee-for-service payments*, where the services in question, e.g., attending to patients when there are no others to assist them, are typically performed by a facility employee who collects the fee directly from a care seeker (family member, friend) and may include services which are already understood to be part of the employee's official functions.
- *Fee-for-commodity payments*, where supplies or drugs are purchased for the patient from the open market and probably with a mark-up.
- *Fee-for-access payments*, where access or improved access is gained for a person seeking care at a facility, e.g., procuring a bed for a patient who has already paid the facility's official admission charge, arranging transport for a patient or family member.

Obviously, there is a considerable ethical and socio-cultural range to the collection of unofficial fees, with some unofficial fees being so integrated into facility work patterns as to seem like officially authorised arrangements to many care seekers. Information about the existence, validity, and extent of unofficial fees is very poorly known to patients coming to hospitals. Indeed, it is virtually unknown to patients visiting a facility for the first time.

In addition, those who collect and use unofficial fees necessarily conceal their actions and identities, since in at least some cases they are performing illegal acts. Generally speaking, not much is known about these individuals and their methods and, as one can imagine, collecting data about these practices is an extremely difficult undertaking. It is not known whether the actual collectors of unofficial health care fees "front" for invisible beneficiaries or merely act on their own impulse. Further, it is not clear whether payment of such fees by the households of a society indicate a public tolerance for unofficial payments and whether the commercial practices of these societies treat unofficial fees as an accepted standard of behaviour. Finally, it is unclear whether those who collect such fees view their activity as a perquisite or entitlement of their position or whether they see such collections as an optional but lucrative practice. This study probes the mechanics of unofficial fee collection only to the extent that it can be inferred or was reported by participants, focusing attention instead on broader economic and policy concerns.

Direct economic effects depend not only upon the scope and intensity of unofficial fee collection but also upon the amount of "consumer surplus" available for fee collectors to capture. In Bangladesh and many other developing countries, public facilities provide highly subsidized "free" care intended for the poor so that the difference between what a consumer pays and is willing and able to pay, the consumer surplus, can be noticeably significant. The rents captured by these near-monopolists come at considerable cost to society and as a significant opportunity cost to the patients who pay for them.

Further, the utility maximising choices of those who seek care are clouded by a lack of information needed to compare facilities, services, and costs, especially for those coming to a facility for the first time or who come for emergency care while expecting "free" service. If some individual or group can extract significant amounts from this consumer surplus for personal gain through unofficial fees, the incentives may override health service reforms and efforts to attain a more equitable distribution of health benefits.

Perhaps more importantly, in countries like Bangladesh, where jobs are hard to find, pay is extremely low, and many employee groups are linked with political party politics, even a modest consumer surplus can powerfully channel behaviour. This article suggests that pursuit of this reward through the extraction of unofficial fees by employee groups at health facilities may have multiple effects upon health service provision.

Section B: Materials and Methods

In Bangladesh as in many developing countries, unofficial fees are collected alongside officially sanctioned ones. At DHs and MCs in Bangladesh this appears to be the case as well. Since, with the exception of selected pilot projects—Hajiganj THC (CIDA) and the Thana Functional Improvement Pilot Project (EC)—official user fees are not collected at THCs, little is known about official and unofficial fee collection at THCs. It is difficult to determine whether official user fees crowd in or crowd out unofficial fees at Bangladesh health facilities, but it appears that unofficial fees always accompany official charges.

This study estimated *unofficial* fee amounts at DHs and MCs by means of a non-random "rapid survey" of recently admitted and treated patients from two DHs—Netrokona District Hospital [NDH] with 50 beds and Jamalpur District Hospital with 100 beds—and one MC Mymensingh Medical College Hospital. Mymensingh is a major MC having 500 sanctioned beds (689 operational in 1996) in its main facility and 146 sanctioned beds for its associated infectious disease hospital. Although the Hajiganj THC study was designed as a report on *official* fees, the findings about unofficial fees drawn from this two-year, random sample study are incorporated into this analysis.

Official Fees

At DHs and MCs fixed, variable, and optional charges are levied [1$ US = Taka 44]:

- Fixed fees. Outpatient admission ticket (DH-Taka 2.2; MC-Taka 3.3)
- Inpatient admission ticket. (DH-Taka 3.3; MC-Taka 5.5)
- Variable fees. Surgery (DH-Taka 250 to 550;MC-Taka 250 to 550—minor/major), ambulance (6 Taka/km—DHs and MC), X-ray (Taka 44 to 55—DHs and MC), ECG (Taka 66—DHs and MC), and other (radiotherapy, blood bank charges, misc.collections)
- Optional fees. "Paying" beds and cabins (DH-20 percent of beds and MCs-30 percent of beds with "paying" at Taka 53.5 (including a food charge) and cabins varying with room size (DHs-Taka 129 to 140; MCs Taka 118, Taka 129, Taka 140—food charge included)

At the Hajiganj THC pilot, staff were allowed to collect Taka 10 per visit for patients over 6 yeas of age and Taka 5 for children under age 5.

It is important to understand the scale of official fee collections at these hospitals, since they represent a resource for the substitution of health revenues at the level of the central government. Extrapolated to the 55 major DHs and 8 major MCs, these official charges generate roughly 12 percent of annual recurrent expenditures for DHs and 3 percent for MCs. The bulk of revenues at DHs come from service charges and the majority at MCs from "paying" beds and cabins. For an 11 month period in 1996 at the Hajiganj THC, Taka 116,000 were collected as official fees, roughly Taka 240 per month.

All official collections are remitted to the Bangladesh government treasury and not retained at local areas, except for collections in pilot project areas. Pilot programs are now seeking a devolution of funds and a decentralisation of their control, but questions about the management of these collections remain an issue for policy-makers.

Facility Service Areas and Study Samples

The primary market service area for MC is roughly 4 million people (1991), while it is 1.7 million (1991) for NDH and 1.9 million (1991) for JDH. Although NDH and JDH facilities are within the referral net of MC, access is not identical within the area, since road and

communication linkages are better between Mymensingh city and Netrokona than between Mymensingh and Jamalpur. The Hajiganj THC service area consists of eleven unions (sub-Thana administrative units), four unions of which were selected for the THC user fee pilot. There, official user fees were collected on a per visit basis (10 Tk) for patients above the age of 6 years and at a reduced rate (5 Tk) for children under the age of five. Poor patients were exempted, on the basis of staff judgment, up to 10 percent of those visiting the facility.

