

Small Applied  
Research No. 13

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**Health Financing  
Policy Reform in  
Tanzania: Payment  
Mechanisms for  
Poor and  
Vulnerable Groups  
in Korogwe District**

*May 2000*

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Partnerships  
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#### **Recommended Citation**

Mubyazi, G.M., J.J. Massaga, K.J. Njunwa K.Y. Mdira, F.M. Salum, M.S. Alilio, M.L. Kamugisha. May 2000. *Health Financing Policy Reform in Tanzania: Payment Mechanisms for Poor and Vulnerable Groups in Korogwe District*. Small Applied Research Report 13. Bethesda, MD: Partnerships for Health Reform Project, Abt Associates Inc.

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**Contract No.:** HRN-C-00-95-00024  
**Project No.:** 936-5974.13

**Submitted to:** Karen Cavanaugh, COTR  
Policy and Sector Reform Division  
Office of Health and Nutrition  
Center for Population, Health and Nutrition  
Bureau for Global Programs, Field Support and Research  
United States Agency for International Development

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# Abstract

This report describes a study of health care financing mechanisms appropriate for the poor and vulnerable groups, performed by the Amani Medical Research Center, Tanzania, under a grant from the small applied research program of the Partnerships for Health Reform. The study was carried out in Korogwe District and used malaria, a relatively endemic public disease in the district, as a tracer disease. Data was collected through qualitative and quantitative techniques, adopting structured and semistructured interview approaches. Multistage sampling method was adopted for selecting study villages and health facilities.

The study sampled households, exit patients, health personnel, central and local government officers, district health management team officers, traditional healers, shopkeepers, and religious leaders. More than 80 percent of the respondents perceived malaria as the major public disease, and some 70 percent said that modern health facilities are contacted for treatment. Nevertheless, self-medication using modern and local medicines and traditional healers were also found to be an important source of care. More than 60 percent of the respondents reported their willingness to pay for health care at public and/or private facilities provided they are assured of good service, although they preferred different modes of payments. Cash payment was generally preferred to in-kind payment, both by the health care providers and the consumers. Women depended on farm crop sales as a source of money for medical care payments more than men ( $p$ -value  $< 0.05$ ). Prepayment mechanisms were suggested as desirable for the poor who are not certain of a steady cash income. Waiver and exemption mechanisms seem to exist but the majority of the respondents had little knowledge of and faith in the way they were implemented, especially in the private sector.

The study concluded that, although residents and officials in Korogwe district find payment for health care in public and private health facilities acceptable, many are concerned about how much they need to pay, why they should pay, and which means of payment they can use. To enhance community participation in payment for health care, efforts are needed to educate and sensitize the population regarding the cost-recovery programs that exist. In addition, a desirable definition of who is "poor" should be put in place, and local people involved in judging who is eligible for waivers.

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# Acronyms

<b>CHF</b>	Community Health Fund
<b>DHMT</b>	District Health Management Team
<b>FGD</b>	Focus Group Discussion
<b>MOH</b>	Ministry of Health
<b>NIMR</b>	National Institute for Medical Research (Tanzania)
<b>PHR</b>	Partnerships for Health Reform
<b>TDR</b>	Special Program for Research and Training in Tropical Diseases
<b>Tsh</b>	Tanzanian Shilling
<b>UNICEF</b>	United Nations Children's Fund
<b>WHO</b>	World Health Organization

## Currency Conversion:

US\$ 1.00 = Tsh 800



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# Acknowledgments

This research project could not have been undertaken without funds. We are very thankful to the Partnerships for Health Reform (PHR), managed by Abt. Associates Inc. for issuing the grant for this purpose. We are also thankful to Jose Ravano, former PHR Small Applied Research (SAR) co-ordinator, who greatly facilitated our research project before he moved to other donor projects in Asia. Fortunately, his gap was filled by Whitney Schott. We highly enjoyed working with Whitney and feel our study could not have achieved most if not all of its predetermined objectives without her reasonable, flexible, timely, and effective co-ordination; follow-up; and advisory support. In addition, our heartfelt thanks are directed to Prof. Lynne Miller Franco for her very good and educating comments regarding the technical review of our research quarterly reports and our final research draft report. Unforgettable is Ellen Bobronnikov, whose financial management expertise in administering, reviewing, and advising on our project's quarterly financial reports allowed us to accomplish our research project's operations. Tracing our history from the period when the study proposal was submitted to Abt Associates, the authors wish to acknowledge communication with PHR director Nancy Pielemeier, and we thank all other Abt Associates staff in the United States who in one way or another contributed to our project's success.

