FORMATIVE PROCESS RESEARCH ON THE LOCAL GOVERNMENT REFORM IN TANZANIA

PROJECT BRIEF NO.5

Deograsias Mushi
REPOA / UDSM

FEES AT THE DISPENSARY LEVEL: is universal access being compromised?

Introduction

The Local Government Reform Programme (LGRP) targets to strengthen grassroots institutions to govern, mobilise, manage resources and provide social services through participatory processes that have been well defined from the hamlet to council level. LGRP seeks to articulate and institutionalise sector based reforms that had started earlier before the wider LGRP. The sector based reforms, which are now described in the context of the LGRP, target to enhance service provision. The health and education sectors take the leading role. The health sector in particular is advanced in terms of reforms that stretch from financing policy to planning and management. However, the reforms constitute a challenge to the traditional government health policy.

Notwithstanding the intention to reform the public health sector in Tanzania, the government did not want to compromise its traditional policies of equity, universal access and affordability. The government has been gradually introducing fees in public health care since 1993 with special attention to those potentially deemed vulnerable to partially commercialised public health services. In view of attaining a balance between the traditional policies and the reforms, the government provided for exemptions and waivers within the cost recovery programme. These would ensure that utilization of health services that are of great public interest is not impaired.

Basically, there are three forms of payments that are currently in operation in public health facilities, either as pilot projects or countrywide programmes. These are user fees, the Community Health Fund (CHF) and the newly introduced Health Insurance Schemes for civil servants.

As expected, there is a potential conflict between the attempt to generate revenue and the protection of potentially vulnerable social groups. Exemptions and waivers are associated with revenue loss, which contradicts the prime objective of fees in public health services. On the other hand, fees deny access to those unable to pay, and are therefore likely to compromise universal access to public health care. Hence, compliance and access to public health care are issues of major concern in the reform process; issues, which this research brief brings out, using examples from Iringa and Kilosa district councils.

As a pilot project to bring out what might be the potential impact of fees on access to public health services at village level, the government in 1999 introduced user fees and the Community Health Fund in selected district councils, including Iringa and Kilosa. Under the CHF, households may join the fund by paying a fixed annual premium of 5,000 Tshs for free access to public health services for a maximum of ten members from each participating household. Alternatively, non-CHF members have to pay a fixed user fee of 1,000 Tshs per each medical problem attended to in public health facilities.

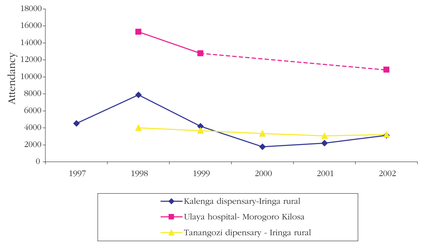
Three issues arise: How has the introduction of user fees impacted on access? To what extent have families joined CHF membership? What is the general compliance with the fees introduced?

REPOA
NIBR Norwegian Institute for Urban and Regional Research
Norwegian Institute for Urban and Regional Research
Chr. Michelsen Institute

Fees and access to public dispensaries: What is the impact?

Figure 1 demonstrates trends in patients' attendance in three selected dispensaries in Iringa and Kilosa since 1999 when fees were introduced at the dispensary level.

Figure 1: Patient Attendance in Selected Dispensaries



Clearly, it is observed that attendance has declined in all dispensaries since 1999. At the same time, there are little doubts that morbidity rates have been on the increase in Tanzania (Mushi, 2001 &1995). There is no reason to believe that there has been a sudden drop in the prevalence of illnesses needing medical treatment.

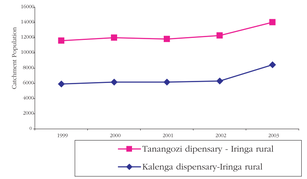
Possible explanatory factors for the downward trend in patients' attendance might be one or a mix of the following:

- The increase of non-government health facilities in the area;
- Population dynamics (a decrease in the catchment's population of the facilities);
- The introduction of user fees; and
- Low response to the CHF.

We observe that the three villages of Kalenga, Ulaya and Tangangozi had no any other health facility different from the public dispensaries, as for neighbouring villages. Therefore, since private facilities are non-existent in the villages studied, the possibility that patients shift from public to other equal substitutes is ruled out.

Next, we have checked the catchment's population for two of the dispensaries. Figure 2 shows that there has been a growth in population in two of the catchment areas. There is no reason to expect a different growth pattern in the third area.

Figure 2: Facility's Catchment Population

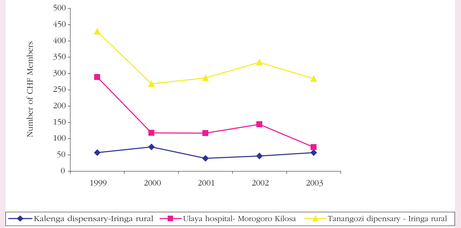


As catchment populations have grown; the relative attendance rate (e.g. number of attendances per 1,000 inhabitants) has dropped more than indicated by the totals shown in Figure 1.

Membership to CHF

Figure 3 shows that membership to CHF has dropped remarkably in Ulaya and Tanangozi dispensaries since its introduction in 1999. For Kalenga membership has been low since its introduction in 1999, and by 2003 there is no significant increase.

Figure 3: CHF membership



The noted decrease in patients' attendance and the low compliance with the CHF may indicate that there are people who not only have opted out CHF membership, but also fail to pay the 1,000 Tsh fee charged to non-CHF patients. The trends observed in Figure 3 may suggest further that user fees are more likely to be more popular than CHF. It may be the case that CHF is associated with implementation problems which will require further research.

Conclusion

Two plausible explanations can be derived from the trends observed.

One is that the fees, just like a sudden price jump, have produced a shock that tends to level down overtime. Studies on user fees indicate that such shocks are temporary or simply reductions in frivolous use of free public health care services (Waddington and Enyimayew, 1990; Litvack and Bodart, 1993). However, in the context of this brief, we do not have detailed information to verify existence or non-existence of frivolous consumption of public health care services in the selected dispensaries.

The second is that based on the findings from the three dispensaries, there are indications that introduction of user fees has a negative impact on dispensary attendance. This is a general indication that people are either unable to pay the fees or unwilling to pay, or both, for reasons known to them. But given our earlier observation that equivalent substitutes are non-existent in the study villages, and the current government initiatives to improve medical supplies, the unwilling-to-pay argument is weakly supported.

The results of the 2000/01 household budget survey for Tanzania show that basic needs poverty is a chronic problem in rural settlements. The three villages surveyed by this study are drawn from two of the lowest income quintile districts in Tanzania. And by implication, inability to pay seems to be a stronger argument for the observed trends than unwillingness to pay.

FOR MORE INFORMATION PLEASE CONTACT
The Executive Director, Research on Poverty Alleviation (REPOA)
Plot 157, Mgombani Street, Regent Estate
P.O. Box 33223 Dar es Salaam, Tanzania
Tel: +255 / (0)22-270 00 83 Fax: +255 / (0)22-277 57 38
Email: **repoa@repoa.or.tz** Website: **http://www.repoa.or.tz**