The patient panel selected for the "rapid survey" at the DHs and MC were admitted within six months of the survey date and were drawn from admission and discharge records of the hospitals. The sample frame for MC consisted of 210 households given by patients as their address and, of these, 115 were visited in July, 1996. A total of 60 patient questionnaires were suitable for analysis from the 115 patients surveyed. During November and December, 1996, similar sample frames were developed for NDH and JDH with the result that 45 suitable patient survey forms were completed from the 60 former patients contacted.

The sampling frame at Hajiganj THC consisted of 4,017 patients from 4 unions who attended the THC during August, September, and October, 1996. The sample consisted of a stratified random sample with a sample size appropriate for a 95 percent confidence limit (1063) from which a proportional allocation method yielded a final stratified sample of 266 former patient households, 263 of which returned questionnaires.

Interview Schedule and Questionnaires

The interview schedule for the 2 DHs and MC sought to isolate the socio-economic background, capacity to pay for services, and previous experience with formal medical facilities. It also sought to evaluate each patient's perceptions of quality at the admitting facility and to capture the amount of unofficial fees paid by the patient or household for services, commodities, and access.

All interviews were conducted in Bengali at the patient's residence by interviewers using a Bengali version of the interview schedule whereby female interviewers spoke with female patients and male interviewers spoke with males. Interviewers made follow-up site visits to NDH, JDH and MC to corroborate facility-specific information. THC data were collected largely from patient questionnaires concerning official fees, but staff focus group discussions and staff interviews concerning official fees were also conducted. Information regarding unofficial fees came as a secondary but nonetheless important body of findings.

Finally, interview reports of unofficial charges in the survey, like other self-reports, must be viewed with healthy skepticism. While the official charges reported in the paper were computed on the basis of authorised charge schedules, unofficial fee amounts based on interview responses cannot be treated in the same manner. Similarly, some patients in the non-random "rapid survey" interviewed nearly six months after discharge from the hospital and THC patients were also interviewed moths after their visits to the Hajiganj facility. For these reasons, the reported unofficial payment amounts are necessarily open to verification and validity difficulties, a common problem with this type of study. Ultimately, these data must be viewed as indicative amounts rather than precise and validated sums so that the most valid generalisations concerning them are comparisons within the reported unofficial amounts.

Summary

- Multiple methods were used in this HEU study to collect data on unofficial fees at Bangladesh health facilities. Chiefly, the results of a random sample survey of 4,017 patients from the Hajiganj THC and an extensive, but non-random, "rapid survey"

interview of 60 recent patients from two District Hospitals (Netrokona and Jamalpur) and the Mymensingh Medical College Hospital..

- All rapid-survey interviews were conducted in Bengali by trained field investigators giving emphasis to detailed information about both official and unofficial fees at the facilities.
- Official fees studied in the survey are clearly defined in GOB circulars and procedures so that all facilities have a definite concept of what official fees can be collected.

Section C: Findings

Patient and Case Characteristics

As Table I indicates, survey participants ranged in age between 30 and 36 years because of the high predominance of obstetrical and gynaecological patients in the survey sample and the facility populations as a whole. NDH (36) and MC (34) patients were closer to the median age for all three facilities than patients from JDH (30 years). Other variables reflected a reasonably consistent differential between surveyed patients from DHs as opposed to MC. Significantly, the median education reported by patients at MC (12 years) is 33 percent greater than at NDH (8 years) and 42 percent higher than at JDH (7 years). Similarly, the reported average household income for surveyed MC patients (Taka 9,217) is 41 percent higher than at NDH (Taka 5,466) and 54 percent higher than at JDH (Taka 4,218). Most Hajiganj THC patients were children under 5 years of age (45 percent) with most adult patients were female (77 percent). Those who could not write their own name represented 41 percent of the adults attending the THC.

Table I.--Personal Characteristics of Interviewed "Rapid Survey" Patients

	District Hospital			MMCH	Overall
	Jamalpur	Netrokona	Total		
Average age of the patient.	30.23	36.06	33.76	35.37	34.32
Average education level of the patient.	6.74	8.31	7.76	12.00	9.82
Average no. of member in household.	6.18	6.64	6.44	6.50	6.46
Average no. of earning member in household.	1.66	1.67	1.67	1.81	1.72
Average no. of days stayed at DH/MMCH	10.22	8.66	9.36	9.39	9.37
Average monthly income of household	4217.78	5466.07	4909.90	9216.67	6410.32
Average monthly expenditure of household for house rent	550.00	408.08	427.00	2015.50	1334.71
Average monthly expenditure of household for education	582.22	875.76	743.67	1826.25	1176.70
Average monthly expenditure of household for medical care	332.73	291.96	309.90	361.57	328.02
Average monthly expenditure of household for food	2577.27	2601.79	2591.00	3709.26	2983.12
Average other monthly expenditure	674.89	592.59	630.00	1046.11	776.86

MC patients represent a higher socio-economic strata than those interviewed from the DHs and the THC. DH patients also had a far greater exposure to the formal medical care system of Bangladesh. Reported family income per THC patient household was Taka 1,949, leaving these households significantly below NDH and JDH patients and far below those at MC. Roughly 70 percent of the patients interviewed from MC reported physician referral prior to admission. These numbers fell significantly at the DHs (NDH-21 percent; JDH-29 percent), to be replaced by self-referral (NDH-66 percent; JDH-45 percent; MC-23 percent) and friends/relatives (NDH-8 percent; JDH-27 percent; MC-2 percent). Similarly, far larger proportions had never visited a hospital prior to admission to a DHs (NDH-67 percent; JDH-60 percent) or the THC (roughly, 63 percen) than at MC (27 percent).

Table II summarises the evident disparities of income between the facilities in the surveys.

Table II: Average Monthly Household Income—THC and DHs as a Percentage of MC

	Hajiganj THC	Jamalpur DH	Netrokona DH
Average Patient Household Income	Taka 1949	Taka 4217	Taka 5466
Average Household Income as a Percent of Average Income at MC	21 percent	46 percent	59 percent

Obviously, the relative wealth (and, presumably, ability and willingness to pay) of MC patients is far greater than that of the patient attending Hajiganj THC. Not only are those who go to tertiary centres considerably more wealthy than those who attended the DHs and the THC in the study, they are also well above the average household income in each of the study areas.