We also acknowledge the National Institute for Medical Research (NIMR) on behalf of the Ministry of Health in Tanzania for the review of our research proposal and granting us ethical clearance that was necessary for this study to be conducted. Mr. Phares G.M. Mujinja provided our research team with useful economic advice relating to the design of our study, and he is thanked for that. Many thanks to Mr. Deogratias Shayo who assisted us in the design of the database into which the data collected from our survey were entered. Our appreciation is also to the scientific research input contributed by Mr. William J. Kisoka and Mr. Prince-Pius Mutalemwa during our research instruments development and who temporarily participated in the data collection process during the pilot and early actual fieldwork in the study. Some data collection activities performed by field assistants—Mr. Aza, G. Kimambo, Mr. K.N. Kanali and Miss Caritas Alphonse—who were able to cope with the trials of fieldwork and who were highly committed to the research are commendable. Also, thanks to Dorica G.M. Mubyazi who gave her time to work with the field manager in various data management activities such as in the arrangement and storage of the research instruments, also in the data entry process and in typing this report. She was very punctual and efficient. Mr. Hamza Mohamed, the driver of the car we used in the project is also acknowledged for his careful and safe driving.

Mrs. B. Rubben, NIMR office secretary, Mr. R.T. Rwegoshora, and Dr. Dan Meyrowitsch are greatly thanked for assisting us in e-mail and fax communications with Abt Associates.

Our gratitude to Dr. M.N. Malecela, the director for Research and Training in the NIMR and Mrs. J.Ikingura on behalf of the NIMR Editorial Secretariat for their support to us on the acquisition of the ethical clearance for this research project. Mr. E.C. Kaitira, the NIMR chief accountant, and his assistants, Mr. Ngao, Mrs. Basheka, and Mr. Kapufi; Mr. FCM Keiya, accountant, and Mr. D.T. Mafie, administrative officer at the Amani Medical Research Center, are thanked for their assistance on this study.

We also sincerely thank the district commissioner and all members of the Korogwe district council. Others greatly thanked include Dr. J.S. Kimey, the Korogwe district medical officer, Mr.

Mwabutu, district government hospital secretary, Dr. Almasi, the medical-officer-in-charge at the district government hospital, Mr. Gervas R. Msuya, who assisted us in the review of the laboratory data relating to malaria patient diagnoses, all officers in charge of the private health facilities surveyed, members of the District Health Management Team, and all individual respondents whose names could not be listed in this report. They are thanked for their consent and kindness to co-operate with our research team.

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# Executive Summary

Even before the 1978 Alma-Ata Declaration, some countries in sub-Saharan Africa were making efforts to ensure greater coverage and equitable access to primary health care to their populations. Tanzania is a good example of such countries: according to the available records, 93-95 percent of its people live within 10 kilometres of a health facility (Abel Smith 1992; Gilson 1995; Newbrander and Sacca 1996; Wyss *et al.* 1996; Ministry of Health [MOH] 1997). In pursuit of achieving equitable access to essential (primary) health care among its citizens, the Tanzanian government provided medical care free of charge to all of its citizens who attended at formal government health facilities (MOH 1996). In 1997 private for-profit medical practice was banned in pursuit of favouring the perceived poor majority and in conformity to the ideology of “socialism and self-reliance” that was launched by the Arusha Declaration of 1967. As it was before the country’s independence, mission health facilities continued to operate as supplementary health care service providers to the government but these have been charging their patient clients, and sometimes they got subsidies from the government (Munishi 1997). With a broader view of improving people’s socioeconomic conditions including health, a free of charge universal primary education was provided whereby all populations were encouraged and offered a chance to join and complete at least seven years of primary school or adult education. The late Mwalimu Julius Kambarage Nyerere, the first president of Tanzania in his socialism and self-reliance related ideological speeches often remarked that, Tanzania is facing three major enemies against her development, “*Illiteracy, illnesses/diseases and poverty*”. This philosophy or conviction is still persisting in the minds of the majority of Tanzanian politicians and the general public alike. Considering the economy and health situations of Tanzania for the last three decades, we may say that there are some truth in such a belief. Also, literature-based evidence that poverty and ill-health are interrelated exist (e.g. Gilson and Mills 1995; Barker 1992).

