

Equity in The Provision of Health Care: Ensuring Access of The Poor to Services Under User Fee Systems

A Case Study: Tanzania

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**Cost Sharing and Access to
Health Care for the Poor:
Equity Experiences in Tanzania**

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BASICS	Basic Support for Institutionalizing Child Survival Project
CSIU	Cost Sharing Implementation Unit
DDH	Designated District Hospital
HHRAA	Health and Human Resources Analysis for Africa Project
MCH	Maternal and Child Health
MOH	Ministry of Health
MSH	Management Sciences for Health
TAG	Technical Advisory Group
TB	Tuberculosis
USAID	United States Agency for International Development

Executive Summary

As the number of countries with user fee systems has increased, the number of countries that have assessed the impact of the fees on access to health services for the poor and other vulnerable groups has remained small. This is one of five country studies that seek to determine the kind of protection mechanisms that can be used to ensure cost recovery efforts do not restrict access by the poor to health services. Hence, the purpose of this study was to determine whether equity of access to health services was maintained in the Tanzanian health system that had user fees. That is, whether fee waivers, the safety mechanisms introduced to ensure poor had access to health care services after the introduction of user fees, were working. Information for the study was obtained from three primary sources: household surveys of the poor, patient exit interviews at health facilities, and surveys of staff at public and mission health facilities.

The Tanzanian Ministry of Health, in developing its cost sharing program, wanted to develop protection mechanisms that would ensure access by the poor and medically needy. To this end, they introduced the use of waivers and exemptions. Waivers are intended to assist the poor by releasing them from payment of user fees because of their inability to pay. Exemptions are intended to excuse from payment certain types of patients (i.e., children under five, the elderly, and women for MCH services) or patients with certain illnesses (i.e., tuberculosis, leprosy, polio, AIDS, cancer, diabetes) regardless of whether they are poor.

The government also sought protection by setting fees at very low levels to ease the transition and burden from a "free" health care system. The fee structure is well below the actual costs of delivering services. Fees are only for hospitals at the present time. Fees vary by the type of hospital, with tertiary hospitals charging the highest fees and regional and district hospitals charging lower fees.

The process for approval of waivers for the poor is done at the local facility level where information is to be gathered and assessed by health personnel. Letters from community leaders were not required. Though the policies for protecting the poor were in place, very few waivers were granted by health facilities. There was a widely variable attitude among government health workers about issuing waivers and exemptions. The administration of the government hospitals emphasized the generation of revenues without a countervailing concern for the access of the poor to services. The poor are benefitting from exemptions though they are not targeted to the poor. Exemptions for children, MCH services, and the elderly are particularly useful in providing access for some of the poor. In addition to fees, the poor tend to incur high travel and time costs in addition to user fees at hospital facilities.

Mission hospitals have a long tradition of charging fees for services in Tanzania, and while no formal mechanisms exist for granting waivers, all patients are treated regardless of their ability to pay. Unlike government facilities that rarely extend credit to patients, patients are asked to contribute whatever they can afford at the time of treatment. As with the government facilities, mission hospital staff have not had formal training for determining waivers, but it could be concluded that clear articulation by senior management of the underlying philosophy present at mission hospitals, among other factors, is sufficient to foster a greater degree of access to the hospital by the poor than may be experienced at a government facility.

There were very few operational guidelines and training for hospital staff in the appropriate use of waivers and exemptions. In addition, little public information has been disseminated about the waivers and exemptions. While there was some initial publicity, very little effort followed. There were posters to inform patients of waivers at only one facility. It is evident that some facilities do not want to "advertise" waivers and exemptions because of concerns of abuse. However, in an attempt to minimize "leakage" (non-poor receiving waivers to which they are not entitled), there may be "undercoverage" in that many poor who should receive waivers do not because of stringency in application of the guidelines. It should be noted that several facilities have initiated their own efforts within the community and have had some success.

The current system for reporting the number of waivers granted to the poor is not functioning. This lack of records makes it difficult for the Ministry to evaluate the waiver and exemption system for the poor on an on-going basis. The effectiveness and cost of the waiver and exemption system cannot be known without such information. Improved record keeping and monitoring of waivers and exemptions would provide baseline data to do regular desk audits of the system.

There is a need to identify a practical means of having information provided to communities, such as through district health management officers and committees since many individuals are unaware of the exemption and waivers that are available. Those who were aware of such mechanisms primarily learned of these through hospital staff or word of mouth from family, friends, or other patients. Conducting a national public information campaign to advise the population of waivers and exemptions may be useful. Adequate training for health staff is also required.

The use of cost sharing revenues requires further strengthening. It was found that many of the facilities are in such dire straits as to funding from the government that the revenues generated by cost sharing are being used as working capital and emergency funds for recurrent costs, such as petrol for vehicles. If the cost sharing program is to be successful and acceptable to the public, it must ensure that the revenues are used to provide improvements in quality and services so patients see an improved system, such as improved drug supply, new sheets for wards, and repaired diagnostic equipment. The monitoring and oversight in the use of cost sharing revenues must be strengthened.

As the government further reviews its fee, exemption and waiver policies, providers must have clear goals about whom they aim to serve and realistic service and financial plans based on the epidemiological and economic profile of the catchment population if the policies are to succeed. They must also have effective monitoring systems to assess if goals and targets are being achieved. Only if these elements are in place will the government and its hospitals be able to determine on an ongoing basis if they are meeting the need to protect the poor.

1. Introduction

In 1977 the principle of Universal Free Medical Services for All Tanzanians was declared (Ministry of Health 1996a). By 1993, economic conditions dictated that the principle be abandoned as Tanzania introduced a cost-sharing scheme in government hospitals to generate revenues to supplement the government budget for providing quality care and ensuring adequate supplies of drugs. Mission hospitals, however, have charged fees since 1928.

Many other developing countries have also had a tradition of free public provision of all health services. However, government resources have decreased in real terms while demand has increased in many of these countries in the last decade. Thus, the need for additional sources of revenue to operate the public sector health system and its services has become more acute. The result has been the introduction of cost recovery schemes in many countries which a decade before considered that possibility impossible because of various social contracts made at the time of independence. Many cost recovery systems have been designed with the sole or primary objective of generating revenues to replace or supplement government funds. In designing such systems, often little consideration was given to the anticipated impact from introducing user fees. As the introduction of such schemes have become more widespread and some of the unintended effects observed, a concern has developed about the equity implications. How have cost recovery systems affected the access to and utilization of health services for the poor and other vulnerable groups? These concerns are based on the belief that health care is a basic right, and its receipt should be based on need rather than on one's ability to pay.

The result of these concerns has been the development of various safeguard mechanisms designed to protect the poor from the effects of user charges. These protection mechanisms have various forms and terms: means testing, direct targeting, characteristic targeting, waivers, and exemptions. These mechanisms are designed to ensure that cost recovery efforts do not create serious financial barriers for the poor, or other groups such as those with certain illnesses, which would unduly reduce their access to care. It is these concerns which caused Health and Human Resource Analysis for Africa (HHRAA) of the USAID Africa Bureau to seek to have a more formal evaluation of the equity implications of cost recovery schemes, to review which systems work the best to maintain equity, and to develop a series of options for policy makers. To do this, HHRAA proposed to develop a methodology, utilize the methodology to carry out five country case studies; synthesize the lessons learned from the country case studies; and use that as a basis to provide guidance and options for future policy development for other countries. This report reflects one of those studies.

The structure of this report is: The second section provides the background on targeting mechanisms and the Tanzanian health system are reviewed. The third section presents the purpose of the study. The methodology used by the study is given in the fourth section. The fifth section describes the various targeting mechanisms, the waivers and exemptions, in the health systems. The sixth and seventh sections present the findings and an analysis of the results from the household and patient interviews respectively. The eighth section presents experience of the health sector with targeting mechanisms and the final section presents some conclusions and recommendations for consideration by the United Government of Tanzania.

2. Background to the Study

2.1 Targeting mechanisms

Various mechanisms have been developed to protect the access of the poor or vulnerable groups to health care or other social services when user charges are introduced. The primary mechanisms, are **direct targeting** and **characteristic targeting**. The former is meant to protect the poor while the latter is aimed at ensuring that a specific group, whether or not they are poor, receive certain services. These mechanisms are defined as

- **Direct targeting:** provision of free or reduced-priced benefits to people who cannot pay because of low income, often using some form of means testing to determine how much people can afford to pay. An example of this is a village chief issuing a certificate for a poor person to receive care at the government health facility without having to pay a fee.
- **Characteristic targeting:** provision of free or reduced-priced benefits to people with certain attributes, regardless of income level which is aimed at ensuring they seek such services. An example of this in the health sector is providing maternal and child health (MCH) services at no charge to all mothers and children regardless of income because the government wishes to promote use of MCH services.

If these protection mechanisms do not work perfectly, there are potential problems. The problems commonly associated with these targeting mechanisms are **undercoverage** and **leakage** (Grosh 1994). Under coverage occurs where the poor do not receive the intended benefits because they are either erroneously categorized as non-poor or they must still pay the fee despite their waiver. In this situation, those who are intended to receive the services at no cost or reduced fees, do not receive such consideration but must pay full fees to receive services. Leakage is where the non-poor receive benefits intended for the poor. Here the non-poor receive the designation of poor, though they are not, which allows them to receive the services at no or a reduced charge though the person has the ability to pay for the services.

Since direct targeting involves identifying the ability of individuals to pay it ought to be more accurate in discriminating between poor and non-poor. To do this, however, usually requires more information and administration than characteristic targeting. Characteristic targeting is more likely to result in more undercharging or leakage, where people pay less than they are able to pay.

2.2 Waiver and exemption definitions

Terms which have been used in Africa to describe these targeting mechanisms to protect the poor are waivers and exemptions. A **waiver** is used to reduce or eliminate fees for the poor based on an assessment of their inability to pay. Waivers relate to direct targeting. **Exemptions** are used to describe when services are automatically provided free because the patient has the characteristic being targeted. At times these terms are used interchangeably by health personnel. It is waivers and exemptions in the Tanzanian context which is the focus of this review.

2.3 The Tanzanian health system

Tanzania has a well developed health system. The principle of primary health care was introduced in 1966 with the Arusha declaration, which emphasized health service delivery in rural areas. The desire to have local decisions, including those related to health services, made at lower levels of government resulted in 1972 the Decentralization Act was introduced and modified by the Local Government (District Authority) Act of 1982.

The pyramid health system's infrastructure in 1996 consists of hospitals at the following levels—6 referral hospitals (two of which are special hospitals, tuberculosis and psychiatric), 20 regional hospitals, and 131 district hospitals (Ministry of Health 1996). Many mission hospitals are integrated in the health system and serve in many places as the Designated District Hospital. These voluntary hospitals are important to the health system as they exceed the number of government hospitals. In addition, there are 20 private hospitals, 90 percent of which are in Dar Es Salaam, and 18 parastatal hospitals. There are 293 government and mission health centers and 2,929 dispensaries. There are also a parastatal and private health centers and dispensaries. Coverage is good, with estimates that nearly 95 percent of the population is within 10 kilometres of a health facility. Though access is good, the issue of the services which can be provided remains an issue as having a regular supply of drugs available at all health facilities remains a problem which the government continues to address.