Predictably, service intensity and case-mix differences exist at THCs, DHs, and MCs, since, as might be expected, the case-mix difficulty of patients admitted to MCs is far greater than for DH care-seekers. Difficult emergency cases are usually referred to MCs and patients and authorities in Bangladesh "self-refer" to DHs on the basis of street-level information. Among survey respondents, this pattern was qualified by two conditions: (1) transport and communication between the DHs and MC is difficult, especially for NDH patients, and (2) most DH patients interviewed were visiting a facility for the first time and thus had little or no contact with physicians who might refer them for service intensity reasons to MC. Unfortunately, interview information about cause of admission could not be used to assess case-mix, since it consisted largely of remarks such as "pain in my stomach" and "headache." Finally, DH and Hajiganj THC admission records are little more than registers of names, addresses, and dates of admission/discharge and therefore could not be used to determine diagnosis or treatment.

In summary, patients at Hajiganj THC and at DHs appear to be quite different from those admitted to MC. They are less educated, have fewer resources and have comparatively less information about the formal medical system into which they are admitted. Unlike MC patients, they appear to have arrived at the hospital either on their own or upon the advice of confidants so that the intensity of services they demand is only slightly higher than those of patients at MC. While Hajiganj THC patients were financially well-off and less educated than DH patients, they appear to be closer to the typical DH patient than the MC patient.

Unofficial Fee Collection Process

As described by DH and MC patients, the collection of unofficial fees is done almost exclusively by third and forth class employees: ayahs [female], wardboys, sweepers, medium and lower support staff [MLSSs], and associates and relatives of the foregoing categories who "guide and assist" patients seeking to register and obtain beds [*dalals*]. These groups are primarily involved in the provision of fee-for-commodity payments, particularly the purchase of medications, supplies, and surgical instruments from outside the facility or in securing patient transport.

Unofficial fee collection methods are standardised at DHs and MMCH with payments being made at periodic intervals during the patient's hospital stay, not as a settlement bill at the time of discharge. Allegations, as is often the case, included some extreme anecdotes. One staff member recounted the admission of a *dalal* whose arm was broken in a fight over a patient. It was alleged by one MC staff member that discharge from some wards and the hospital has required both a physician's signature *and that of an ayah, wardboy, MLSS, or sweeper.* Allegedly, extensive fee-for-access payments were secured for such "unofficial discharge" signatures. While interesting anecdotes, no evidence emerged from the interviews of the MC sample to corroborate these extreme claims.

The Hajiganj THC study did not delineate the process whereby unofficial fees are collected. But 7 percent of those attending the facility paid unofficial fees to staff through the unofficial collection process. Most learned about both official and unofficial fees after arrival at the THC and paid them at the point of service.

Official and Unofficial Fees--Average Per Patient Payments

Table III shows computed average official (computed) and unofficial (reported) direct payments for patients at DHs, MC, and across all facilities.

Table III.--Average official and unofficial fees at DHs and MC

	Total official payment	Total unofficial payment	Unofficial payment		Total
			Paid for medicine	Service charges	
OVERALL	**241**	**2951**	**2506**	**685**	**3191**
Cabin	1370	6389	5583	2175	7759
Paying bed.	464	3375	2950	889	3839
Non-paying bed.	15	2245	1894	365	2260
Floor	36	1564	1383	218	1601
Paying bed to Cabin	3005	6500	5000	4505	9505
Non-paying to Paying bed.	225	5700	5000	925	5925
Floor to Non-paying bed	193	3710	2908	996	3903
JDH	**99**	**3837**	**3195**	**742**	**3937**
Cabin	1005	4405	3500	1910	5410
Non-paying bed.	5	3533	3002	537	3539
Floor to Non-paying bed	285	5024	3961	1348	5309
NDH	**5**	**1193**	**974**	**224**	**1198**
Paying bed.	6	252	250	7	257
Non-paying bed.	5	1233	1005	233	1238
Floor	6	302	300	7	307
Floor to Non-paying bed	6	907	700	212	912
MC	**602**	**4035**	**3522**	**1115**	**4637**
Cabin	1426	6694	5904	2216	8120
Paying bed.	488	3539	3092	935	4027
Non-paying bed.	93	3018	2655	457	3112
Floor	43	1817	1600	260	1860
Paying bed to Cabin	3005	6500	5000	4505	9505
Non-paying to Paying bed.	225	5700	5000	925	5925
Floor to Non-paying bed	11	1140	833	318	1151

If computed official payments are combined with reported unofficial payments at all facilities, an average out-of-pocket payment per patient of Taka 3,191 results. Expressed as an average expenditure per patient per day, the amounts are as follows: Netrokona DH—Taka 140 per patient per day (average length of stay or ALOS of 8.6 days), Jamalpur—Taka 386 per patient per day (ALOS of 10.2 days), and MC—Taka 493 per patient per day (ALOS of 9.4 days). As was noted earlier, computed official payments are likely to be slightly overstated and reported unofficial payments may be either over or underreported sums. Nevertheless, Table III indicates that average levels of per patient unofficial fees reported interviewees in the "rapid survey" were reported to be 12 times the amounts that could be expected in official payments—assuming that no respondents were exempted from paying official fees.

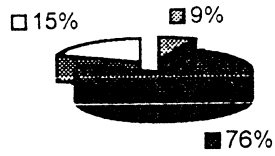
Perhaps still more interesting from the standpoint of this article, the reported average unofficial payments at MC (Taka 4,035), where the maximum amount of options for collecting official fees exist, were 3.4 times greater than at Netrokona DH (Taka 1,193)—

where only admission tickets and "paying" beds are options for official fee collection. This comparison within reported amounts points to a pattern that held throughout the interview-based data: reported unofficial fee collections were highest where official fee options were greatest and official fee collections were potentially highest.

Unofficial Fee Components

The reported average per patient unofficial fee payments consist largely of fee-for-commodity payments (medicines and in some cases supplies and surgical equipment items—85 percent), while fee-for-service (attendant care or medical interventions) and fee-for-access (better bed status, transportation) payments account for the remaining 15 percent. Medicine payments are assumed to include the costs of pharmaceutical items themselves as well as cash paid to the individual who obtained the medicines for a patient.

