Unofficial fees in Bangladesh: price, equity and institutional issues

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The widespread collection of unofficial fees at health facilities is a common form of rent-seeking behaviour in Bangladesh. Typically, unofficial fees come in the form of cash payments for the performance of required services, for direct purchase of drugs and medical-surgical requisites, and for service access. Using observational and interview methods, this study explores linkages between official and unofficial fees at three Bangladesh health facility levels: primary care Thana Health Complexes, secondary or district hospitals, and medical college hospitals. The study estimates payment levels for different income classes and different payor types at these facilities, thereby highlighting potential equity, price and institutional questions associated with unofficial fees. Not only does the practice have clear income and equity effects, there also appear to be direct effects upon patient satisfaction, perception of quality, and the ability to pay for health services. The article concludes with a discussion of ‘rent capture’ processes at Bangladesh facilities and the effect of unofficial fees in six areas of health sector reform: displaced official policies, reduced merit goods production, upward income redistribution, distorted human resource development, growth of facility inefficiency, and obstruction of market reforms.

Introduction

Unofficial fees in developing country health systems need careful definition. Are they involved when health sector reform experiments link public with private health practice – for example, where government-approved health sector reforms treat after-hours use of public facilities for private practice as an incentive? By the definition provisionally offered here, officially promulgated governmental policies that sanction a mix of public and private health services do not involve unofficial fees. Until an economic model is provided to describe these fees, unofficial health care fees at government health facilities can be defined as unauthorized 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. In this study, the focus is on collections by non-physician employees, acting largely as a ‘satellite’ market appended to the ‘core technology’ of the hospital. As quasi-rents, these 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. Functionally and for the purposes of this discussion, they fall into three broad categories:

• Fee-for-service payments – where services, for example 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). Unofficial service payments may extend to presumably ‘free’ services forming a part of the employee’s official duties.
• Fee-for-commodity payments – fees charged for supplies or drugs purchased for the patient from the open market, usually with a mark-up, and presumably ‘free’ at the government facility.
• Fee-for-access payments – where access or improved access to services is obtained for a care-seeker, for example procuring a bed for a patient who has already paid the facility’s official admission charge or arranging transport for a patient or family member.

These fees may not be visible to care-seekers or, in some cases, may be well-known. Further, there is a considerable ethical and socio-cultural range involved with the collection of unofficial fees. Some unofficial fees are so integrated into facility work patterns that they are mistaken for officially authorized levies. Where information about the existence, validity, and extent of unofficial fees is poorly known, unofficial fees are generally thought to be official. They were, for example, virtually unknown to hospital patients of this study who visited a facility for the first time.

Since in some cases those who collect and use unofficial fees are performing illegal acts, the collectors necessarily conceal their action and identity. Generally speaking, little is known...
about these individuals and their methods (see Ensor and Savelyeva 1998; McPake 1997). Collecting data about such practices is an extremely difficult and potentially hazardous undertaking. It is not known whether the actual collectors of unofficial health-care fees ‘front’ for invisible beneficiaries and beneficiary ‘chains’ or merely act on their own impulse. The extent to which they form an actual ‘satellite’ market appended to the ‘free’ or ‘non-market’ hospital services remains unclear. Further, it is not understood whether payment of unofficial fees indicates a public tolerance for unofficial payments or whether such fees are thought to be an accepted standard for commercial behaviour in the areas of their extensive collection. Finally, it is unclear whether those who collect the fees view their activity as a perquisite or entitlement of their position or whether they see such collections as an entrepreneurial option.

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 as rents. In Bangladesh and many other developing countries, public facilities provide highly subsidized ‘free’ care intended for the poor, so the difference between what a consumer pays and is willing and able to pay, the consumer surplus, can be noticeably significant. Rents captured by these near-monopolists, however related to actual shortages at the facility, are collected alongside officially sanctioned ones at District Health Complexes or DHs. The primary market service area for the Mymensingh Medical College Hospital (MMCH) – 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. One THC, the Hajiganj THC, is also included in this report. There, a study was designed to report on official fees. The incidental findings about unofficial fees drawn from this two-year, random sample study are incorporated into this analysis.

