FORMATIVE PROCESS RESEARCH ON THE LOCAL GOVERNMENT REFORM IN TANZANIA

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IS THE COMMUNITY HEALTH FUND BETTER THAN USER FEES FOR FINANCING PUBLIC HEALTH CARE?

Local institutions have huge potential for improving public health services if they could effectively manage the local delivery process, and where feasible, mobilize community contributions to complement the resources they receive from the government. The Local Government Reform Programme (LGRP) seeks to strengthen grassroots institutions towards this endeavour. Where councils have introduced fees for health services, a typical household is faced with two options to pay their medical bills: either pay an annual amount to join the Community Health Fund (CHF) for free services at public health facilities, or to pay Tsh 1,000 for every episode of illness attended to at a public health facility. These fee structures are still under a pilot trial, and the decision to roll them out is yet to be made. This project brief discusses the results of an assessment of the economic costs to households in two CHF participating districts, Kilosa and Iringa Rural. One major concern is the access by the poorest households to health services.

Survey Results from Iringa Rural and Kilosa Districts

A total of five hundred households were visited and interviewed in Kilosa and Iringa between October and December 2003. The respondent households were randomly selected from villages and wards identified on the basis of income and geographical location so to include different socio-economic factors. The interviews covered information on all the household members with regards to illness, health care seeking behaviour, and household expenditure during the last twelve months.

The survey data show that 57% of household members reported at least one episode of illness during the last twelve months. Of those, 52% were over five years in age; therefore constituted as statutory payers of fees for public health care services. The data shows that of all the households in the sample, 94% reported one to five episodes of illness during the last twelve months.

Regarding the use of payment options, Community Health Fund membership in 2003 was estimated at 24%, and there is virtually no difference between poor and non-poor households. Membership of the CHF decreased from 32% in 1999 to 24% in 2003. This reflects a drop of 8% during the period, and it is worth noting that the study indicates a lower drop out rate for poor households relative to the non-poor (Table 1).

Table 1: CHF Membership and Drop Outs by Income Groups: 1999 – 2003 as a Percentage

	% Non-poor	% Poor	% All
CHF Membership 2003	23.9	21.3	23.5
Drop Outs from CHF	8.8	4.9	8.3
Never Been CHF Members	67.3	73.8	68.2

Two major issues arise from observations in the above table:

- Why is membership with the CHF so low?
  Is it because households prefer user fees rather than the CHF?
- Why are there fewer dropouts from CHF among poor households?
  Is the CHF friendlier to the poor than the user- fee scheme?

Comments on Our Findings

The observed low membership rate of the CHF suggests that the fund is more expensive than the user-fee scheme. In order to test this hypothesis, we estimated the medical bills of a household for the two payment options. We started by grouping all the respondent households according to the frequency of the reported illnesses. Next, we computed the mean expenditure on health care during the last twelve months by the different groups of households. We then computed what would have been the total costs on health care of the household if the payment method was exclusively user fees. Similarly, we calculated the total costs if they had been paying exclusively through the CHF. Finally, a comparison between the costs arising from the two payment methods, both actual and potential, was made.

This computation cum analysis showed that if all the sick had decided to consult public facilities and pay the user fee of Tsh 1,000 per each episode of illness, they would have paid far less than the CHF annual premium of Tsh 5,000. The potential user fees were less than those from the CHF membership fees for more than 94% of all the households in the sample. By implication, one saves money by opting to pay the user fee rather than the CHF premium. We also noted that even if all the sick had decided to consult public facilities and pay the user fee, they would still have paid less than if they had joined the CHF.

However, there are other reasons why people do not join the CHF. The major ones are lack of money, poor services and management of the CHF. These are indications that provide further evidence that CHF is more expensive than the user fee.

Table 2: Reasons for Not Joining the CHF

Reason	% of Non-Poor	% of Poor	% of All
Lack of Money or Too Expensive to Pay	59.6	77.7	61.8
Poor Services and Management	11.1	19.4	31.7
Not Aware of CHF	4.1	0	3.6
Other Reasons	3.3	0.1	2.9

We have observed that the rate of dropout for the poor is lower than that of the non-poor. This might be explained by the fact that many poor households are big in size (67% in the sample), and once they have paid the annual fee they will have less incentive to go back to paying user fees. For obvious reasons, bigger households are likely to see a greater benefit of membership of the CHF. It follows that small poor households have the least incentive to join the CHF.

Policy Implications

These results of the survey suggest a need to make the CHF annual premium more affordable by lowering it. The survey data shows that most respondents would prefer to pay between Tsh 2,000 and 3,000. The premium could be adjusted gradually to reflect a realistic rate. This would also give people time to become accustomed to the "pay-to-get" (user pays) health service system at village level.

The study has also shown that, in addition to being expensive, membership of the CHF is discouraged by poor services and bad management. This is a disadvantage to CHF members. Ensuring that quality of health services in primary service outlets corresponds to the level of the CHF premium, and therein management of the services, is a strong precondition for a successful health insurance scheme at the village level.

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