Chart I: Official and Unofficial Fee Proportions and Components



Official fees Unofficial medicine fees Other unofficial fees

Of course, numerous possibilities exist in such a transaction, since the intermediary can easily mark-up the price of drugs or share a mark-up with the supplier. The fee collector can also vary prices charged to the patient depending upon the degree of apparent need felt by the patient and the patient's perceived willingness and ability to pay for the service. It is assumed here that all of these options are operative and that patients will pay variable amounts of unofficial fees for identical services. It is important to see that the market for drugs, though unofficial and secondary, addresses a clear deficiency of the "free care" system. Reported fee-for-commodity payments distribute themselves, again, in a pattern that reflects options for official collections—where options for official fee collections are potentially greatest, unofficial fee-for-commodity payments are highest.

Official and Unofficial Fees—Average Per Patient Day Payments

Average daily payments for official and unofficial fees have been disaggregated for medical and surgical treatments in Table IV. The reported average unofficial charges per patient day are higher across the board for surgical treatments than for medical treatments. Every sub-category of patient is charged more for surgery than for medicine, except cabin payments for medicine (where patient distribution skewed the results). Ultimately, the higher charges for surgery are related to the higher charges for fee-for-commodity payments (medications) associated with surgical procedures. Since the bulk of these procedures were carried out at MC, it is also predictable that MC average unofficial charges would be higher than those at DHs.

Table IV.--Average per Patient Day Unofficial Fees: Pay Categories by Medical and Surgical Treatment

	Distnet Hospital			MMCH	Overall
	Jamalpur	Netrokona	Total		
Medical Treatment					
Cabin	1034	0	1034	338	892
Paying bed	0	36	36	427	401
Non-paying bed	263	179	211	411	230
Floor	0	75	75	152	137
Paying bed to Cabin	0	0	0	0	0
Non-paying to Paying bed.	0	0	0	0	0
Floor to Non-paying bed	365	302	355	198	303
Total	322	177	236	360	269
Surgical Treatment					
Cabin	0	0	0	587	587
Paying bed.	0	0	0	1032	1032
Non-paying bed.	474	129	315	424	335
Floor	0	0	0	962	962
Paying bed to Cabin	0	0	0	433	433
Non-paying to Paying bed.	0	0	0	570	570
Floor to Non-paying bed	609	0	609	0	609
Total	515	129	370	667	548

Relative Contribution of Socio-Economic Factors

Recorded patient status (cabin, "paying bed," etc.) refer to categories used at the facilities; obviously, floor and non-paying beds are categories containing mostly poor patients. In Table V average unofficial fee payments made per day by patients in these "poorer" categories at DHs are compared with similar payments at MC. It appears at first glance that patients in the "poorer" categories fare worse at the DHs than at the MCs. At MCs roughly 70 percent of the average daily fee payments are paid by persons in paying beds and cabins compared to 21 percent at DHs.

Table V—Percentage of Total Unofficial Fees made per day by Different Patient Paying Classifications—Bed Type

Bed type	DHs	MC	Overall
Cabin	7.95%	27.55%	17.89%
Paying bed.	0.14%	41.52%	21.14%
Non-paying bed.	76.42%	17.00%	46.26%
Floor	0.29%	5.86%	3.11%
Paying bed to Cabin	0.00%	1.62%	0.82%
Non-paying to Paying bed.	0.00%	4.25%	2.16%
Floor to Non-paying bed	15.21%	2.22%	8.61%
Total	100.00%	100.00%	100.00%

To further investigate the relationship between poor and non-poor patients, the computed average amounts paid by different income groups were compared. Table VI compares

average official and unofficial payments per patient by various income categories at each facility.

Table VI: Average Official and Unofficial Payments by Income Group*

	JDH				NDH			
	Income group				Income group			
	Tk 5000 or less	Tk 5001-10000	Tk 10000 & above	Total	Tk 5000 or less	Tk 5001-10000	Tk 10000 & above	Total
Overall Average monthly income	2827	7050	1300	4218	2949	8090	15500	5466
Total paid officially	73	25	905	99	5	5	4	5
Total paid unofficially	3397	5216	4205	3837	1139	1531	795	1193
Paid as service charge	703	697	1610	742	230	242	149	224
Paid for medicine	2767	4544	3500	3195	914	1295	650	974
Total charges paid	3470	5241	5110	3937	1144	1537	799	1198

	MC				OVERALL			
	Income group				Income group			
	Tk.5000 or less	Tk.5001-10000	Tk.10000 & above	Total	Tk.5000 or less	Tk.5001-10000	Tk.10000 & above	Total
Overall Average monthly income	3427	8481	14438	9217	2964	8070	14583	6410
Total paid officially	142	449	1178	602	52	249	862	241
Total paid unofficially	1667	3787	6081	4035	2131	3486	4603	2951
paid as service charge	414	927	1915	1115	448	703	1448	685
paid for medicine	1395	3309	5344	3522	1734	3032	4017	2596
Total charges paid	1809	4236	7259	4637	2182	3735	5465	3191

*Table IV excludes extreme income earners, defined as those whose incomes are either 2 standard deviations above or below the mean for the class.

Middle income groups appear to pay relatively more than other groups. Only at MC did households from the income category Taka 5000-10,000 report paying proportionally *less* than the high income category. And at NDH, the lowest income category paid 143 percent of what the highest income group reported paying. These findings suggest that, overall, middle-income patients and to some extent the poor may pay a relatively greater proportion of unofficial fees than the comparatively wealthy.

When the average payments per patient are expressed as proportions of the overall average unofficial fees for DHs and MC, it becomes still more clear that the Taka 5001-10,000 households report paying the greatest proportion. Average payments for the lowest income group are 72 percent of the overall average, the mid-level group pays 118 percent, and the high income group pays 156 percent. These comparisons of averages are, however, strongly influenced by the payment pattern at MC. Table VII expresses unofficial payments as a proportion of average monthly household income for the various income groupings.