**Materials and methods**

In Bangladesh as in many developing countries, unofficial fees are linked with local or national political organizations, incentives to hold on to ‘entitlements’ may compete with the implementation of health service reforms or efforts to attain a more equitable distribution of health benefits. Further, in countries like Bangladesh – where jobs are hard to find, pay is extremely low, and employee groups are strong – access to even a modest consumer surplus remains noticeably significant. Rents captured by these near-monopolists, however related to actual shortages at the facility, are collected alongside officially sanctioned ones at District Health Complexes or DHs. The primary market service area for the Mymensingh Medical College Hospital (MMCH) – 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. One THC, the Hajiganj THC, is also included in this report. There, a study was designed to report on official fees. The incidental findings about unofficial fees drawn from this two-year, random sample study are incorporated into this analysis.

This study estimated *unofficial fee* amounts at DHs and MCs by means of a non-random ‘rapid survey’. Recently admitted and treated patients were selected for the survey exercise from two DHs (Netrokona District Hospital (NDH) with 50 beds and Jamalpur District Hospital (JDH) with 100 beds) and one MC (Mymensingh Medical College Hospital (MMCH) – 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). One THC, the Hajiganj THC, is also included in this report. There, a study was designed to report on official fees. The incidental findings about unofficial fees drawn from this two-year, random sample study are incorporated into this analysis.

### Official fees

At DHs and MC fixed, variable, and optional official charges are levied (US $1 = 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% of beds and MC–30% of beds with ‘paying’ at Taka 53.5 (including a food charge) and cabins varying with room size (DHs–Taka 129 to 140; MC–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 six years of age and Taka 5 for children aged under five.

The scale of official fee collections at these hospitals, though relatively small, represents a potential resource for the cross-subsidy of primary care services. Extrapolated to the 55 major DHs and eight major MCs, these official charges generate roughly 12% of annual recurrent expenditures for DHs and 3% 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 US$ 240 per month. This represents a significant cost-recovery amount, being roughly comparable to the amount spent by the Ministry of Health and Family Welfare’s nutrition programming in the country’s THCs. All official collections are remitted to the Bangladesh government treasury, except for collections in pilot project areas. Pilot programmes are now considering how to devolve policy for user fee funds, but questions about the management control of these official collections remain an issue for policy-makers.

### Facility service areas and study samples

The primary market service area for the Mymensingh 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 11 unions (sub-Than 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 six 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, making up to 10% of those visiting the facility.

The patient panel for DH and MC ‘rapid survey’ consisted of patients admitted within six months of the survey date based on a random sample drawn from admission and discharge records of the hospitals. The sample frame for MC consisted of 210 households given by patients as their address; 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 4017 patients from four 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% 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 NDH/JDH and for MC sought to isolate the socioeconomic 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. 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. Hajiganj 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 authorized 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’ were interviewed nearly six months after discharge from the hospital and THC patients were also interviewed months after their visits to the Hajiganj facility. For these reasons, the reported unofficial payment amounts are necessarily subject to verification and validity difficulties, a common problem with this type of study. Ultimately, the specific amounts must be viewed as indicative figures rather than precise and validated sums so that the most valid generalizations are comparisons amongst the reported unofficial amounts.

Results

Patient and case characteristics

As Table 1 indicates, rapid 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 NDH/JDH as opposed to MC. Significantly, the median education reported by patients at MC (12