General health statistics indicate that infant mortality is 100 per 1000 live births. The country's morbidity patterns indicate that malaria, upper respiratory tract infections, diarrhoea, pneumonia, and unspecified diagnoses are the most common diagnoses at outpatient clinics and for admission to hospitals. AIDS now accounts for over 5 percent of all deaths recorded and is increasing. The health system had over 42,769 health personnel in 1995: 1,264 physicians, over 26,000 nurses, and 15,482 allied health personnel.

The expenditures of the Ministry of Health (MOH) for recurrent health services expenses increased 20 percent, to 16.5 billion Tanzanian shillings (Tsh.) from the 1993/94 to the 1994/95 fiscal year. However, the recurrent budget decreased in real terms with inflation at over 27 percent in 1994, and 36 percent in 1995. The capital expenditure for the Ministry was 1.1 billion that same fiscal year (in July 1996 approximately Tsh. 600 = US \$1). Donors contribute nearly 90 percent of the health system's development expenditure. Final accounts are not currently available from the Ministry of Finance, but it is estimated that the MOH's recurrent expenditure decreased by 26 percent in 1995/95, to Tsh. 12.2 billion, though capital expenditure is expected to increase to 1.4 billion Tsh.

The level of finance which the government has been able to provide for its health system has not been sufficient to sustain the operation of the facilities and the system for some time. This has been true in other sectors as well, including education, as the government has had to reduce public expenditure. It was in this context that the cost sharing scheme was introduced in 1993.

3. Purposes of the Study

The case studies undertaken to examine equity and coverage of health care provision are to be practical as a source of information which may be used immediately by the MOH and USAID mission of the host country in assessing its existing exemption systems. Tanzania was asked to be one of the country case studies because of its cost sharing program. Each case study is also to provide a basis for making cross-national comparisons and learning about successful mechanisms which ensure equity under a user charges system. The studies will be used to synthesize lessons learned, identify policy options for exemption systems under cost sharing schemes, and provide some operational guidelines. These will be presented at regional meetings and will provide guidance to other countries which have or are soon to introduce user charge systems.

Tanzania, as with other countries that have introduced cost sharing programs, has had one dominant question since the expansion of user fees: how effective are the safety mechanisms, namely fee waivers and exemptions, in protecting the access of the poor to health services? To assess this issue of achieving equity under cost recovery, it agreed to serve as one of the five country case studies to obtain an evaluation of its waiver and exemption systems. A review of waiver systems in non-government institutions is included in this review to see if there might be lessons to be learned from the private sector. Thus Tanzania is not only contributing to the international study on equity and user charges, but should benefit directly from the findings of this case study.

The purposes of conducting this study are summarized by these basic questions: Are the poor who visit government health facilities receiving waivers from paying fees? Are there poor who are eligible for waivers who do not receive them? If so, where do these people receive care? And are the non-poor receiving waivers which they are not eligible for?

The purpose of this study is to answer those questions. The specific study objectives are

- Review and contrast public and private sector waiver systems.
- Assess the effectiveness of waiver (means testing) and exemption systems.
- Estimate the costs of these safety mechanisms.
- Make recommendations for policy changes for the national cost sharing program.

4. The Study Methodology

The basic methodology for this study was prepared by Management Sciences for Health (MSH) for BASICS and reviewed by a Technical Advisory Group (TAG) before any of the case studies were initiated. The detailed background information and basis for the methodology is in "Methodology for Equity and Coverage of Health Care Provision Study" by William Newbrander and David Collins, Management Sciences for Health, April 1995 (Newbrander and Collins, 1995). The design for this particular country study was adapted from those methodological guidelines by the authors and the MOH's Cost Sharing Implementation Unit and Health Systems Research Unit to fit the circumstances and issues of Tanzania so it was relevant to the needs of the MOH, while also meeting the overall study objectives for the multi-country study.

The study was designed to gather data for two purposes: to provide descriptive information on the waiver and exemption systems and to enable an assessment of the effectiveness of the waivers and exemptions. The descriptive information relates primarily to the operational issues of the system. It provides data about how the system works, the actual waivers and exemptions granted, and experiences of the poor, non-poor, and exempt patients in using the system for those who were accessing health services. The assessment process evaluates the effectiveness of the systems in achieving equity.

As outlined in the methodology, there are four basic outcomes with waivers targeted for the poor. Two are appropriate: the poor who receive a waiver from paying fees, and the non-poor who do not receive a waiver from paying the user charges. Two other outcomes are inappropriate: the poor who are eligible, but do not receive a waiver from paying fees, and the non-poor who are not eligible for a waiver from paying fees, but do receive a waiver. These inappropriate outcomes are referred to as undercoverage and leakage, respectively. Leakage and undercoverage are measures of the ineffectiveness of waiver systems designed to protect the poor. To attain data on appropriate use of waivers and leakage required gathering of information from patients and staff at hospitals. Information was not gathered from health centers or dispensaries as cost sharing has not been extended to this level of the health system yet. Data on undercoverage required obtaining information from households who had not presented at the health facility for care. These were people who either had not used the available health services due to the fees charged, even though they were eligible for fee waivers, or people who had elected to use other health providers or facilities. This latter group may have been the poor who could not pay fees or those who could pay, but elected to use alternative facilities or providers.

Thus, to determine the waiver system's effectiveness in providing access to health services for the poor while minimizing the number of non-poor who are provided waivers, the study had to obtain information about patients, poor and non-poor, who receive treatment at health facilities, as well as those poor who are not receiving services at health facilities. To meet the study objectives of evaluating effectiveness required that data be gathered to evaluate the impact of the waiver and exemption system on two groups: those receiving care and those not receiving care. Hence, the basic sources of data gathered and analyzed were

- information and data available at health facilities
 - hospital administrative staff interviews
 - hospital clinical staff interviews
 - hospital patient interviews
 - review of hospital records
- information and data available only from household interviews
 - interviews with those poor not presenting at the hospitals to learn of their ability to access the system through waivers and their choice of health care providers.

Details on the information gathered from each of these data sources is presented below.

4.1 Hospital facilities survey

The data gathered from health facilities was quantitative and qualitative. Quantitative data was obtained by examining records of the health facilities, where available, to determine how many waivers and exemptions were granted and the value of such waivers. Qualitative information was obtained to supplement and corroborate the quantitative data obtained. This was obtained by interviewing staff and patients. The following information was gathered at health facilities:

Health facility administration: Structured interviews with the hospital administration, such as the medical superintendent, hospital secretary, hospital matron, chief medical officer, and administrator, were held at each health facility. The interviews gathered information on the community and catchment area of the health facility; the types of services provided; the fee structure for those services; policies and procedures for granting waivers and exemptions; the systems in place for granting the waivers and exemptions; and the information about waivers and exemptions provided to staff, patients, and the community. Data was also gathered from records of the facility on the number of waivers and exemptions granted, the value of those waivers and exemptions, and the total volume and revenues of the facility, if it was available.

Health facility staff: At each facility, structured interviews were also held with the hospital or health centre staff who implement the waiver and exemption policies. The staff interviewed included the inpatient ward and outpatient clinic matrons and nurses; clinical officers; social workers; staff in service areas which charge fees, including pharmacy, laboratory, and radiology; and staff in the accounts or revenue departments of the facility. The interviews gathered information on the fee system, how the waivers and exemptions were granted, and the role the staff had in initiating, recommending, and approving individual patients for waivers. Staff were also questioned about any training they had received concerning waivers and exemptions, as well as information about waivers which they provided to patients. This information was used to corroborate the implementation practices on the facility's waiver and exemption policies specified by the administrative staff.

4.2 Patient exit interviews

To substantiate how the system works in practice, it was necessary to gather information on the users' experiences and knowledge of the waiver and exemption system. Patient exit interviews were held in the outpatient clinics and on the inpatient wards, with both poor and non-poor patients. The information

obtained included the distance patients had traveled to receive care; how long they had waited after the onset of illness before seeking care; if they had paid for services and how much; the source of the money to pay for care; and their knowledge and use of waivers and exemptions. Patients were also asked about other people's experiences in seeking care and the reasons for any access barriers they might have experienced.

4.3 Household surveys

The above data provided information about how the system worked, the actual waivers and exemptions granted, and experiences in using the system for those who were accessing health services. The other key issue of effectiveness of waiver systems is to know about the poor who are not using health services at the sampled facilities. For this, there were interviews of the poor in their households in the communities around some of the health facilities surveyed.

The household survey samples were purposive: they sought to maximize the number of poor households interviewed to learn the effectiveness of the waiver system. So the first step at each site surveyed was to identify the neighborhoods around the health facility where many poor lived and conduct the survey there. This maximized the number of poor households surveyed. Secondly, because there was an interest in learning of use or non-use of health services by the poor, only those households where someone in the household had experienced an illness in the last month were surveyed. All household interviews were held with an adult. Respondents were asked if a health provider was sought for the episode of illness, and if so, where did they go for care. If they did not seek care, or sought care at some provider other than the nearest government or mission health facility, they were asked the reason for their particular choice. The survey also assessed the household's knowledge and experiences in using and accessing the waiver and exemption systems, the source of that knowledge, and their knowledge of the experiences of other people in seeking care, and the reasons for any access barriers they may have experienced.

4.4 The sample

Ten health facilities, listed in Table 1, were sampled for this study. They represented a variety of characteristics: urban and rural facilities; various facility types, including referral, regional, and district hospitals; and government, mission, and private facilities. The study's time frame limited the size of the sample, and the primary questions of interest of this study related to issues concerning primarily the poor. Information about areas of the community where the most poor households were located was obtained locally. National surveyors were used to make a subjective assessment as to whether a patient or household was poor. Observed factors—such as the appearance and value of the home, property in the home and outside (e.g., livestock), educational levels and enrollment of children in school, clothes, shoes, and dress and appearance of relatives—were used to make the assessment of whether a patient or household was poor.

The household interviews were done only in rural and peri-urban areas, not in large urban areas. This was because the catchment areas were more easily defined in rural and peri-urban areas and the choices for care were easily identified. This was important as it was desired to know the health seeking behavior of the poor.

Table 1: Hospitals Surveyed and Type of Data Collected

Hospital	Population Served	Type	Level	Administration and Staff Survey	Patient Survey	Household Survey
Kilimanjaro Christian Medical Centre	Urban	Voluntary	Referral	Yes	Yes	No
Kibaha	Rural	Voluntary	District	Yes	Yes	Yes
Same	Rural	Government	District	Yes	Yes	No
Tanga	Urban	Government	Regional	Yes	Yes	No
Muheza	Rural	Voluntary	District	Yes	Yes	No
Bagamoyo	Rural	Government	District	Yes	Yes	Yes
Kisaware	Rural	Government	District	Yes	Yes	Yes
Aga Khan	Urban	Private	Referral	Yes	No	No
Mission Michenko	Urban	Private	Referral	Yes	No	No
Muhimbili Medical Centre	Urban	Government	Referral	Yes	Yes	No

5. Description and Experiences with Targeting Mechanisms

5.1 Current fee structure

Government hospitals

The government introduced cost sharing in a phased manner beginning in 1993. The phased approach was adopted to ease the public's transition from a "free" to a payment-based and to be able to learn from each phase of the experience and make modifications to future phases.