The health sector in Tanzania has faced budget shortages for many years (Ilomo 1989). Statistics indicate that the Tanzanian economy has not performed well since the 1970s. The government continued to finance and provide medical care free of charge to its citizens despite an inadequate revenue base, which made financing the health sector a major challenge. Underfunding at all levels in the health sector contributed to shortages of drugs and medical supplies, deterioration of the physical infrastructure, and low staff morale (MOH 1997a). The increasingly poor economic performance, change in disease pattern, and escalating cost of disease management ultimately made it difficult for the government to provide medical services free of charge to all citizens (Munishi 1997; MOH 1996). The private for-profit medical practice that was banned in 1977 was legally reinstated to operate under the new economic recovery/trade liberalization programs (MOH 1997a; Munishi 1997). Under its cost-sharing strategy, in July 1993 the government started a phased implementation of user fees for certain health care services that had previously been provided free of charge to citizens in its referral, regional and district hospitals. To ensure that the poorest were not barred from using government hospital care because of their inability to pay the existing fee rates, the Ministry of Health developed waiver and exemption guidelines (Newbrander and Sacca 1996; Mmbuji *et al.* 1996).

In consideration of policy advocacy/advice from the World Bank, UNICEF, and other international organizations, health care financing mechanisms alternative to user fees were established by the Tanzanian government, the implementation of which was planned to take place in phases. These include the community health fund (CHF) and national (compulsory) health insurance scheme. All these were aimed at ensuring that communities participate in contributing to the cost of provision of some of the health care services they sought at government health facilities through

direct and /or indirect risk pooling mechanisms (MOH 1994; MOH 1997a). While the CHF is primarily intended to benefit the majority of the informal sector (e.g., the self-employed), the national health insurance is targeted to formal employees (e.g. civil servants) and some of their dependants (MOH 1997a and b). Under the CHF and national health insurance scheme, payment contributions for health care by the members have to be made in advance (prepayment) of their facing health problems.

The need to strengthen community support mechanisms for those without income access to services and developing payment mechanisms compatible with seasonal income patterns is among the policy advocacy of the Bamako Initiative (Hunson and McPake 1993). As other literature verifies, alternative community health care financing mechanisms, such as in-kind payments, have increasingly been advocated and discussed in the previous and contemporary research and policy debates. Even if the Tanzanian Ministry of Health has not yet formally institutionalized them in the public health sector the thinking and debate about such mechanisms continue among Tanzanians. The important questions at the moment are which in-kind mechanisms are feasible, and when, where, and how to implement them.

In addition to the Tanzanian case, empirical evidence from studies in other countries indicates that the poorest are at the greatest disadvantage in a health care system that charges out-of-pocket fees, and the problems seem to be more intense if the system has not been in place before. As found in various microeconomic texts, the economic theory of demand identifies the disposable income of an individual or household as one of the most important factors that influence their consumption of health care. In light of this, the Tanzanian government, like many others, developed waiver and exemption guidelines as a means for protecting the poorest and vulnerable population groups from barriers of charging to health care utilization. While the vulnerable (Newbrander and Sacca 1996; Mubyazi 1998 and 1999) can be easily identified on medical examination basis, the question of identifying the poorest among a large community regarded as poor, in order for them to be exempted from fees has remained a critical issue in Tanzania.

Between April 1999 and April 2000, a cross-sectional survey was undertaken in Korogwe district in northeastern Tanzania to assess the existing health situation, the current and the preferred health financing mechanisms, and their implications on people's health care seeking behavior, especially of the poor and vulnerable groups.

Quantitative and qualitative data collection methods were used. Data was collected using semistructured questionnaires, focus group discussions, in-depth interviews, documentary review, and investigators' observations.