Table VII: Unofficial fee payments as a Percentage of Average Monthly Income

Facility	Taka 5000 or less	Taka 5001-10,000	Taka 10,000 & above
JDH	120 percent	74 percent	32 percent
NDH	37 percent	19 percent	5 percent
MC	49 percent	45 percent	42 percent

This information suggests that patients relatively better able to pay are paying a comparatively smaller amount of their disposable income in unofficial fees than are patients with realtively greater household income.

Interestingly, findings from the Hajiganj THC suggest roughly the same pattern. Table VIII below indicates that reported average unofficial fees were greatest for those whose monthly income category was less than Taka 1,000.

Table VIII: Unofficial fee payments and Income levels at Hajiganj THC

Income Categories	Average Unofficial Fees Paid	Probability of Paying Unofficial Fees
Less than Taka 1,000	Taka 51	0.52
Taka 1,001 to Taka 1,500	Taka 12.5	0.22
Taka 1,500 & above	Taka 23.5	0.08

In effect, those in the Hajiganj sample earning less than Taka 1,000 were 2.3 times more likely to pay unofficial fees than those earning Taka 1,001 to Taka 1,500. When those earning Taka 1,500 and above were compared with those earning less than Taka 1,000, they were shown to be 6.25 times more likely to pay unofficial fees.

A regression analysis for the combined sample of "rapid survey" respondents across DHs and MC was carried out to to identify the relative contributions of various socio-economic and background factors in accounting for high unofficial payments at a facility. Total unofficial payments as a percent of total payments (U_1) were linked with the following variables:

X_1=median years of schooling
X_2=total monthly income reported
X_3=previous visits to facility (first time=1;previous visits=2)
X_4=electircity used in homestead (yes=1;no=2)
X_4=patient visit at MC (yes=1;no=2)
X_5=patient visit at Netrokona DH (yes=1;no=2)

Candidate variables were included those that reflected relative wealth of patient households and the degree of information a patient was likely to have about a particular facility.

The results for equation [U_1] were:

$$U_1 = .95 - .0034X_1 - .00001X_2 + .09X_3 + .02X_4 - .1X_5 + .01X_6 \ldots$$
(26.28) (0.2) (2.1)* (0.6) (1.2) (4.8)* (0.6) [t-test values]**

R^2=.35 F=14.48
*values significant at the 95% confidence level
**an analysis excluding medical fee-for-commodity payments found no significant t-test values.

Although the total variance accounted for [R^2] was relatively small, two variables exerted statistically significant levels of influence in U_1: total monthly income reported and the patient being an MC patient. Although the analysis is only indictive, U_1 results suggest that relatively poorer patients pay a higher proportion of their total payments (official and unofficial) to cover unofficial payments than do the non-poor. Presumably, poor patients also fare worse in this regard at an MC than at a DH, particularly when medication commodity payments are considered.

Common sense also supports this finding. Patients at a tertiary care center are likely arrive at the MC with comparatively more serious conditions, having sacrifed their local support

network for higher level care. Since, comparatively speaking, they represent a higher income group as well, they are likely to be a more attractive target for unofficial fee collectors. Focus group discussions with patient families support this view. Jamalpur and Netrokona DH focus group members contended that DH staff collecting unofficial fees were open to localistic restraint exerted through personal connections and patient/family reputation. MC focus group discussions suggested that only education and wealth were reported to restrain unofficial fee collectors with villagers travelling some distance being vulnerable to collections for medicine and services, regardless of ability/willingness to pay.

As employees use more of their time to capture rents and patients seek defenses for themselves, the cost to society of this unproductive secondary market increases while the likelihood of concern for quality declines.

Quality of Service Perceptions

"Rapid survey" respondents were asked to assess quality of care. Hajiganj THC patients were asked to make the same assessment. Quality issues are important since they should reflect the fact that some staff categories are active fee collectors and that areas of low quality at a facility are the target zones for unofficial fee collection. In a related manner, those who allow such target zones to develop should be identified as responsible for low quality zones susceptible to unofficial fee collections, particularly in the case of medicines. To ensure that these issues were explored fully, focus group discussions were held with DH and MC patients and their family members to provide a deeper understanding of relationships between perceptions of facility quality and unofficial fees.

Table IX summarises the results of interview schedule responses concerning quality at DHs and MC. The t-test values in the table indicate strongest approval for the quality of professional staff but reasonably low approval ratings for all other staff: wardboys, ahyas, and administrators. For facility cleanliness, food quality, and food quantity moderate to low quality evaluations were found with a low rating for cleanliness at all facilities. In making

Table IX: Percived Differences in Quality (t-test of level of significance) between District hospital and MMCH

	Weighted mean value responses		T-value	Significance Level	
	District hospital	MMCH			
Quality of Doctors	2.51	2.4	0.92	0.361	
Quality of Nurses	2.76	2.83	-0.52	0.604	
Quality of Wardboy	2.93	3.35	-2.79	0.006	***
Quality of Aya's	2.96	3.66	-5.19	0.001	***
Administration	2.91	3.2	-2.39	0.018	***
Cleanliness of the hospital	3.43	3.52	-0.79	0.429	
Quality of food	3.36	3.55	-1.53	0.128	**
Quantity of food	3.31	3.52	-1.71	0.090	**

Note: Weighted mean calculated by defining excellent=1; good=2; average=3; poor=4; lower mean value implies higher satisfactory ranking
** Significant at 95% confidence level
***Significant at 99% confidence level

comparisons between the mean of DHs and MC, Professional staff quality ratings remained high and facility cleanliness mean scores remained low across all facilities while significant differences were observed in the rating of wardboys, ayahs, administration, food quality, and food quantity: MC ratings were consistently lower than those for DHs in these areas. When asked to rank the top three areas interviewees would like to see improved, cleanliness, medical supplies (medications, primarily), and food quality appeared in 1,2,3 order.

It is important to know more about how unofficial fee collections and quality perceptions interact. It is likely, for example, that the role of wardboys, ayahs, MLSSs, and sweepers earn low marks because they levy unofficial fees. Focus group discussions indicated that their low ratings were linked to a tension between their acknowledged function (improving cleanliness and performing low-level operational chores) and their main function (performing fee-for-service, fee-for-commodity, and fee-for-access tasks). Cleanliness, presumably a main duty of these 3rd and 4th class employees, was deplored at all facilities.