<table>
<thead>
<tr>
<th>District Hospital</th>
<th>Total</th>
<th>MMCH</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jamalpur</td>
<td>30.23</td>
<td>36.06</td>
<td>33.76</td>
</tr>
<tr>
<td>Netrokona</td>
<td>8.31</td>
<td>7.76</td>
<td>12.00</td>
</tr>
<tr>
<td>Average education level of the patient</td>
<td>6.18</td>
<td>6.64</td>
<td>6.44</td>
</tr>
<tr>
<td>Average number of members in household</td>
<td>1.66</td>
<td>1.67</td>
<td>1.67</td>
</tr>
<tr>
<td>Average no. of days stayed at DH/MMCH</td>
<td>10.22</td>
<td>8.66</td>
<td>9.36</td>
</tr>
<tr>
<td>Average monthly income of household</td>
<td>4217.78</td>
<td>5466.07</td>
<td>4909.90</td>
</tr>
<tr>
<td>Average monthly expenditure of household for house</td>
<td>550.00</td>
<td>408.08</td>
<td>427.00</td>
</tr>
<tr>
<td>Average monthly expenditure of household for food</td>
<td>582.22</td>
<td>875.76</td>
<td>743.67</td>
</tr>
<tr>
<td>Average monthly expenditure for medical care</td>
<td>322.73</td>
<td>291.96</td>
<td>309.90</td>
</tr>
<tr>
<td>Average monthly expenditure for education</td>
<td>2577.27</td>
<td>2601.79</td>
<td>2591.00</td>
</tr>
<tr>
<td>Average other monthly expenditure</td>
<td>674.89</td>
<td>592.59</td>
<td>630.00</td>
</tr>
</tbody>
</table>
Average household income as a percentage of average income at MC: 21%, 46%, 59%.

Average patient household income:
- Taka 1949 (NDH), Taka 4217 (JDH), Taka 5466 (MC).

Table 2. Predictably, service intensity and apparent case-mix differ—household income in each of the study areas.

Between the facilities in the surveys. Obviously, the relative income disparities of income JDH – 60%) or the THC (roughly 63%) than at MC (27%).

Similarly, far larger proportions had never visited a hospital prior to admission to a DH (NDH – 67%; JDH – 60%) or the THC (roughly 63%) than at MC (27%).

Table 2 summarizes the evident disparities of income between the facilities in the surveys. Obviously, the relative wealth (and, presumably, ability and willingness to pay) of MC patients is far greater than that of patients 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 apparent 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.
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 an MC.

In the final analysis, information about cause of admission did not yield precise case-mix data, 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 levels associated with official and unofficial fee collection.

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

According to DH and MC patients, collection of unofficial fees is done almost exclusively by third and fourth 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 collection of fee-for-commodity payments, particularly for the purchase of medications, supplies, and surgical instruments from outside the facility or in securing patient transport.

Unofficial fee collection methods are virtually standardized and routinized at DHs and the MC, with payments being made at periodic intervals during the patient’s hospital stay, not as a settlement bill at the time of discharge. Some patients, however, provided extreme anecdotes concerning exceptions to routine unofficial fee collection practices. One staff member, for example, 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 that these patterns are routine methods at DHs and MC.

The Hajiganj THC study did not detail the unofficial fee collection process. But 7% 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.

Table 2. Average monthly household income – THC and DHs as a percentage of MC

<table>
<thead>
<tr>
<th></th>
<th>Hajiganj THC</th>
<th>Jamalpur DH</th>
<th>Netrokona DH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average patient household income</td>
<td>Taka 1949</td>
<td>Taka 4217</td>
<td>Taka 5466</td>
</tr>
<tr>
<td>Average household income as a percentage of average income at MC</td>
<td>21%</td>
<td>46%</td>
<td>59%</td>
</tr>
</tbody>
</table>
Table 3. Average official and unofficial fees at DHs and MC