At the time cost sharing was introduced, four principle objectives were announced

- To generate additional revenue for health facility operations with all revenue being retained at the facility.
- To increase quality of health services in government facilities.
- To strengthen the referral system and rationalize utilization of health services
- To improve equity and access to health services.

Phase I of the program introduced charges at referral, regional and district hospitals for grade 1 and 2 services. Grade 1 services offers a single or double room with a private bathroom and other amenities such as telephones and air conditioning. Grade 2 services provide semi-private ward accommodations and some amenities. The pricing structure for Grade 1 and 2 services include the cost of accommodation and food only, and are on a per diem basis. All services for health care and drugs are an additional charge. At the time of the survey, not all hospitals offered Grade 1 and 2 services, and of those that did, reported that the demand for has not been overwhelming.

In January 1994, Phase II was launched, which introduced Grade 3 services at referral and regional hospitals. No difference in service exists between different Grades for outpatient outpatient services, but Grade 3 inpatient services offer basic health services such as a public ward with six to eight patients (or more). In July 1994, Phase 3 extended Grade 3 services to district hospitals. There is a one-time admission fee for Grade 3 inpatients which is the same amount, regardless of the length of stay, and includes food and drugs. Phase 4 is the final phase and although not yet implemented, will introduce charges at all health centres and dispensaries.

The fee schedule for some common services at government, mission, and for-profit private hospitals are shown in Table 2. A complete schedule for all services at government hospitals is provided in Appendix A. For comparison, a bottle of Coca-Cola cost Tsh. 200. The fee schedule for government facilities has not been adjusted since it was introduced. All government hospitals must use the national fee schedule unless they request and receive approval for alternative charges. In June 1996, a revised national fee schedule was developed and introduced on July 1, but this was rescinded within a few days of its introduction due to concerns about the timing of these new fees. In mid-July 1996, consultation fees were abolished.

Table 2: Fees Charged at Various Types of Hospitals
(in Tanzanian Shillings: Tshs)

Service	Government Hospitals			Mission (Designated District) Hospital	Private For-Profit Hospitals
	Tertiary	Regional	District		
Inpatient Ward	500	300	150	1,000	10,000 - 12,000
Private (Grades I and II)	1,000 - 2,000	750 - 1,500	300 - 500	1,500 - 3,000	16,000 - 28,000
Outpatient GP	300	200	150		900
Consultation	500	300	200		3,000 - 7,300
Delivery Charge	400	300	100	3,000	15,000 +
X-ray				500	N.A.
Laboratory test	1,000	200-500	100 - 300	100 - 200	N.A.
Drugs (per item)	40	40	40	50% of cost	Cost+

The MOH has a Cost Sharing Implementation Unit (CSIU) to design, introduce, and coordinate the cost sharing program. Members of the CSIU undertook study tours to several countries, including Kenya, Ghana, Swaziland, Zimbabwe, Thailand and South Korea, prior to launching cost sharing in Tanzania. Prior to introducing cost sharing, the CSIU developed comprehensive operational and accounting guidelines for use by MOH facilities to delineate the policy, operational and accounting aspects of cost sharing to hospital staff. The CSIU has also conducted training for staff of all regional hospitals and for district hospital staff in 5 of 17 regions though resource constraints have restricted further training from taking place.

Non-government hospitals

Mission (voluntary) hospitals are an integral part of the Tanzanian health system, representing nearly half of all hospital facilities in Tanzania. Early in the development of the Tanzanian health systems, mission hospitals were an integral part of the government health system, and became known as Designated District Hospitals (DDH). As a DDHs, they continue to be operated as private institutions; however, the government provides funding for all recurrent costs, including salaries. In most DDHs, some of the staff are civil servants. Mission hospitals have had a tradition of charging for their services since 1928, and that segment of the Tanzanian population who have historically utilized mission hospitals are accustomed to paying for services. Mission hospitals designated as DDHs are provided with the

government fee schedule, but are not obligated to use this and are free to modify prices at their discretion, based on local economic conditions.

Private hospitals not affiliated with the government are charging higher fees which more closely reflect the actual costs of providing services. For example, outpatient services range from Tsh. 900 to 7,300, and between Tsh. 10,000 to 28,000 for inpatient services. At one hospital, drug charges are 50 percent of the cost of that drug, which is the fee proposed in the revised government fee schedule in June 1996, but later rescinded. Table 2 compares fees for different types of facilities.

5.2 Current mechanisms to protect the poor

Government hospitals

Several mechanisms exist to assist poor Tanzanians access health services at free or significantly subsidized levels. Waivers are the most direct mechanism, since patients who are determined to meet the criteria established by the hospital do not pay for services. Indirect mechanisms include exemptions for specific types of care or medical conditions and subsidized fees for services, supplies and drugs.

Direct mechanisms

In most government hospitals, waivers are granted to the poor at government facilities by a member of the care-giving staff. Typically this responsibility is concentrated in a small group who have been given primary responsibility for interviewing the patient and making an informed assessment regarding his/her ability to pay. Officially, final approval is to be given by the medical superintendent, nursing officer in charge or other authority, based on the recommendation of a direct care-giver, but often they are not included in the process. When possible (usually at larger facilities), hospitals may utilize the services of an on-staff social worker to conduct interviews, although the initial screening is still done by the care-giving staff. In relatively few (non-emergency) instances, the waiver process requires prospective patients to obtain written documentation from the district Office of Social Welfare, community leaders, or in the case of referrals, from the previous facility prior to receiving treatment.

However, it should be noted that many variations were noted in the procedures outlined above, particularly by initial care-givers who decided that a person was not eligible for a waiver and did not encourage prospective patients to appeal this decision to a higher level in the hospital. On the other hand, several clinicians at support service departments (laboratory, radiology, etc.) revealed that they often did not bother to seek payment from people who appeared poor. In one facility using the Office of Social Welfare, social workers were boasted that no waiver had been granted in more than six weeks, indicating that a culture exists within the hospital that staff should not grant waivers unless it is absolutely essential.

The CSIU guidelines for cost sharing state a policy and operational procedures for waivers which directly support one of the four stated objectives for cost sharing: to improve equity and access to health services. When cost sharing was first implemented, a five-part form was developed by the CSIU for hospital staff to use to determine eligibility for waivers. This form included sections for identification, background, assessment from health personnel, other health facilities, and sign off from a senior health administrator to approve the waiver.

During the cost sharing development process, other, more formalized procedures were explored by the CSIU, but were not adopted, such as requiring all patients to have a letter from community leaders. In practice, very few formal, written processes were in use at hospital facilities at the time this study was undertaken. None of the hospitals were using the five-part form, and most were not using any documentation at all. The typical procedure was for outpatient or admission staff to make the assessment on their own, with little or no participation by senior staff or, if a waiver was granted, little written documentation to support the decision.

The most significant finding from the study has been that the lack of operational guidelines and training have resulted in hospital staff interpreting the cost sharing program to be focused on generating revenues for the hospital at the expense of ensuring access to the poor. Accepted professional standards stated that no one is turned away from a facility because they do not have money; however, the management of this principle was found to vary significantly between facilities. The result is that in many of the hospitals visited, equity and access in for the poor has not been accomplished.

Indirect mechanisms

There are two mechanisms in the cost sharing program which are not targeted at assisting the poor specifically, but do provide substantial benefits to those who can not pay. These include exemptions and subsidized fees for services, particularly for Grade 3 services.

Exemptions

There are two types of exemptions: exempt patients and exempt illnesses. Exemption is based on the individual characteristics of the patient or types of health problems. These are health problems or services which qualify for being excused from paying fees at government facilities. Eligibility for an exemption is determined at the point of service and requires no formal process. In most facilities, a patient requesting an exemption due to illness will pay until such time that an investigation or test results confirm that an exempt illness is present. The exemption for outpatient visits applies to the treatment, x-ray(s), and laboratory fees.

Exempt patients

- children under five years of age
- MCH/FP services
- elderly
- civil servants

Exempt illnesses

- tuberculosis
- leprosy
- polio
- AIDS
- cancer
- diabetes

Subsidized Fees for Services

The Ministry of Health intentionally set fees at very low levels when introduced in order to ease the transition from "free" health care. It is estimated that current fee levels for services cover less than 5 percent of actual costs to deliver services, and the fee for drugs is much lower. Current fee levels do not present a significant cost burden for all but the poorest segment of the Tanzanian population; however, there is a strong perception that patients receive little for the money they spend, since drugs and supplies are in short supply at most government-operated facilities, food is typically not available for inpatients, and the consultation time spent by a trained care-giver is not highly valued. Interestingly, this perception does not hold true for the more expensive health services found at mission or private facilities, probably because historically, people have always paid, and the perception of quality is higher. In spite of the low perceptions of quality, patient surveys indicated that people spent a significant amount of money (and time) on transportation to come to a health facility.

Examples of the fee structure

- The current inpatient admission fee for Grade 3 services a district hospital is Tsh. 150 per day. This is a one-time fee for bedding and health services (surgery, etc.), and includes food and drugs, when available. It should be noted that Grade 1 and 2 services are calculated on a per diem basis and do not include drugs and cost of health services.
- Outpatient services are also subsidized at all levels in that the fees are substantially less than the actual costs of providing services.
- There are no fees for return visits for follow-up treatment for the same episode.
- The fees are "flat fees," that is, services or drugs which are more expensive have the same price as those drugs or services which are less costly.

In the first half of 1996, the Ministry of Health revised its fee structure with effect from 1 July 1996, which included charging 50 percent of the cost of each drug product rather than Tsh. 50 for any drug supplied. This order was rescinded on 3 July.

Non-government hospitals

Mission hospitals have a long tradition of charging fees for services, and while no formal mechanisms exist for granting waivers, all patients are treated regardless of their ability to pay. Unlike government facilities which rarely extend credit to patients, patients are asked to contribute whatever they can afford at the time of treatment. If a patient is not able to pay the registration fee at the time of presenting at the hospital (in a non-emergency situation), then an interview is arranged with a person at the facility who has been designated as in charge of waivers and exemptions. If an alternative payment plan is granted, then a note is included in the patients medical record which specifies the outstanding balance. The next time the patient returns to the hospital for treatment, the outstanding balance is discussed with the patient and a contribution made. One mission hospital has undertaken a collection program which follows up with patients who have outstanding balances (or contacts the community leader in the patients village), but has acknowledged that this system did not yield high results. Some estimates indicate that some type of waivers to the poor account for around 10 percent of total patients, particularly if outstanding receivable balances from patients is converted to a bad debt expense.

As with the government facilities, mission hospital staff have not had formal training for determining waivers, but it could be concluded that clear articulation by senior management of the underlying philosophy present at mission hospitals, among other factors, is sufficient to foster a greater degree of access to the hospital by the poor than may be experienced at a government facility.

Not all mission hospitals implement a formal exemption system for patients with specific medical conditions or types of patients (children under five, MCH, etc.), but for those that do, the procedure is similar to that of government facilities.

5.3 Discussions with hospital staff

The information presented in this section is based on interviews at government health facilities with the administrators, the clinical staff, reviews of the institution's records, and observations made the consultants.

