FORMATIVE PROCESS RESEARCH ON THE LOCAL GOVERNMENT REFORM IN TANZANIA

PROJECT BRIEF NO.9

June 2004

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ARE FEES THE MAJOR BARRIER TO ACCESSING PUBLIC HEALTH CARE?

The major concern of the current health sector reforms is the impact on the poor on their access to public health services. Research on the performance of user fees at the hospital level in Tanzania has found that the expenditure contribution from cost sharing has averaged between 20% to 65% and the availability of drugs has improved; however, the access to public health facilities has recorded mixed results. The poor are particularly identified as the victims. This project brief aims to highlight the impact of travelling costs and perceptions about the severity of illnesses. It seeks to emphasise the importance of the geographical expansion of primary health services to provide wider coverage, particularly for poor communities.

Evidence from Iringa Rural and Kilosa Districts

Included in a recent fieldwork survey of 500 households in Iringa Rural and Kilosa were questions regarding the costs of accessing health care services. Also investigated were patients' coping strategies, and their opinions on fees and the quality of public health services. We used the standard household budget survey method to identify the poor versus non-poor, and found that 16% of the sample was basic needs poor. A further analysis of the data gave the following results:

- Approximately 49% of the respondents regarded as poor and 59% of the non-poor reported an illness during the last twelve months;
- Of those who reported that they had suffered from an illness, 21% did not seek medical consultations. We did not find major differences between income groups.

When asked why they did not seek medical care, they gave the following reasons:

Table 1: Reasons for Not Seeking Medical Care

Stated Reason	% of Non-Poor Stating	% of Poor Stating	% of All Who Didn't Seek Medical Care
Minor Illness	40.6	75	43.8
No One to Accompany the Sick	10.6	0	9.7
Could Not Afford to Pay for Medical Services	3.8	12.5	4.5
Lack of Money to Pay for Transport	24.4	6.3	22.7
Chronic Disease	8.7	6.3	8.5
Other Reasons	11.9	0	10.8

From the above table we observe that overall the costs of medical care do not feature as the major reason for not seeking medical consultation. Of all the poor who did not seek care, the majority indicated the illness as being a minor health problem. This may indicate that the poor have a relatively higher degree of risk at which a health problem is perceived as illness that would need the attention of a medical doctor.

Contrary to the costs of medical services, transport costs feature as the main barrier to accessing health facilities. An analysis of transport costs as a percentage of medical expenses gives the following results:

Table 2: Transport Costs as a Percentage of Medical Costs (Mean by Wards)

Ward Name	Transport Costs as a % of Medical Costs
Chanzuru	45
Ulaya	64
Kimamba	69
Kalenga	104
Ulanda	60
Mseke	51

Comments on Our Findings

Firstly we note that the non-poor have a higher reported frequency of illness than the poor. With the understanding that poor people are exposed to higher morbidity rates than their counterparts, we could expect more reported incidences of illness among the poor. The results for Iringa and Kilosa are not consistent with this contention; as in our survey the non-poor reported more illness than the poor. One possible explanation to this paradox is that the poor people did not consider many of their health problems as an illness requiring the attention of a medical doctor. We consider this a disadvantage to the poor. Even those non-poor who did report that they suffered an illness considered some of the illnesses to be 'minor', and therefore sought medical care less often than the non-poor. Without analysing the nature of each illness reported during this twelve-month period it is difficult to establish whether categorising the illness as minor and the consequent decision to not seek medical care was correct. But there is a possibility that regarding the illness as minor could have reduced the chance of a medical consultation, and thus denied access to services that could have improved their health status and reduced the days of illness.

Secondly, we turn to those who fell sick but did not seek a medical consultation, about 21%. Table 1 is a summary of the reasons why those surveyed did not seek a medical consultation. Transport costs constitute the major reason for not seeking medical care. Contrary to what most people would argue, for most households medical costs per se did not feature as the major barrier to accessing health care. We note from the results of Table 2 that accessing health facilities involves substantial transport costs, therefore the argument that fees constitute the major barrier to public health services becomes a secondary consideration for the poor. As an example, it was reported in the Nipashe newspaper of Monday June 21st 2004 that mothers from Mapogoro village in Iringa give birth in the bush because their nearest health facility is 15 kilometres away.

But more critically, one could argue that given the spatial distribution of the current public health facilities, and the associated transport costs, free public health services have serious equity implications. Those who have to pay transport costs to access health services are doubly disadvantaged; in that they can incur substantial costs in addition to the normal costs of medical care. Also, they spend more time travelling to the health facility, particularly when an illness requires several visits to the doctor. We have observed earlier that the poor consult when they are seriously sick, and by implication, the possibility of their requiring more than one consultation are relatively higher, thus incurring additional travel costs. Proponents of user fees argue that free public health services suffer from inefficiencies and abuse, significantly compromising quality. As a result, people can travel long distances in search of appropriate medical care, thus incurring increased transport costs and more time. This has implications for equity and household welfare as well.

Emerging Policy Issues

Given the issues of time and travelling costs, it would be appropriate to devote more public resources to expand health services so as to reach more people within the closest feasible distance. As councils continue to prioritise geographical coverage in the short term, additional sources of funds may be necessary to complement efforts addressing quality gaps. The latter would minimise travelling costs and potentially increase the ability to pay for the improvement of local health services.

We note from the reports of the assessment of Central Health Fund that drug shortages have been resolved in some of the participating pilot districts. Also the latest assessment of cost sharing by the Ministry of Health shows that the contribution of cost sharing has reached 50% for some regional and district hospitals. By implication, the removal of fees at these facilities would compromise quality, and could potentially increase the patients' transport costs and time searching for appropriate medical care.

How do we protect the poor? Many reports and public opinion are pessimistic about an effective exemption and waiver systems in Tanzania. Observation has been made that more than 50% of all patients attending public hospitals end up being exempted from fees, though not necessarily because they are poor. A consideration to strengthen the exemption and the waiver system by involving grassroots institutions would be more beneficial to the poor than the complete abolition of fees. This is plausibly the way forward, considering the current achievements of cost sharing and the efforts made in instituting these fees.

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