<table>
<thead>
<tr>
<th>Facility</th>
<th>Total official payment</th>
<th>Total unofficial payment</th>
<th>Unofficial payment</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>241</td>
<td>2951</td>
<td>2506</td>
<td>3191</td>
</tr>
<tr>
<td>Cabin</td>
<td>1370</td>
<td>6389</td>
<td>5583</td>
<td>7759</td>
</tr>
<tr>
<td>Paying bed</td>
<td>464</td>
<td>3375</td>
<td>2950</td>
<td>3839</td>
</tr>
<tr>
<td>Non-paying bed</td>
<td>15</td>
<td>2245</td>
<td>1894</td>
<td>2260</td>
</tr>
<tr>
<td>Floor</td>
<td>36</td>
<td>1564</td>
<td>1383</td>
<td>1601</td>
</tr>
<tr>
<td>Paying bed to cabin</td>
<td>3005</td>
<td>6500</td>
<td>5000</td>
<td>9505</td>
</tr>
<tr>
<td>Non-paying to paying bed</td>
<td>225</td>
<td>5700</td>
<td>5000</td>
<td>925</td>
</tr>
<tr>
<td>Floor to non-paying bed</td>
<td>193</td>
<td>3710</td>
<td>2908</td>
<td>3903</td>
</tr>
<tr>
<td>JNH</td>
<td>99</td>
<td>3837</td>
<td>3195</td>
<td>3937</td>
</tr>
<tr>
<td>Cabin</td>
<td>1005</td>
<td>4405</td>
<td>3500</td>
<td>5410</td>
</tr>
<tr>
<td>Non-paying bed</td>
<td>5</td>
<td>3533</td>
<td>3002</td>
<td>3539</td>
</tr>
<tr>
<td>Floor to non-paying bed</td>
<td>285</td>
<td>5024</td>
<td>3961</td>
<td>5309</td>
</tr>
<tr>
<td>NDH</td>
<td>5</td>
<td>1193</td>
<td>974</td>
<td>1198</td>
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<tr>
<td>Paying bed</td>
<td>6</td>
<td>252</td>
<td>250</td>
<td>257</td>
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<tr>
<td>Non-paying bed</td>
<td>5</td>
<td>1233</td>
<td>1005</td>
<td>1238</td>
</tr>
<tr>
<td>Floor</td>
<td>6</td>
<td>302</td>
<td>300</td>
<td>307</td>
</tr>
<tr>
<td>Floor to non-paying bed</td>
<td>6</td>
<td>907</td>
<td>700</td>
<td>912</td>
</tr>
<tr>
<td>MC</td>
<td>602</td>
<td>4035</td>
<td>3522</td>
<td>4637</td>
</tr>
<tr>
<td>Cabin</td>
<td>1626</td>
<td>6094</td>
<td>5904</td>
<td>8120</td>
</tr>
<tr>
<td>Paying bed</td>
<td>488</td>
<td>3539</td>
<td>3092</td>
<td>4027</td>
</tr>
<tr>
<td>Non-paying bed</td>
<td>93</td>
<td>3018</td>
<td>2655</td>
<td>3112</td>
</tr>
<tr>
<td>Floor</td>
<td>43</td>
<td>1817</td>
<td>1600</td>
<td>1860</td>
</tr>
<tr>
<td>Paying bed to cabin</td>
<td>3005</td>
<td>6500</td>
<td>5000</td>
<td>9505</td>
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<tr>
<td>Non-paying to paying bed</td>
<td>225</td>
<td>5700</td>
<td>5000</td>
<td>925</td>
</tr>
<tr>
<td>Floor to non-paying bed</td>
<td>11</td>
<td>1140</td>
<td>853</td>
<td>1151</td>
</tr>
</tbody>
</table>

Official and unofficial fees – average per patient payments

Table 3 shows computed average official (computed) and unofficial (reported) direct payments for patients at DHs, MC, and across all facilities. If computed official payments are combined with reported unofficial payments at all facilities, an average out-of-pocket payment per patient of Taka 3191 (US $72.50) 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 under-reported sums. Nevertheless, Table 3 indicates that average levels of per patient unofficial fees reported by interviewees in the ‘rapid survey’ were 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 4035), where the maximum amount of options for collecting official fees exist, were 3.4 times greater than at Netrokona DH (Taka 1193) – where only admission tickets and ‘paying’ beds are options for official fee collection. Perhaps ability to pay is greatest at the MC hospital. Whatever the causal connections, 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%), while fee-for-service (attendant care or medical interventions) and fee-for-access (better bed status, transportation) payments account for the remaining 15% (see Figure 1). 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.
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 and again, 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 4. 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 probably 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 the MC, it is also predictable that MC average unofficial charges would be higher than those at DHs.