Fee structure

In virtually all government facilities, the fee structure in place was exactly the same as the national government fee schedule, although several administrators of government facilities thought that patients would easily accept higher fees, particularly for drugs, if those higher fees could translate directly into higher quality services, especially a consistent supply of drugs and medical supplies. However, no facilities had approached the MOH to seek increases in the fee schedule. This was markedly different from the situation at mission hospitals, where the fee schedule was higher than the government schedule. One mission hospital conducted a quality of care study of over 1,500 patients in early 1994, which included a section on cost sharing. Over 70 percent responded that the fee schedule was "very appropriate, and 29 percent thought it was inappropriate. Similarly, 70 percent thought that the charges were "fair," compared to 29 percent who considered it unfair.

All facilities visited charged fees for referral patients, even though they may have paid at another hospital prior to coming to the second facility.

Overall functioning of the waiver and exemption system

There was a wide range of perspectives on the waiver and exemption system from hospital staff, largely dependent on the type of facility. Staff from the government hospitals often affirmed that systems were in place and believed that they functioned as they were intended to, although many admitted that inconsistencies existed within facilities on granting waivers, as the decision was dependent on a single person, with no documentation retained. The exemption system was stated to be far easier to implement, since once a person was determined to be exempted (from test results), this information was retained in the patients record. Staff from mission and designated hospitals took a more critical perspective and in some private facilities, there were no formal exemption or waiver systems. Instead, they opted to have all patients attempt to pay something toward the cost of services, and often running totals were kept of a patient's account. It should be noted that in these situations, a patient was never denied access if he or she could not pay.

Knowledge and attitudes of waivers

Generally speaking, staff from government facilities were knowledgeable of waivers and when they should be granted, but an overwhelming number of staff did not believe that people were really so poor

that they could not afford to pay the very modest fees, particularly when one compared the cost of services to other commodities. As a result, waivers were not easily granted at these facilities, and it is likely that patients who could not afford to pay were discouraged from returning for services unless and until they had money. It should be noted this was highly variable between hospitals, and perhaps within the same facility, with more compassionate staff member granting waivers at the point of admission more easily than others.

Since many of the mission hospitals adopted a practice that encouraged everyone to pay whatever they could afford, overall they seemed more understanding of the plight of the poor.

Knowledge and attitudes of exemptions

In facilities where an exemption policy existed staff at government facilities were significantly more knowledgeable and tolerant of exemptions. This is probably due to two reasons: the number of patients presenting for exemptions was much greater, and it was far easier and more objective to determine an illness which could be exempted than to attempt to determine if someone was poor or not. Surprisingly, few staff members took issue with this policy which enabled anyone, regardless of their ability to pay, to be exempted from paying.

Costs of implementing waiver and exemption policy

With the exception of one DDH that had hired a person to attend to waivers and exemptions only, no additional costs were incurred by government or mission facilities. The larger hospitals had social workers on staff who were utilized to determine eligibility for waivers (exemptions were determined at the clinical level, based on examinations/test results); it may be argued that these people could have been doing something else (i.e., comforting terminally ill patients, families of patients who had died, etc.), but since the overall number of exemptions is so small, the cost is negligible.

Importance of cost sharing funds on operations

In every hospital, cost sharing funds had become an essential component of working capital to ensure that some level of basic operations took place. Most all staff cited the lack of government allocations as the primary reason for critically needing revenue from cost sharing. In addition, several of the mission hospitals noted the absence of transfers for treating civil servants as being a major drain on hospital resources. One DDH refused to treat civil servants until the government paid the invoices for treatment of civil servants until promised that payment would be forthcoming. Some funds were transferred, the treatment was resumed, and then payment stopped again.

Rather than using cost sharing funds for quality improvements, the hospitals were forced to use it to purchase essential drugs and supplies, and often to pay for salaries, petrol, and other recurrent expenditures. Many of the hospital administrators were critical of the MOH decision not to raise fees for services and to eliminate the fees for consultation.

Record keeping

The quality of and appreciation for record keeping varied widely between facilities visited, however, there was a distinct difference between government and mission hospitals in what was actually practiced. Although the central MOH had issued guidelines for record keeping, the only consistent report produced at all facilities was the income and expenditure report for cost sharing funds. Two facilities collected information on waivers and exemptions, but neither calculated the cost of those services.

Overall, the lack of training on the collection and use of information was cited as the primary reason for not consistently collecting and reporting waivers and exemptions.

6. Experiences of the Poor with Targeting Mechanisms: Findings from Household Surveys

To ascertain if there were poor who were not presenting at the health facility, and their experience with obtaining care, waivers, and exemptions, household interviews were conducted in communities near three of the health facilities surveyed. All three areas surveyed were considered to be rural. The sample was purposive, in that poor households which had a household member sick within the past month were sought out. At each location, communities with a predominant number of poor households was sought out to maximize the number of poor households interviewed. The first question put to the person in the household was whether anyone in the household had been sick in the last month. If the response was negative, the household was not included in the sample, and the interviewer went to the next house. This purposive sample of poor households with a sick person was desired, because the experiences of the poor in obtaining waivers and their health seeking behavior were the questions of interest.

Whether a household was considered poor was based on the assessment of the interviewer. The judgment to classify the household as poor or non-poor, was based on several factors: appearance of living quarters or home, property (land, cattle, crops, other), educational level of household members, number of children enrolled in school, or clothes and shoes worn.

6.1 Characteristics of household interviewees

A total of 150 households were interviewed at three sites, 60 at two sites and 30 at one. One hundred and twelve of the 150 households interviewed, or 75 percent, were poor. This high percentage was expected since the survey sample was not random: the surveyors were seeking out those poor households that should be eligible for waivers to learn of their experience and utilization of health services.

6.2 Do people seek care when they are sick?

Due to the prescreening of those in this purposive sample, all the households had someone who had been sick in the last month. Overall, 95 percent of these households who reported sickness sought care. Surprisingly, the proportions between poor and non-poor who sought care is identical (95 percent), which is coincidentally the same as the overall percentage of households seeking care.

Although there is no difference in the proportion of poor and non-poor respondents seeking care, a potential distinction which must be considered is when they seek care. The household survey did not ask residents to identify how long they waited prior to seeking care (as had been done in the patient survey), but it is possible that we would see the poor waiting longer to seek care, in order to obtain funds before they seek care, either for hospital fees, drugs and supplies, or both.

Because a formalized system is not uniformly implemented, and because of the limited amount of staff training which has taken place in the districts where the study took place, access by the poor to hospitals is dependent on the interpretation of the cost sharing guidelines and specifically, the waiver and exemption policy on the part of hospital staff.

6.3 Where do people seek care when they are sick?

Seventy percent of all respondents who sought care went to a government facility, indicating that government facilities are often the only available sources of care for rural populations. Of these, 75 percent are poor, and 25 percent non-poor. Fifteen percent of all households undertook a self treatment program by purchasing drugs at a kiosk; however, within this group, 86 percent were poor. Figure 1 delineates the responses for all households for all types of care sought.

6.4 Why do people choose certain health providers or facilities?

For those households who choose not to go to a formal health care facility, they were asked why. Eighty percent of all those who responded were poor. As shown in Figure 2, 36 percent responded that they did not go because of the lack of drugs, and 24 percent cited lack of money. Twenty percent did not go because of distance to a health care facility or inconvenience.

6.5 Are people able to pay? Do fees create access barriers?

Households were asked if they knew anyone who did not seek health care because they could not pay. Overall, 69 percent of all respondents stated they knew someone who could not go for care because they could not pay and among this group, 78 percent were poor. Family members represented two thirds of all people who could not go.

In addition to inability to pay, nearly half, 49 percent, of the respondents stated there were other access barriers, such as distance, waiting time, and quality of care, which prevented someone they knew from seeking care.

Figure 1

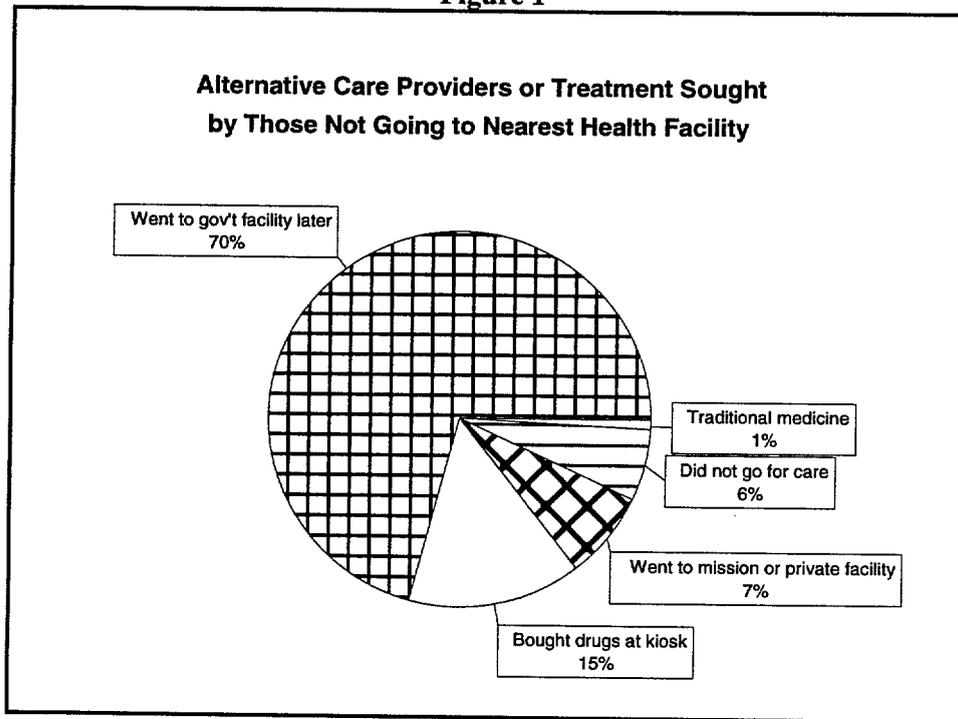
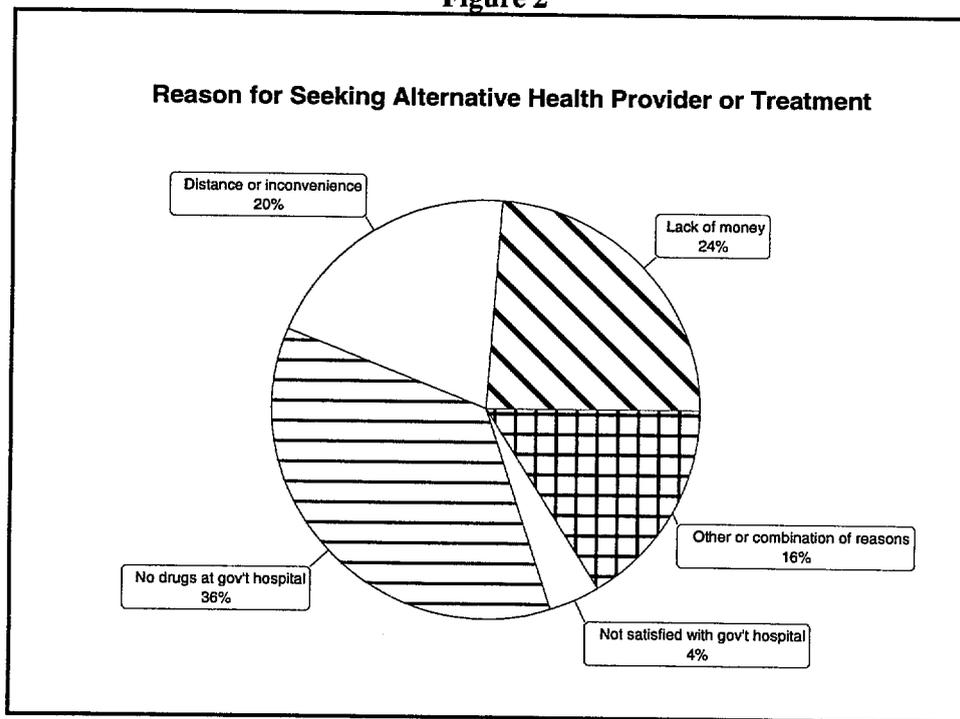


Figure 2



6.6 Do people know about waivers and exemptions?

Sixty-two percent of all respondents believe the poor have to pay for services at government health facilities, and among this group, 81 percent were classified as poor. Only 21 percent were aware of the waiver policy and stated that poor did not have to pay; 17 percent were either not sure or had not heard of waivers.