To gain a more thorough understanding of patient perceptions of quality, the 166 respondents were categorized as either less than "3" (104 rating quality as "excellent" or "good") or greater than "3" (62 rating quality as "average" or "poor"). A "discriminant analysis" technique was applied to this dichotomous classification of the respondents to identify differences between the 2 groups with the result that duration of stay and number of past visits to a facility most strongly affected respondents' views of facility quality. Repeated exposures and long stays apparently promote a view of quality as less than "3."

Hajiganj THC questionnaire data showed that 67 percent of the respondents said they would go again to the THC for treatment if they were sick, with only 16 percent saying they definitely would not. Leading reasons had to do with cost of treatment being low (25 percent), that Hajiganj treatment, though unsatisfactory, was better than anywhere else (33 percent), the likelihood that they will get better medicine than elsewhere (16 percent) and that the facility is near their homes (17 percent). Of those saying they would not return to the THC, 10 percent identified high fees and 54 percent singled out the lack of proper medicine. In all, the dissatisfaction of THC patients in the sample appears to be for THC quality and the quality of alternatives as well.

Summary

- Personal characteristics of MC patients differed from those of DH's in important ways, but monthly income, average patient education level, monthly expenditure, and number of earners per household were the most prominent differences. THC patients represented a still lower socio-economic strata, so that patients appear to attend various levels of the Bangladesh health system in a virtually tiered or "layered" manner.
- At THC and District Hospital levels, a far greater number of "first-time" patients and poor patients attend the facility than at the MC level, where previous users are not exceptional.
- Unofficial fee collections are virtually standardised at all facility levels, with some categories of unofficial fee collectors having specific names [*dalals*].
- Third and Fourth Class employees predominate as the collectors of unofficial fees.
- Drug payments predominate among the objects for which unofficial fees are collected and with only a few categories of patients paying both high official and high unofficial fees.
- Average combined official and unofficial payments were reported to be Taka 3,191 across all facilitiesWith average unofficial fees at MC reaching Taka 4,035 per patient.
- About 76 percent of all unofficial fees were for fee-for-commodity (largely drugs) payments while 15 percent fee-for-services or fee-for-access payments. Official fees amounted to 9 percent of the total collected at DH's and MC.
- Poor patients appear to pay relatively greater unofficial fees per day at DH's than at MC. Further, the middle-income groups appear to apy the greatest relative amounts of unofficial fees at DH's and MC while the very poorest patients pay the greatest amount of unofficial fees at the THC surveyed in the report.
- At THC's patients reporting earnings of less than Taka 1,000 per month were over 2 times more likely to be charged unofficial fees than other income categories.

- The collectors of unofficial fees appear to be linked in the patient's mind with low quality services. Of those saying they would not return to the THC, over 10 percent identified high fees and over half identified lack of proper medications.
- A tension was identified in the focus group discussions of the "rapid survey" between the perceived primary job of Third and Fourth Class employees and their fee collection tasks; quality apparently was linked with this tension.

Section D: *Rent Capture* in Bangladesh Health Facilities

Consumer Surplus and "Rent Capture" Behaviour

The collection of unofficial fees is very similar to "rent seeking" behaviour. In pure form, a "rent seeker" extracts excess profits from some government program once the government in question has granted the rent seeker a virtual monopoly of access to benefits from that same program. Furthermore, the individual or group holding the near monopoly commonly uses legislative action to capture the public subsidy.

Unofficial fee collection involves a more generalised form of "rent seeking." There, public employees who can position themselves as near-monopolists simply seek rents by charging fees greater than the opportunity costs of the next best alternative available to the patient—over and above the cost of producing the service, commodity, or accessibility for which the patient pays and under near-monopoly conditions *tolerated* at a public facility.

The unofficial fee collection process—here called *rent capture*—takes place because a government program fails to deliver required levels of services, commodities, or accessibility, under conditions where "free care" is provided by the government itself. In response to the shortcomings of the public "free care" program, unofficial fee collectors:

- recognize that essential or nearly essential deficiencies exist in the program of free care being offered.
- determine that consumers at health facilities would be willing and able to pay as individuals for a set of substituted and *ad hoc* services, commodities, and access arrangements.
- rightly believe that the government will either suspend enforcement against those who provide *ad hoc* versions of missing or ignore such initiatives.
- anticipate that implicit government policy will tolerate the exercise of a near-monopoly by unofficial fee collectors, provided that their secondary market does not become too obvious or draconian.
- assume that information disparities exist between fee collectors (near-monopolists) and patients (consumers) which can be exploited to the advantage of the fee collectors—provided that patient defenses can be thwarted or overcome.

Yet it is vital to see that *rent capture* can occur only when a sizeable consumer surplus is available. In the case of required but missing services, commodities, and access arrangements at DHs and MCs, a sizeable consumer surplus does indeed exist. Patients at DHs and MCs lack the information needed to judge which services, commodities, and forms of access are essential for their health. Physicians and other professionals (agents for the patient), substitute their trained professional judgment for that of the patient (the principal or consumer). Told by the physician or other professional agent that something required for their health is not available or seeing that they need a service or minimal access to care, patients will seek required yet missing elements from any available source.

The patient is then primed for *rent capture* by anyone who can position themselves as a near-monopolist to exert control over price and quantity. The unofficial fee collector simply *captures* part of the difference between what the consumer is able and willing to pay and what they have been required to pay at the facility, i.e. nothing in the case of "free care."

Unofficial fee collectors assess the ability to pay and willingness to pay of each individual patient so that they can seek rents from a first-degree price discrimination position. The first-degree positioning of patients contrasts with traditional or third-degree price discrimination, where customers are grouped into price classes and frequently pay less than what the

monopolist can maximally extract in a first-degree case by settling into arbitrage-free classes. Second-degree price discrimination can also exist at health facilities. There, fee collectors *know the demand characteristics of patients in general but cannot tell which patient has which* characteristic and, as a result, which price to charge. Under the ambiguities of second-degree price discrimination, the patient has some defenses against a maximum unofficial rent capture approach. First-degree price discrimination in health care is the most difficult position for consumers, since the near-monopolist is able to identify the exact level of individual patient demand and then use superior mobility, authoritative positioning, and tolerated information control techniques to thwart collective defense by patients.