Relative contribution of socioeconomic factors

Patient hotel service status (cabin, ‘paying bed’ etc.) refers to categories used at the facilities, with floor and non-paying beds categories obviously containing mostly poor patients. In Table 5 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 MC. At MC roughly 70% of the average daily fee payments are paid by persons in paying beds and cabins compared to 21% at DHs.

To further investigate the relationship between poor and non-poor patients, the computed average amounts paid by different income groups were compared. Table 6 compares average official and unofficial payments per patient by various income categories at each facility. Middle income groups appear to pay relatively more than other groups (upper income levels in the study were high for Bangladesh). 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% 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% of the overall average, the mid-level group pays 118%, and the high income group pays 156%. These comparisons of averages are, however, strongly influenced by the payment pattern at MC. Table 7 expresses unofficial payments as a proportion of average monthly household income for the various income groupings.

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 relatively greater household income.

Interestingly, findings from the Hajiganj THC suggest roughly the same pattern. Table 8 indicates that reported average unofficial fees were greatest for those whose monthly income category was less than Taka 1000. In effect, those in the Hajiganj sample earning less than Taka 1000 were 2.3 times more likely to pay unofficial fees than those earning Taka 1001 to Taka 1500. When those earning Taka 1500 and above were compared with those earning less than Taka 1000, they were shown to be 6.25 times more likely to pay unofficial fees.

Patients at a tertiary care centre are likely to arrive at the MC with comparatively more serious conditions, having sacrificed 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 local 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

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**Table 7. Unofficial fee payments as a percentage of average monthly income**

<table>
<thead>
<tr>
<th>Facility</th>
<th>Tk.5000 or less</th>
<th>Tk.5001–10 000</th>
<th>Tk.10 000 and above</th>
</tr>
</thead>
<tbody>
<tr>
<td>JDH</td>
<td>120</td>
<td>74</td>
<td>32</td>
</tr>
<tr>
<td>NDH</td>
<td>37</td>
<td>19</td>
<td>5</td>
</tr>
<tr>
<td>MC</td>
<td>49</td>
<td>45</td>
<td>42</td>
</tr>
</tbody>
</table>

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**Table 8. Unofficial fee payments and income levels at Hajiganj THC**

<table>
<thead>
<tr>
<th>Income categories</th>
<th>Average unofficial fees paid</th>
<th>Probability of paying unofficial fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Taka 1000 or less</td>
<td>Taka 51</td>
<td>0.52</td>
</tr>
<tr>
<td>Taka 1001–1500</td>
<td>Taka 12.5</td>
<td>0.22</td>
</tr>
<tr>
<td>Taka 1500 &amp; above</td>
<td>Taka 23.5</td>
<td>0.08</td>
</tr>
</tbody>
</table>
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 9 summarizes 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, ayahs 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 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, and 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 two 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% of the respondents said they would go again to the THC for treatment if they were sick, with only 16% saying they definitely would not. Leading reasons had to do with cost of treatment being low (25%), that Hajiganj treatment, though unsatisfactory, was better than anywhere else (33%), the likelihood that they will get better medicine than elsewhere (16%) and that the facility is near their homes (17%). Of those saying they would not return to the THC, 10% identified high fees and 54% 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.

Discussion

Consumer surplus and 'rent capture' behaviour

The collection of unofficial fees represents a variant of 'rent seeking' behaviour. In pure form, 'rent seekers' extract excess profits from government programmes once the government in question has granted the rent seeker a virtual monopoly of access to benefits from that same programme. Furthermore, the individual or group holding the near monopoly commonly uses legislative action to capture the public subsidy (see Tullock 1989; Bhagwati and Srinivasan).