More people knew about an overall exemption policy than waivers, with 81 percent responding overall that people with certain conditions did not have to pay for health services, regardless of their ability to pay. Of this group, more non-poor people were aware of exemptions than poor (90 percent to 78 percent respectively). Only 7 percent stated that exemptions do not exist, and 12 percent were not sure or not aware of an exemption policy overall. However, when it came to identify specific exemptions, respondents were most familiar with only two of the nine conditions asked about. Table 3 indicates the responses by all the respondents, the poor and the non-poor.

Table 4 shows where the information of exemptions or waivers came from. Hospital staff, word of mouth, and the media were the means by which people learned that certain types of patients did not have to pay for care.

7. Experiences of the Poor with Targeting Mechanisms: Findings from Patient Interviews

7.1 Characteristics of patient interviewees

Patient exit interviews were conducted with 187 patients at eight facilities. The division of interviewees into the discrete categories of poor and non-poor was based on the interviewer's subjective assessment, so it is not an absolute standard. Of those patients interviewed, 43 percent were assessed as being poor, and 57 percent as non-poor. The interviewers sought to obtain respondents from a cross section of the hospitals' wards and outpatient clinics.

Of those interviewed, 70 percent were patients at government facilities, and 30 percent at private facilities. Forty-seven percent of the interviews were conducted with patients at rural health facilities, 53 percent at urban facilities.

Of the poor interviewed, it was almost evenly divided between those who were inpatients and outpatients: 47 percent were inpatients. A little more than half (52 percent) of the interviewees were inpatients. Of the inpatient and outpatient interviews, 57 percent, and 43 percent were poor, respectively.

Table 3 Interviewees Knowing the Categories of Patients Which are Exempted from Fees

Categories Exempted from Fees	Percentage Aware of Exemption		
	Non-Poor interviewees	Poor interviewees	All interviewees
Poor do not have to pay	29%	18%	21%
Children under 5 years of age	3%	16%	13%
MCH Services	3%	17%	13%
TB patients	3%	10%	8%
Leprosy patients	3%	10%	8%
Polio patients	3%	18%	14%
Cancer patients	3%	12%	9%
AIDS patients	3%	11%	9%
Elderly patients	3%	10%	8%

Table 4: How People Learned of the Exemptions

	Non-poor	Poor	All Respondents
Signs or posters at hospital	6%	4%	5%
Information from hospital staff	21%	32%	29%
Word of mouth	42%	24%	29%
Media (newspaper, radio, or TV)	18%	10%	12%
Did not know of any exemptions	13%	30%	25%

7.2 Do people seek care when they are sick?

Interviewees were asked how long they waited before they sought care. Specifically, they were asked if they sought care immediately, waited less than one week or waited more than one week. Overall, 60 percent of all respondents stated they waited more than one week before seeking care, though 68 percent of the poor waited more than a week, compared to 54 percent of the non-poor. For the remaining 40 percent of patients who responded, half sought care immediately, and the remaining sought care within a week of the onset of their illness (see Figure 3 and Table 5). Since the survey did not provide any information regarding the patient's clinical condition, it is not possible to draw concrete conclusions, but a possible explanation for the delay of the poor to seek care may be attributed to the need for the poor to obtain money from family, friends or through the sale of personal belongings to pay for transport and health facility fees.

Figure 3

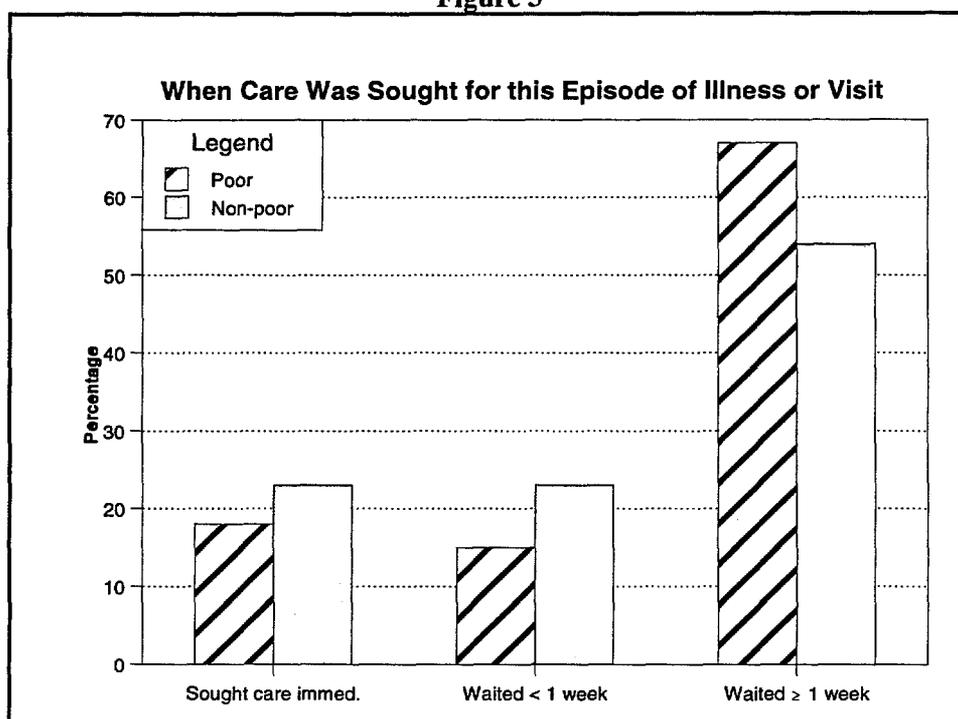


Table 5: When Care Was Sought for this Episode of Illness or Visit

	TOTAL	Poor	Non-poor	Poor at government hospital	Poor at mission facility
Sought care immediately	20%	18%	23%	17%	21%
Waited less than one week	20%	15%	23%	17%	7%
Waited one week or more	60%	67%	54%	66%	71%

An important element of access is proximity to health facilities. Interviewees were asked how far they traveled, the approximate cost of travel, and the length of time it took them to reach the health facility. Of the people who responded, 46 percent came from within 5 kilometres of the health facility, however, 7 percent traveled more than 100 kilometres, with the longest recorded distance being 800 kilometres. There was relatively little variation between the distances traveled by the poor and non-poor, with 42 percent of the poor traveling 5 kilometres or less, and 50 percent of the non-poor traveling the same distance. Inpatients traveled further than outpatients, and people traveled greater distances to reach government facilities than missions. People also traveled further to reach urban facilities than rural facilities, but this is probably due to some patients traveling long distances to reach a specialized referral

hospital in Dar es Salaam. Figure 4 and Table 6 provide further information on distances traveled by the different categories of patients and facilities.

Figure 4

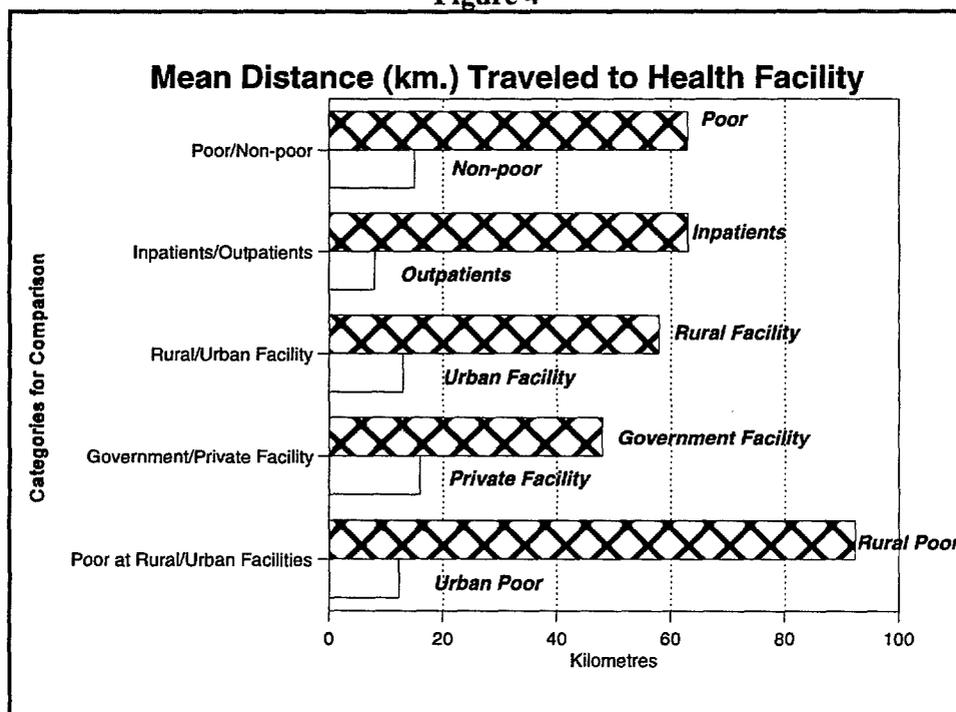


Table 6: Mean and Median Distance (Km.) Traveled to the Health Facility

	Mean Distance (Km.)	Median Distance (Km.)
Poor	63	9
Non-poor	15	6
Inpatients	63	10
Outpatients	8	5
Rural facility	58	7
Urban facility	13	7
Government hospital	48	7
Mission hospital	16	7
Poor at rural facility	92	9
Poor at urban facility	12	8

Nearly half of all respondents (49 percent) traveled by bus to reach health facilities, followed by walking (14 percent); however people took a variety of transport, including boats and trains. Sixty five percent of all respondents spent up to Tsh. 500 (nearly US\$ 1) for one-way transport to reach a health facility, but some respondents reported spending up to Tsh. 8,000 for one-way transport.

7.3 Where do people seek care when they are sick?

Overall, the majority of respondents (86 percent) stated that they utilize more than one health facility on a regular basis, with little distinction between the poor and non-poor. Table 7 details the specific choices made between poor and non-poor and type of facility. Sixty percent said that they had been to another facility prior to coming for treatment at the facility where they were interviewed.