For facilities of the rapid survey, it appears that collectors attempt to exploit patient ignorance and the requirements of health care treatments to capture first-degree price discrimination rents. Patients, not well fitted into classes, resort to pleading poverty or use local influence to limit the damage which would be inflicted by first-degree price discrimination. Where possible, patients will "exempt out" of unofficial fee collection in all its forms if they can. But, failing that, they apparently try to settle for second-degree price discrimination.

It is not clear at what points patients make market comparisons or search through family members for alternative sources of supply. Here information and collusion become conjointly important. If unofficial fee collection operates largely because patients have little or no information—apparently the case for first time patients at Hajiganj, DHs, and MC—then near-monopolist employees will maximise their gains by keeping patients uninformed about alternative sources of supply or about the ability of others to provide commodities, services, or access. Where patients are least informed, that is, unofficial fee collectors are likely to pursue an *information control strategy*. If collusion is needed to consolidate information controls, then fee collectors are likely to launch an active effort to vertically integrate sources of supply (e.g., pharmacies near the facility) or service access (e.g., residents or administrators at various levels). This latter approach might be termed a *collusive control strategy*.

Rent seeking near-monopolists will try to maximise their position while patients and their families will attempt to protect themselves from information vulnerability. The extreme positions in this drama are indicated in Table X.

Table X: Unofficial Fee Collectors vs. Patient Vulnerabilities

Preferred "Rent Seeker" Position	Preferred Patient Position
Emergency	Non-emergency
First-time Attendance	Previous Attendance
Ability/Willingness to Pay is known by rent seekers	Ability/Willingness to Pay is unclear or not known by rent seekers
Patients priced as individuals	Patients priced as classes or groups
Information and *Collusion Strategy* in use by rent seekers	Only *Information Strategy* in use by rent seekers
Activity tolerated by facility	Activity discouraged or banned by facility
Arbitrage present	Arbitrage absent

What Table X cannot show, however, is the extent to which social welfare loss accrues due to the amount of resources expended by rent seekers and patients to minimise one another's power. It is reasonable to believe that such costs may be quite limited where unofficial fee takers provide valuable services or provide essential commodities and much needed access in the view of the patient (consumer). But Hajiganj, the DHs, and MC, the attitude of patients toward 3rd and 4th class employees and the quality of their service is uniformly low, thereby suggesting that social welfare costs for rent capture in Bangladesh may be significantly high.

But these matters are far from crystal clear. The large proportion of fee-for-commodity payments in the total leave it unclear whether dissatisfaction is focused upon specific personnel groups or on the shortages of drugs and supplies with which they are associated. Another ambiguity is introduced by the chain-market nature of hospitals. The hospital's lack of unity as a provider is reinforced when many agents collect unofficial fees, at times directly competing with one another, with the effect that goals other than rent capture enter the picture. Fear of detection may lead a fee collector to modify the intensity of effort involved. For instance, the near-monopolist many not wish to charge the rich and influential for services when they might make life difficult subsequently. With price variability dependent upon so many forces and *ad hoc* considerations, price disclosure occurs only at the point of purchase so that the consumer has very little information about the real price of health care. The patient perceives price as a virtual lottery of prices. Reacting against the immediate tensions of the situation, patients use the weapons at hand, raise the social cost of health care, reduce the efficiency of the health care market, elevate their level of dissatisfaction, and raise the probability that utilisation rates at public facilities will reach still lower levels.

Further, if both a *collusion strategy* and an *information strategy* are at work at the facilities surveyed, it would seem reasonable to expect attitudes to be most negative toward 3rd and 4th class employees at those facilities where rent seeking takes the greatest bite from household income. But the results are inconclusive instead. Attitudes toward these employee groups are most negative at MC (see Table VII, above), where the effect on household income is greater than at NDJ but far less than at JDH.

It is likely that still other factors are at work, including the burdensome effect of enlarged opportunity costs, the perceived seriousness of the patient's illnesses, treatment-specific quality assessments made by the patients, and a wide range of other possible explanations. It is clear that additional research concerning unofficial fees, social costs, and quality must be carried out.

Rent Capture and Quality Reforms

The hope that *rent capture* can be minimised or eliminated by enforcement strategies tends to overlook the functional interests of unofficial fee collectors for several reasons:

- First, unofficial fee collectors apparently provide substitutes for quantity and permanent quality improvements.
- Second, they must ensure that the substitutes for which fees are charged do not permanently improve quality.
- Third, unofficial fee collections apparently rely upon perpetually low levels of quality so that a consumer surplus can be raided for personal gain again and again. If quality were raised or quantities made sufficient, unofficial fee services, commodities, and accessibility could not be substituted at the facility. In effect, collectors of unofficial fees depend upon the lack of quantity and quality improvements ensure that the vast bulk of patients with a willingness to accept their *ad hoc* services.
- Fourth and finally, should attempts be made to raise quality on a permanent basis, then it is reasonable to hypothesize that patients would choose between permanent quantity/quality services and *ad hoc* substitutes, thereby putting unofficial fees at risk.

Essentially, the secondary market of unofficial fee collections involves, in addition to services, commodities, and access, "quality" as well. Unofficial fee collectors have a strong functional interest in keeping quality low and in short supply. Patients, seeking to maximise utility under conditions of relative ignorance and having some ability to pay find themselves clearly disadvantaged if rent capture interests are allowed free play.

The policy impact of allowing the functional interests of unofficial fee collectors to become institutionalised are multiple, but perhaps the main effect of their operation in a facility-based secondary market is this: where unofficial fee collection has taken a solid hold, the path to reform becomes quite stony. As efforts to raise quality through health sector reform encounter the vested interest in low and insufficient quality, several scenarios are likely develop—depending upon the incentives operative for the unofficial fee collecting group.

- **Active resistance.** Without significant incentives, fee collectors may simply resist permanent quantity/quality improvements. If they see that patients might be allowed to substitute permanent quality for *ad hoc* substitutes and recognize that their marketplace could disappear, they are likely to resort to sabotage.
- **Extortionary buy-out.** If, however, fee collectors are given inducements of a sizeable amount, the costs of raising quantity/quality may exceed the reach of those promoting the reforms. Where employee unions are both political and economic institutions—as is the case in Bangladesh and many parts of South and Southeast Asia—unofficial fee collectors can count on backing from national political parties. Privatisation and other reform efforts are likely to share a common fate with efforts to curb unofficial fee rent seeking.
- **Fee ownership.** Another possibility, is that unofficial fee collectors might somehow become participants in the management and use of significant official fee amounts. If this were the case, however, the "ownership" of the fees might become quite a literal matter, so that official fees were used as a substitute for unofficial income and not for permanent quality improvements.