Unofficial fee collection constitutes at least a more generalized form of 'rent seeking', where public employees, who position themselves as near-monopolists, seek rents by charging fees greater than the opportunity costs of the next best alternative

<table>
<thead>
<tr>
<th>Table 9. Perceived differences in quality (t-test of level of significance) between District hospital and MMCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weighted mean value responses</td>
</tr>
<tr>
<td>District hospital</td>
</tr>
<tr>
<td>Quality of doctors</td>
</tr>
<tr>
<td>Quality of nurses</td>
</tr>
<tr>
<td>Quality of wardboy</td>
</tr>
<tr>
<td>Quality of ayahs</td>
</tr>
<tr>
<td>Administration</td>
</tr>
<tr>
<td>Cleanliness of the hospital</td>
</tr>
<tr>
<td>Quality of food</td>
</tr>
<tr>
<td>Quantity of food</td>
</tr>
</tbody>
</table>

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.
available to the patient. The rents collected exceed the cost of producing the service, commodity, or accessibility, and the patient pays in under near-monopoly conditions tolerated if not informally linked with the official services of a public facility.

The unofficial fee collection process – here called rent capture – takes place because a government programme fails to deliver (or is made to fail to deliver) required 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’ programme, unofficial fee collectors:

- recognize that essential or nearly essential deficiencies exist in the programme 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 services or ignore such initiatives;
- anticipate that implicit government policy will tolerate the exercise of a near-monopoly by unofficial fee collectors, provided that their satellite 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.

It is vital to see that rent capture can occur when a sizeable consumer surplus is available. For 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 the patient’s (the principal or consumer). This latter approach produces the service, commodity, or accessibility, and the patient pays in under near-monopoly conditions tolerated if not informally linked with the official services of a public facility.

For facilities of the rapid survey, it appears in Bangladesh that unofficial fee 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 the second-degree.

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 maximize 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 maximize 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 10. What the table cannot show is the extent to which social welfare loss accrues due to the amount of resources expended by rent-seekers and patients to minimize 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 at 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.

While these formalizations may stimulate thought, unofficial fee collection still remains far from crystal clear. The large proportion of fee-for-commodity payments in the total leaves it unclear whether dissatisfaction is focused upon specific groups or on the shortages of drugs and supplies with which
they are linked. Another ambiguity is introduced by the chain-market nature of hospital activities. The hospital’s lack of unity or ‘plurality’ as a provider is reinforced when many agents collect unofficial fees. At these centres directly compete with one another, thus injecting goals other than rent capture into 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. 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 utilization 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 on this issue in the Bangladesh survey are inconclusive. Attitudes toward these employee groups are most negative at MC (see Table 7), where the effect on household income is greater than at NDH and 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 minimized or eliminated by enforcement strategies tends to overlook the functional interests of unofficial fee collectors for several reasons:

- Unofficial fee collectors apparently provide substitutes for quantity and permanent quality improvements.

- Collectors must ensure that the substitutes for which fees are charged do not permanently improve quality.

- 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, ensuring that the vast bulk of patients are willing to accept their ad hoc services.

- Finally, should attempts be made to raise quality on a permanent basis, patients might be likely to frame a choice between permanent quantity/quality services and ad hoc substitutes, thereby putting unofficial fees at risk.

Essentially, the ‘satellite’ market of unofficial fee collections probably 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 maximize 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 institutionalized 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 to 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.
Privatization 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.

**Broader health service implications**

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 are the following.

- **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 greater appeal to facility-level public employees. The comparatively indirect and professionalized 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, unofficial 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 fee collections difficult to control.

- **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. Programmes 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.

- **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.

**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 labour 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 labour substitution.

- **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 generalized 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.

- **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 decentralized 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 decentralization just as they have fought, at some hospitals in Bangladesh at least, efforts to contract for private sector provision of hospital services or institute performance reviews for civil service promotion.

- **Policy considerations**
  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. 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. Standardization 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 minimized. In Bangladesh, a recent privatization of fares on a commuter train raised fares by 600% while apparently raising consumer satisfaction as well.

3. 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 mobilize the support of patients for quality improvements, particularly for drugs and supplies.

4. 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 reduced.

Endnote

1 Thompson’s idea that all organisations build around a ‘core technology’ helps distinguish between services, whether official or unofficial (Thompson 1967).

References

Ensor T and Savelyeva L. 1998. Informal payments for health care in developing countries. The views expressed are not necessarily those of DFID.

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