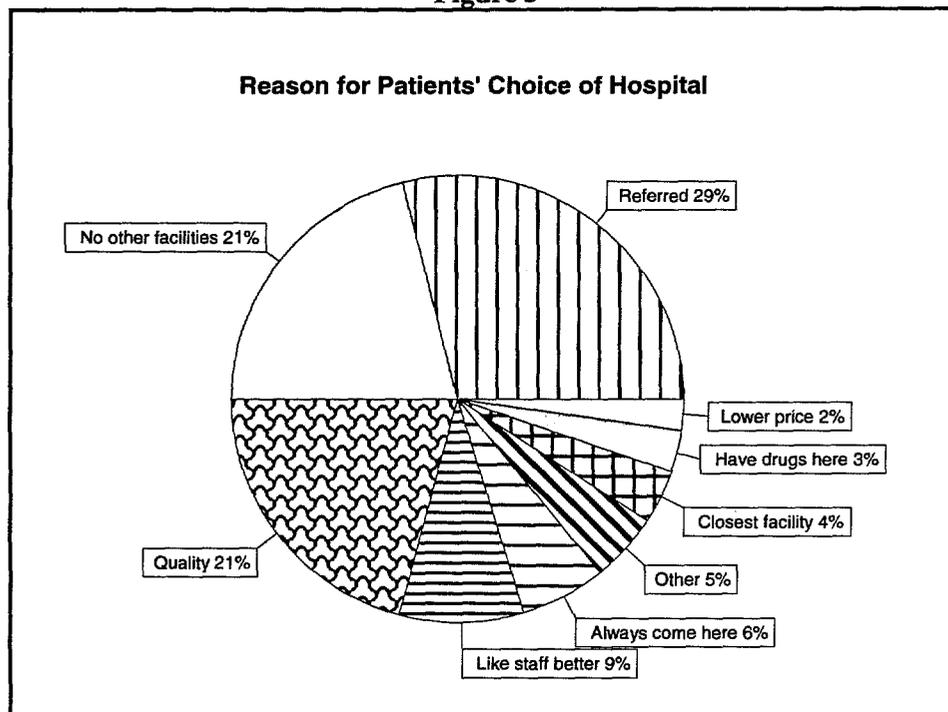
Table 7: Health Seeking Behavior: Where Patients Seek Care
For patients who go to other providers for care, which other providers do they use?
(More than one choice possible)

	Poor	Non-poor	All Respondents
Government health centres	48%	45%	47%
Government dispensaries	36%	42%	39%
Private hospitals	25%	34%	30%
Private clinics	47%	38%	42%
Mission health centres	35%	25%	29%
Traditional healers	10%	6%	8%
Self treatment	27%	23%	25%

7.4 Why do people choose certain health providers or facilities?

The single largest reason given for attending the hospital on the day of the interview (29 percent of respondents) was because they were referred from another health facility (see Figure 5), followed by quality considerations and the lack of alternative facilities to choose from (both at 21 percent). Overall, quality measures such as preferences for staff, availability of drugs and overall quality accounted for 37 percent of the reasons poor gave, compared to 34 percent of non-poor. Interestingly, price or cost was not an issue as quality was. Even among inpatients and outpatients, there was no appreciable issues of price. There was no difference in the price issue between the poor and non-poor. Presence of drugs at the hospital was not an important factor in the decision of where to seek care either, unless respondents subsumed that issues in their responses under the category of quality.

Figure 5



Three quarters of the patients interviewed stated that the other facilities they sometimes attend are closer to their home than the facility where they were interviewed, with slightly more non-poor attending closer facilities than the poor.

7.5 How much do people pay?

Interviewees were asked how much they were asked to pay for care (the actual amount billed), as well as how much they actually did pay for care. The mean and median amounts paid by patients by various categories of patients or by type of service or facility are shown in Table 8. Forty-six percent of the poor paid for services, compared to 64 percent of non-poor respondents. However, of those that did not pay, nearly half of all patients (48 percent) were there on a follow up visit or were inpatients and had not yet received a bill for services (27 and 21 percent respectively). Thirty-two percent did not pay for services, claiming exemptions, and 12 percent were waived due to socio-economic reasons. Other reasons accounted for the balance of 9 percent.

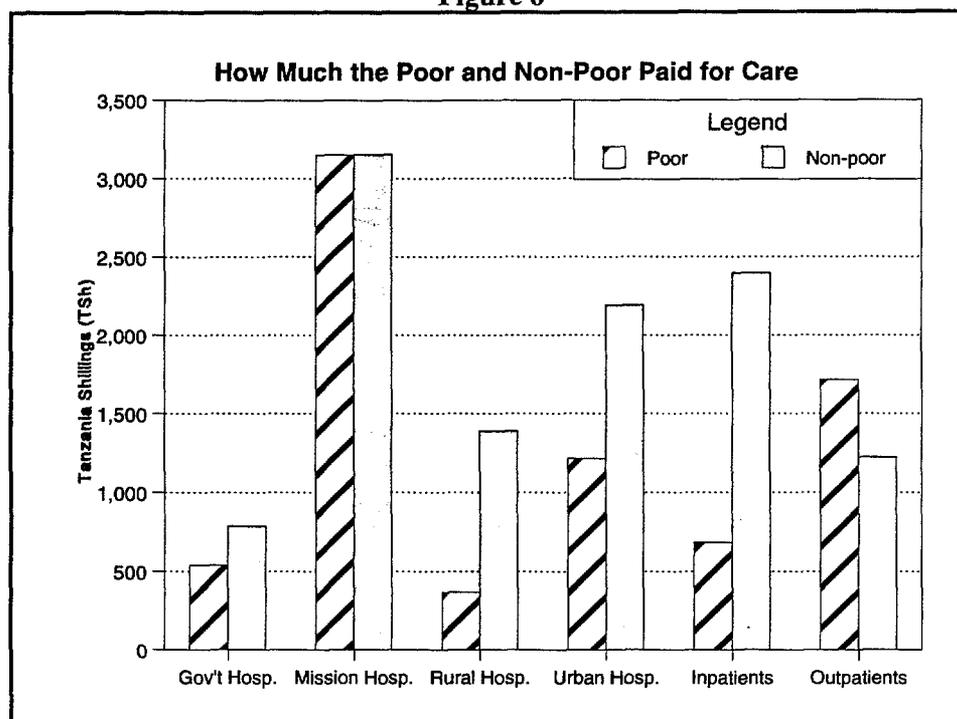
Table 8: The Amount Patients Paid for Care in Tanzania Shillings (Tshs)

	Mean Payment (Tshs)	Median Payment (Tshs)
Poor	962	500
Non-poor	1,792	500
Inpatient services	1,612	500
Outpatient services	1,335	400
At government hospital	676	500
At mission hospital	3,153	2,500
At rural hospital	1,135	350
At urban hospital	1,762	500

Sixty-one percent of all respondents were charged Tsh. 500 or less for services, and 36 percent of the poor paid for care, compared with 66 percent of the non-poor interviewees. Of those people paying for care, 54 percent paid the full charges or bill. The 46 percent of patients who paid partial amounts of their bills, the majority were inpatients who had paid their admission fee; which for Grade 3 patients may also represent the entire amount they would be asked to pay for their stay.

Of the poor who did pay, 54 percent paid in full, while 46 percent made partial payments. The experience of the nonpoor was similar. The difference in amounts paid by the poor and non-poor are shown in Figure 6. The two groups paid nearly identical charges in mission hospitals.

Figure 6



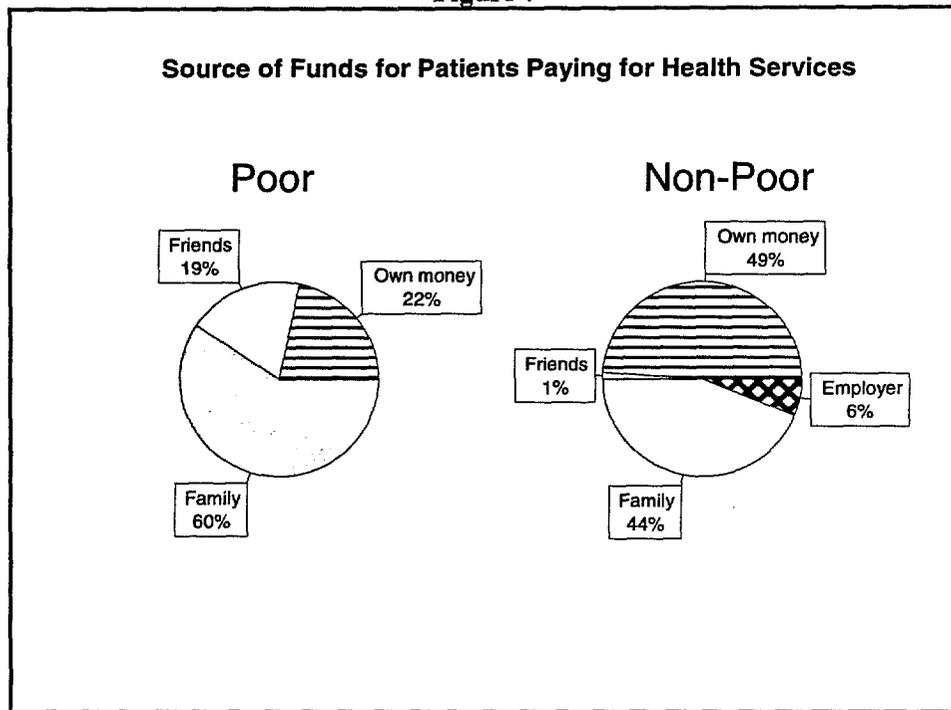
7.6 Where do people get the money to pay for care?

The source of funds that patients used to pay for services is shown in Figure 7. When combining the poor and non-poor, the single greatest source of funds came from family members (49 percent), followed by use of their own funds (40 percent). There is a marked difference between the non-poor and poor's ability to pay for services using their own funds (49 percent to 22 percent, respectively). This indicates that the poor, without their own resources, are more dependent on family members to assist with the payment for health services.

Patients were also asked if they knew anyone who could not go to the hospital because they were unable to pay. Forty-eight percent of all patients responded affirmatively, and over half of these (52 percent) were poor, with only one third of all respondents citing this happens on a frequent basis (the response from the poor was about the same).

Patients were also asked if they knew of other reasons why people did not go to the hospital (other than inability to pay), such as lack of drugs, no money for transport, distance to the hospital, or poor quality of service. Their response was similar to ability to pay, with 34 percent responding that they were aware of such situations.

Figure 7



7.7 Do people know about waivers and exemptions?

To determine whether the public was familiar with the existence and policy on waivers, interviewees were asked if the poor could obtain waivers from paying health facility fees. Thirty-four percent of all respondents believed that all people must pay, which was based on personal experience, from word of mouth, or their perception (lack of knowledge). Only 30 percent stated definitively that the poor did not have to pay; 20 percent thought the poor had to pay a partial amount, and 15 percent did not know anything about waivers. Figure 8 illustrates these responses.

Of those people who were aware of waivers, they were asked how they knew they existed. Table 9 indicates that most people (49 percent) learned from discussions with hospital staff, followed by word of mouth (29 percent), and newspaper, radio or television (20 percent).

Overall, people seemed to be more aware of exemptions than waivers, which is consistent with the number of people actually seeking exemptions (see section 7.5 above), but the percentage of people who did not know exemptions existed for all diseases and conditions was above 50 percent. Details are provided in Table 10.