Summary

- Rent capture—unofficial fee collection resulting from government failure to provide required levels of services, commodities, or accessibility under "free care" arrangements—allow the development of near-monopolies for unofficial fee collectors who take full advantage of information disparities between what they know and what a patient knows
- Because a sizeable consumer surplus is available for rent capture at health facilities in Bangladesh, rent capture proceeds on a patient-by-patient basis or what is called "first degree price discrimination." Where a patient cannot plead poverty or resort to local influence to evade almost full rent capture by the near-monopolist unofficial fee collector, maximum amounts of rents are likely to be captured.
- The fee collectors at Bangladesh facilities are likely to control both information and the various levels at which fees are collected—an *informational* and a *collusive control* strategy for fee collection.
- The powerful vested position of the unofficial fee collector, the amounts collected, and the relative job security that fee collection brings leaves quality reform in jeopardy at Bangladesh facilities.
- Active resistance, extortionary "buy-outs," and eventually fee "ownership" are likely barriers to quality reform under conditions of excessive unofficial rent capture.

Section E: Policy Issues and Implications for Bangladesh

If unofficial fees prove difficult to reform, they may also prove to have far wider and more negative consequences for the overall social benefits expected from public provision of "free care" and, still more generally, health services themselves. Among the more likely policy implications are the following main effects:

1. **Displacement effects**. A widespread toleration of unofficial fee collection practices or resignation to their presence at health facilities can disorient efforts to make health services more financially sustainable. Tapping a consumer surplus directly has far great appeal to facility-level public employees. The comparatively indirect and professionalised processes of official fee collection and management may appeal to ministry officialdom, but, for 3rd and 4th class employees, the appeal of unofficial income is obviously far greater. And as this study has suggested, official fee collections seem to accompany official fee collections. In effect, unofficial fee collection practices displace institutional rules for the treatment of official user fees—in some instances leading employees to view the official fees as yet another source of income and making official collections difficult to control.

2. **Reduction of Merit Goods Production**. The negative impact of unofficial fees upon poor and vulnerable populations can be extensive. Unofficial fees provide incentives that may sap efforts to remedy "market failures" through improved health service access. In effect, unofficial fees often produce the largest gains for individuals who can best mediate or restrict health care access. Programs intended to ensure that service levels reflect social merit and support maximum social welfare clash with the incentives of unofficial fees and worsen the inequities associated with gender, poverty, and location. It is curious yet possible that comparatively small amounts of unofficial fees collected at a facility may be sufficient to upset millions of public expenditures for overall health services.

3. **Upward Income Distribution**. Since unofficial fees are levied without regard to income, they act like a form of "flat tax." Commonly, unofficial fees interact with mechanisms used to manipulate facility exemption systems for the poor or other administrative arrangements designed to distribute benefits downwards that are, in fact, upwardly distributive. As a result, unofficial fees almost certainly reinforce the distributive unfairness of subsidies already being extended to well-positioned and influential members of society.

4. **Human Resource Distortions**. Incentives for human resource development and, hence, facility efficiency are weakened once unofficial fees are informally accepted as an "entitlement" benefit for specific public employees. As human resources flow into areas where they are not needed, a market for un-needed "inputs" of labor at the facility may develop that undermines the status of marginal professional groups such as lower-grade nurses and nurse-aides—often the very employment groups expected to raise efficiency by means of labor substitution.

5. **Facility Resource Inefficiencies**. In general, then, unofficial fee collection reduces the allocative efficiency of health care. Inefficiencies appear in health care delivery and in the market for health care services, in large part through the unproductive efforts of unofficial pricing agents and the unproductive damage limitation exercises of patients. At the facility level, unofficial fee collections siphon resources away from productive activities and into unproductive ones so that allocative efficiency drops and valued facility services are under-produced. When generalised to all health system levels and across entire health systems, the practice will restrict the overall quantity of socially desirable care made available to the population.

6. **Obstruction of Health Sector Market Reforms**. In the context of widespread unofficial fee collections, larger health sector reforms such as hospital autonomy, the cultivation of greater managerial responsibility, and the decentralised control of health care resources may be significantly undermined. If employees having a vested interest in unofficial fees view reform as a direct threat to the pursuit of their interests, they may attack internal market reform and decentralisation just as they have fought efforts to contract for private sector provision of hospital services or institute performance reviews for civil service promotion.

Section F: Policy Recommendations

Information about unofficial fee collection practices is not sufficient for the evaluation of these broad and significant claims and certainly research far beyond the scope of this study should be vigorously pursued. Given the limited samples involved in this study, a major research initiative may be warranted to explore the social costs and actual impact of unofficial fees.

Nevertheless, the initial findings of this article point to recommendations that merit consideration:

1. **Drug rationalisation and controls.** Medications appear to be a central feature of unofficial fee practices in Bangladesh. Unofficial fee collectors apparently can capture rents because of weaknesses in the distribution and control of drugs and other essential supplies. Official fees that ensured accountability and adequate supplies for these commodities might significantly curb the consumer surplus available for unofficial charges.
2. **Standardisation.** Standardisation of unofficial fees or their conversion to official revenue through sub-contracting or other mechanisms might be used to shift patients from a first-degree price discrimination circumstance to a third-degree situation. Arbitrage would be reduced and social welfare losses due to excessive monopolist-vs-consumer struggles might be minimised. In Bangladesh, a recent privatisation of fares on a communter train raised faires by 600 percent while apparently raising consumer satisfaction as well.
3. **Publicity.** Published unofficial fee lists and consumer awareness campaigns could strengthen the position of the patient so that some semblance of patient rights or consumer rights could emerge in the situation. Fee lists might mobilise the support of patients for quality improvements, particularly for drugs and supplies.
4. **Policy consensus.** Political consensus articulated at the highest level regarding unofficial fee collection may be required, along with signification reforms and quality improvements. If the scale of social welfare losses and consumer opportunity costs are fully understood and set forth at the level of public policy, toleration for the most pernicious forms of unofficial fee rent capture might be drastically reduce.