Figure 8

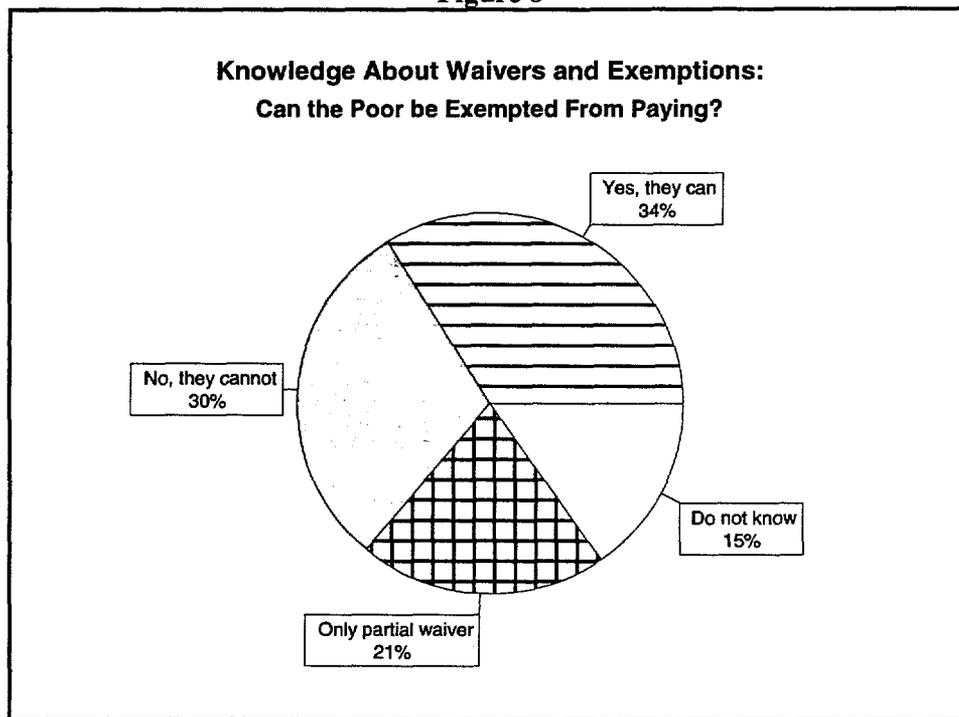


Table 9: Source of Information about Waivers

	Poor	Non-poor	All Respondents
Hospital staff	54%	45%	49%
Word of mouth: friends or relatives	29%	29%	29%
Media (newspaper, radio, TV)	13%	26%	20%
Other	4%	0%	2%

Table 10: Percentage of Interviewees Knowing the Following Categories of Patients are Exempted from Fees

Exemption Category	Percentage positive responses
Children under 5 years of age	13%
MCH services	5%
TB patients	7%
Leprosy patients	5%
Polio patients	4%
Typhoid patients	9%
Cancer patients	6%
AIDS patients	4%
Elderly patients	2%

8. Experience of the Health Sector with Targeting Mechanisms

8.1 Is there a policy to encourage access for the poor?

- A formal waiver policy exists.

In virtually all sites visited, health staff cited their professional commitment to serving all people who present themselves at a hospital. However positive the intent, there was a high degree of variation between facilities, perhaps due to the caliber of the management staff in place and their own understanding of the waiver and exemption system and their ability to convey and enforce the appropriate operational guidelines, as well as philosophical perspectives which are critical to the implementation of the program. There are significant problems with the actual implementation of the waiver system however, and at several locations, interviews with patients and households indicated that people were not going to receive services if they did not have money. In this respect, it is clear that however well-intentioned, access by the poor is hampered.

- Highly variable attitude of government workers toward waivers and exemptions compared to mission staff.

Health staff's commitment to their job and clarity of the facilities' overall goals appear stronger at missions. Leadership and direction are also stronger. Altruistic motives do not appear to be present in government facilities to the same degree as in mission hospitals, which may contribute to impediments to access for the poor. Social workers at government facilities displayed strong adverse reactions to the idea that a patient really could not pay, instead insisting that the patient may choose not to pay, but that everyone had the means to do so if they wished.

- Quality elements have not been adequately addressed at the facility level.

It was clear from site visits and discussions with hospital staff that the quality of services at government facilities and DDHs is no better off now than it was two years ago when cost sharing was implemented. The underlying cause of this situation was primarily attributed to irregular government allocations, which were consistently below budgeted levels. As a result, facilities are forced to use cost sharing funds as working capital and to fund essential recurrent costs. Lack of drugs is a major impediment effecting the general public's perception of quality and value for money.

8.2 Does the price structure facilitate access for the poor?

- The fee structure is well below the actual cost of delivering services.

The national fee schedule and any fee schedule in effect at mission hospitals represent a fraction of the actual cost of delivering services and this serves as an incentive to promote access. Interestingly, there is strong evidence from and around government health facilities, based on interviews, to suggest that people have not yet accepted paying for services *at government facilities*. There are two possible explanations for this point: patients could still be unaccustomed to paying for services which were previously “free,” or people do not perceive the quality of service at government facilities justify paying for them. From site visits to hospitals, it was clear that mission hospitals were handling many more patients than government hospitals and that their fee schedule was higher in almost all cases, which would support the second explanation regarding quality of service.

- Acceptance by public.

The reaction by general population has not been opposed to the fee structure. However many respondents continued to see government provision of health as a “free” good and the government and reversed its promise, declared as little as 15 years ago. It is likely that had the quality of services improved noticeably with the imposition of cost sharing, acceptance would be higher. One of the most significant issues people mentioned during the patient survey was the lack of value for money, questioning the need to pay for a consultation fee when they would receive no drugs, only a prescription. It was noted over and over that patients were willing to pay large sums of money to transport themselves to health facilities, to purchase drugs and medical supplies from private pharmacies and to bypass government facilities to go to more expensive mission or private facilities.

- Attitude by hospital staff.

Many staff members of government facilities possess a narrow interpretation of waivers and combined with their lack of training, blockages go up to many people who otherwise should be receiving care at reduced or no cost.

- Non-facility costs incurred by poor (travel and time).

Study results demonstrated that people will spend a significant amount of money on travel to health facilities and drugs and medical supplies, which increasingly must be purchased by patients themselves rather than being supplied by hospitals. In most government facilities inpatients must supply all drugs and medical supplies, including injections, syringes, and food.

8.3 Do the poor benefit from exemptions?

- Exemptions not targeted to the poor, but the poor do benefit.

The poor do benefit from exemptions, since a large degree of patients who present themselves at hospitals with chronic medical conditions are low income or poor. Exemptions for children and MCH services and elderly are particularly useful to the poor.

- Not all hospitals are using exemption policy.

Some mission hospitals have opted not to implement the exemption policy, and instead seek contributions from all patients. It has not been determined whether this blocks access by poor or sick patients, but from patients' responses, the quality of care was reported to be higher at mission than at government facilities, so it may appear not to be a factor.

8.4 How effective are the mechanisms in ensuring access for the poor?

- The theoretical construct of the waiver mechanism is sound, but the implementation of is flawed.

Three primary factors account for the poor effectiveness of waivers: lack of training of hospital staff, lack of records maintained regarding the number and value of waivers, and lack of information to promote waivers among communities and the public.

- The administration of the government health facilities emphasized generating revenues rather than ensuring access to the poor.

Consequently, the government facilities minimized non-leakage of the system at the expense of increasing the undercoverage rate. The pressure that facilities felt for generating revenues resulted in making waivers extremely difficult to obtain at government facilities: three of the five government institutions gave none or nearly no waivers. The administration at these facilities were more concerned about leakage in the system (i.e., the non-poor requesting and receiving waivers) than about undercoverage (i.e., the poor not receiving waivers they were entitled to). The result was a stringency in granting any waivers to ensure that the non-poor did not obtain unwarranted waivers. Little consideration was given to the fact that there may be some poor patients who should receive waivers for care and do not, or that some are deterred from even coming to the facility because they are not aware that they would be eligible for a waiver of the fees.

8.5 Are there targets for waivers?

- Targets have not been developed for any type of hospitals.

With few exceptions, facilities keep no records, have no idea how many waivers are granted and what the value of those waivers are, thus value of revenue not known, nor is the actual number of poor.

- Targets are not included in any long-term plans or in the annual budget process.

There are no records kept of the number of waivers granted to the poor or the value of those waivers. If there were targets for the value of waivers to be granted, it would assist the budgeting process. At some hospitals, staff are unnecessarily strict in not granting waivers because of the fear that the revenues foregone will prevent the hospital from obtaining the revenues needed to supplement their government budget. By having targets for number of waivers and their value, this loss of revenue would already be accounted for in hospital budgets and not provide a reason to staff to not grant waivers to the poor.

8.6 Is there an effective system for recording and reporting waivers?

- Not implemented on a consistent basis, few facilities document.

Though the MOH procedures existed for facilities to report monthly their revenues collections from fees and the value of exemptions and waivers granted, such reports were not maintained or available at the Ministry. Thus it is difficult to know fully the extent of the actual number of waivers granted. At the facilities where records were kept, there was no monitoring of the number and value of waivers granted. The emphasis is at all facilities was on reporting the revenues generated each month.

8.7 How have cost sharing revenue been used at health facilities?

- Cost sharing revenues are used for working capital, minor repairs, drugs, fuel, and other recurrent costs. Expenditure patterns not always appropriate to a situation of facility.

Many facilities consider cost sharing funds essential for basic operations, given inconsistent allocations of government funds to facilities. The sentiment was often, "Due to government reductions in our budget, we could not live without cost sharing revenues to simply provide the most basic of items such as petrol for vehicles." The use of the money for government facilities to simply fill in gaps in the Ministry budget to buy petrol, which is quickly used up and does not benefit patients on an on-going basis, was prevalent. The problem with this is that cost sharing revenues are intended to provide quality enhancements to supplement the hospital's budget. Patients are then able to see "value added" from the money they are asked to pay in the form of user charges. The mission facilities appeared to do a better job of using cost sharing revenues for enhancements which patients could see. Local committees did exist at some facilities to manage the use of cost sharing revenues. However, they do not consistently provide the quality leadership and guidance necessary to make cost sharing successful and facilitate its expansion.

- Regular reports to MOH on revenue and expenditure information, but not of much informational value (among other things, they do not record any information regarding the number and value of waivers and exemptions).

Reporting on the actual use of cost sharing revenues is highly variable between sites. Some maintained records of local community health council minutes to record decisions on use of the monies. There were auditors from the MOH who had visited one site to review the records of the finances for the cost sharing fund. This is a good mechanism to ensure the integrity of the funds and their use. Unfortunately, the capacity of the Ministry to audit all facilities on a timely basis does not exist. However, other facilities did not maintain such records. Thus the monitoring of the funds and the manner in which use of the money is decided is critical to the continued success of cost sharing.

- No long-term plan at facilities on use of cost sharing funds to improve quality and the facilities.

The lack of a long-term plan on use of the monies has resulted in *ad hoc* use, without any pattern to be able to show patients that cost sharing produces value added. This serves to increase the sustainability of the cost sharing program. For instance, if the drug outages are substantially reduced because cost sharing

monies supplement the drug budget, and medicines are purchased to minimize outages, patients will be pleased with the service. The result will be more people using government facilities due to the improved drug supply which will, in turn, generate more revenues from cost sharing. Having a long-term plan at each facility for use of the funds and establishing a priority list of how future monies will be expended will minimize the opportunity to use the funds for every financial crisis which occurs. If many of these crisis situations are simply addressed by using cost sharing revenues, then there is no opportunity to prioritize use of the funds. There may be no incentive to economize or improve efficiency if the cost sharing revenues always provide a convenient "safety valve" from such crises.

8.8 What is the cost of administering protection mechanisms?

- The costs of administering the cost sharing system have been negligible based on district hospitals visited.

The actual costs of administering the system are low. There is no information campaign, little training of staff in the system, and there are not multiple forms or processes. Hospitals have not taken on any additional staff to handle the administration of the cost sharing system. The primary direct costs of this system are the staff time required to obtain information and determine whether a waiver should be sought for a patient. This does not occur regularly, however, so the time costs are also minimal. Overall, the direct costs of administering this waiver system are minimal.

8.9 What examples exist in other social sectors?

- There are no significant systems in place in other sectors which are appropriate for health to emulate.

There are few waivers in education sector and none in utilities or agriculture. Waivers actually began in education sector. Village chiefs and leaders have always been relied on to make assessments of who is poor and non-poor for the waivers rather than individuals in the educational sector. However, the educational sector announced in July 1996, large increases in fees. This will test the system and its viability in the future.

8.10 What public information exists about waivers and exemptions?

- Little public information has been disseminated about waivers and exemptions.

Other than some initial publicity, there has been no or minimal efforts. There were posters to inform patients of waivers at only one facility. It is evident that some facilities do not want to "advertise" waivers and exemptions because of concerns of abuse. However, in an attempt to minimize "leakage" (non-poor receive waivers to not pay fees which they are not entitled to), there may be "undercoverage," in that many poor who should receive waivers do not because of the stringency of the application of the guidelines. It should be noted that several facilities have initiated their own efforts within the community and have had some success.

9. Conclusions and Recommendations

The review of the Tanzanian cost sharing program found several key points:

- Some poor are receiving free care under various exemption categories (characteristic targeting).
- The low levels of fees—especially for inpatient services—and the safeguards in the fee structure, mean that no patient is exposed to a catastrophic financial risk.
- Some poor people are not getting treated at government hospitals because they don't know that waivers are available.
- Some poor people are paying for treatment at government facilities when they should not be, because they don't know about waivers and staff don't want to publicize them.

Based on the analysis and comparison of the various mechanisms in use in Tanzania, the following conclusions and recommendations are provided for the government and providers.

9.1 Fee structures

Conclusions

All of the hospitals included in the study deliver services to low income groups. The prices at these facilities are below actual costs; hence, all patients, including the poor, benefit from the low prices. This is a form of characteristic targeting which benefits all patients and does not necessarily target the poor for receipt of essential services.

Recommendations

The fees should be reviewed by level of facility (referral, regional, or district hospital) and by location to recognize that ability to pay will differ by catchment area. The government may consider having fee schedules differentiated by location so fees are lower in poorer areas and districts than in richer ones.

The government may also consider adjusting future changes to the fee structure based on actual costs, but will have to review the mechanisms for protecting the poor and their effectiveness. Setting charges according to costs has already been considered for drugs, where it is proposed that the fee charged be half of the actual cost of each drug. This will generate more revenues to secure a better and constant drug supply, but may also cause greater hardship for the poor if there is no direct targeting mechanism to ensure they have access to essential drugs. This system will also increase the complexity of enforcing the fee schedule as the clerks and a staff will have to be familiar with a much longer list of fees.

9.2 Reporting system

Conclusions

The current system for reporting the number of waivers granted to the poor is not functioning. This lack of records makes it difficult for the Ministry to evaluate the exemption system for the poor on an on-going basis. The effectiveness and the cost of the exemption system cannot be known without such information.

Recommendations

Improved record keeping and monitoring of waivers and exemptions would provide baseline data to do regular desk audits of the system. In addition, periodic field evaluations may be needed to validate the monitoring system every two to four years. The frequency is hindered by the cost of such reviews, but they are essential to ensure that the Ministry is fully aware of how the system is functioning.

9.3 Information to communities and individuals

Conclusions

The surveys indicated that much of the information about waivers and exemptions is not known by those in the communities. There is a need to identify a practical means of having information provided to communities, such as through district health management officers and committees, and a means of monitoring what is being done. Many of those in exemption categories and those eligible for waivers are unaware of the existence of such programs. Many individuals are unaware of the exemption and waivers which are available to ensure that all have access to services, as shown in Tables 3 and 10 and Figure 8. Those who were aware of such mechanisms primarily learned of them through hospital staff or word of mouth from family, friends, or other patients.

Recommendations

Conduct a national public information campaign to advise the population on exemptions—especially for treatment of children under 5 years old and for MCH services—and about waivers for the poor. Information must be provided to the public and patients about the fee structure, automatic exemptions, and the availability of waivers for the poor. The information must also attempt to dissuade the non-poor from seeking waivers to pay less than they can afford. Improved communication and education of the public through the media, campaigns, posters at hospitals, and hospital staff are important if these protection mechanisms are to work properly. Adequate training for health staff is also required. Lack of funds had allowed training-of-trainers to train hospital staff in the user fee system in less than half of the regions.

9.4 Use of cost sharing revenues

Conclusions

It was found that many of the facilities are in such dire straits as to funding from the government that the revenues generated by cost sharing are being used as working capital and emergency funds for recurrent costs, such as petrol for vehicles. These uses simply fill in gaps from the government budget rather than provide improvements in quality and additional supplies and equipment for the hospitals. At some hospitals, patients had to pay the fee and then found that there were not adequate supplies or drugs needed for their treatment. Hence, patients often did not see that their user fees providing “value for money.”

Recommendations

If the cost sharing program is to be successful and acceptable to the public it must ensure that the revenues are used to provide improvements in quality and services so patients see an improved system, such as improved drug supply, new sheets for wards, and repaired diagnostic equipment. The monitoring and oversight in the use of cost sharing revenues must be strengthened.

9.5 Decentralized pricing

Conclusions

In principle, the fee schedule for the cost sharing program is established at the national level. In reality, many DDHs (mission hospitals) and some government hospitals are already adjusting the fee schedule to local conditions without prior approval by the Cost Sharing Implementation Unit.

Recommendations

Make a decision for decentralized pricing. Decentralization allows facilities to price services according to local conditions and ability to pay. The disadvantage is that it may cause disparities among regions or patients to shift.

If the decentralization of setting fee schedules is not acceptable, then the Ministry must reinstate the importance of standard pricing at the national level and be capable of enforcing the policy. The system for determining waivers should also be simple and decentralized in that it is not run by the central Ministry. Each local institution should determine the criteria it will apply in granting a waiver. In addition, it is the local institution's chief executive who has the authority to grant all waivers at that facility. Thus the system is not too bureaucratic nor administratively burdensome. The cost of administering the system remains low. It is useful to have a decentralized waiver system for determining guidelines and using the staff in applying them. These are key components for a continued successful system.

9.6 Policy guidelines

Conclusions

Some believe that because of the difficult financial situation of the government and the need for revenues for facilities to purchase necessary items to supplement their budget, waivers and exemptions should be eliminated to minimize confusion and maximize revenues. If exemptions were done away with, there would be a need for a stronger waiver system to protect the access of the poor to health facilities. Then the poor who need access to basic services would receive them regardless, while those who can afford to pay for essential services would pay and would not be exempted.

However, waivers are much more difficult to administer than exemptions. If waivers were eliminated, the system would need to ensure that the exemption categories are adequate to cover most of the poor. This would work to minimize costs only if the exemption groups covered most of those conditions or types of people who are predominantly poor. This is not likely to be the case, however. Hence, neither system can be completely done away with.

Recommendations

Guiding principles for the national cost sharing program relative to waivers need to be formalized so they are recognized and accepted by all as national policy. This would provide the basis for revisions to the system now and in the future. Below are an illustrative list of what some guiding principles might be:

- Ensure access to care.
- Maintain low cost to the facility of administration of waiver system.
- Leadership and institutional culture of ultimately existing to serve people is important to balance business and revenue interests with need to ensure all have reasonable access to health services.
- Keep decision-making decentralized (no national card system for poor or standard set of questions to determine eligibility).
- Minimize leakage, but not at the cost of freezing out the poor from access.
- Minimize loss of revenue through leakage (non-poor receiving waivers).

Such guiding principles would help set boundaries to continue to guide the refinement of the Tanzanian cost sharing program. For example, if only the first principle is followed there is the possibility that systems which are extremely difficult to administer might arise in the future. By having another principle, shown in the second statement, to maintain a balance of the various issues would ensure that extremely bureaucratic, complicated systems are not proposed to deal with access for the poor. These principles would have to be developed within the Tanzanian context so they are appropriate and acceptable, but would provide long-term stability to the concept of ensuring the poor have access to care in the midst of a national cost sharing program.

Appendices

Appendix A
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Appendix B

Cost Sharing Fees Established by the Ministry of Health

Cost Sharing Fees Established by the Ministry of Health

Rates Recommended By MOH, 1993/94

1. Payments for Fees for General Health Services

TYPE OF SERVICE	AMOUNT (Tsh)
Drugs for Outpatients (per item)	50
Medical examination	
Students	500
Workers - civil servants	1,500
Special diagnostic service	3,000
Workman's compensation	3,000
Medical Board (physically disabled)	10,000
Gate toll for vehicles	
Motor vehicles	100
Motorcycles	50
Bicycles	20
Mortuary services	
Post mortem	1,000
Storage (per day, after grace period)	200

2. Consultation Fee (Outpatient)

LEVEL OF SERVICE	GRADES I AND II	GRADE III
Referral hospital	500/=	300/=
Regional hospital	300/=	200/=
District hospital	200/=	150/=

3. Inpatient Hospitalization Fees

LEVEL OF SERVICE	WITHOUT FOOD OR DRUGS (per day)		INCLUDES DRUGS AND FOOD (for the whole period as inpatient)
	GRADE I	GRADE II	GRADE III
Hospital: Referral	2,000/=	1,000/=	500/=
Hospital: Regional	1,500/=	750/=	300/=
Hospital: District	1,000/=	500/=	150/=

4. Fees for Different Services for Grades I and II

TYPE OF SERVICE	AMOUNT (Tsh)
Diagnostic service:	
Laboratory services	(average) 1,000
Eye examination	1,000
Operation services:	
General surgery:	
Major	15,000
Minor	3,000
Eye surgery:	
Major	15,000
Minor	2,000
Ear/Nose/Throat surgery:	
Major	7,500
Minor	1,500
Orthopedic and trauma:	
Major	15,000
Minor	3,000
Neurosurgery:	
Major	40,000
Minor	10,000
Urology surgery:	
Major	8,000
Minor	3,000
Obstetrics/Gynecology:	
Major	15,000
Minor	4,000
Normal delivery:	
Referral Hospital	400
Regional Hospital	300
District Hospital	100

5. Fees for Foreigners

TYPE OF SERVICE	AMOUNT	
	(US \$)	(Tsh.)
Consultation fee (outpatient)	20	10,000
Appointment consultation	20	10,000
Admission per day fee	30	15,000
General diagnostic services	10	5,000
Special diagnostic services	50-200	30,000-100,000
Minor surgery	50	25,000
Major surgery	200-2,000	100,000-1,000,000
Storage of body (mortuary fee)	30	15,000
Post-mortem fee	100	50,000