Overall, the study covered 30 villages in which 451 heads of households or their representatives were interviewed and in which 24 focus group discussions with at least six participants in each were conducted. Also one district government hospital, five private for-profit and five private not-for-profit (mission) health facilities were surveyed with 40 exit patients interviewed at each; in total 442 exit patients were interviewed. In addition, 44 private health staff and six government hospital staff, 39 local community leaders, 29 local government tax revenue officers, and 17 traditional healers were covered by the study. Others interviewed were retail antimalarial drug sellers at private pharmacies, ordinary shops, and kiosks, six members of the district management team (DHMT) and five district-level officers working in the district central and/or local government administration (particularly in the district local government council). A review of the district hospital daily-routine files and other books was also made.

The upper limit of the percentage referred to in this report being 100 percent, the analysis of the data collected shows that malaria was generally reported by over 80 percent of respondents as being

the major disease facing the communities in the areas surveyed. Ninety-seven percent of exit patients/escorts reported to usually seek for health care from modern health facilities when they face various health problems. In addition to these, 72 percent of focus group participants, 97 percent of local community leaders, and more than 50 percent of private health facility health staff reported that the majority of the population seek for care from modern (formal) health facilities, and the rest from retail drugs sources (72 percent) and local medicines (83 percent). A similar answer was obtained from retail drug sellers, of which 100 percent reported mentioned modern health facilities and 75 percent mentioned retail drug sources. However, all the interviewed reported that alternative measures such as self-medication using local plants and traditional healers are taken as well. Traditional medicines were also mentioned to have been used for the treatment of several other individual or community health problems. Witchcraft was perceived to be a result of jealousy and spiritual powers of some people over others and that it was intended to retard their progress.

Also, data indicate that 78 percent of heads of household respondents, 79.2 percent of focus group discussion participants, 100 percent local community leaders and 100 percent of the traditional healers interviewed were aware of the existence of the government health care cost-sharing policy and its implementation in the public health sector. Nevertheless, only 17 percent of the focus group participants and 44 percent of household interviewees knew why the policy had been introduced. But 100 percent of the health staff interviewed at the district government hospital and at private health facilities seemed to be knowledgeable about the reasons for such a policy. One of the cross-tabulated data found that this knowledge was greater among the household respondents who had completed higher classes in school than those who had completed lower classes. This difference in knowledge was statistically significant ( $p\text{-value} < 0.05$ )

Most of the respondents who were aware of cost-sharing policy implementation in the public health sector reported to have obtained information through Radio Tanzania announcements, direct communication with health staff and reading posters at the district government hospital, newspapers (not specifically pointed out), and local public political meetings. The cross-tabulation of the data on respondents' gender category and their knowledge about waiver and exemption mechanisms indicated that men had a greater chance/probability than women of being aware of waiver and exemption mechanisms, and this difference was statistically significant ( $p\text{-value} < 0.05$ ). The possible factors attributing to this are discussed in detail in this document.

Seventy-five percent of focus group participants and 72 percent local community leaders interviewed expressed their support of the government's decision to establish a cost-sharing policy in the public health sector. All six DHMT members (100 percent) and all five other district-level government officers (100 percent) interviewed expressed a similar positive attitude. In addition, 52 percent of households, 80 percent of district government hospital staff, 77 percent of traditional healers, and 100 percent of the private health staff were in favor of the policy. About 83 percent of heads of households expressed willingness to pay for health care provided at public and/or private health facilities. Other (though relatively fewer) interviewees in each of the categories mentioned were of the view that the government's decision was inappropriate because many people cannot afford to pay due to poor economic conditions.

The majority of the respondents (>50 percent) reported to participate in small-scale farming as the main economic activity. The mean household's monthly income was 42,887 Tanzanian shillings (Tsh) (US\$ 55), and median income was Tsh 19, 852 Tanzanian shillings (US\$ 26). Note, however, that this income is just an estimate, as it does not imply in actual sense that households earn this amount of income promptly and in cash terms. Also, evidence shows that people sometimes hesitate stating their actual earnings because of the fear of being taxed by government tax authorities (Ensor and Whitter 1997).

The cross-tabulation of data on patients' gender and reported sources of money used to pay for health care indicated that there was a significant statistical difference between male and female respondents in their alternative ways of access to cash. With regard to this issue, the selling of farm crops was proportionately a more reliable source of money for women than men (*p-value* < 0.05). Similarly, proportionately more males than females seemed to have used money from their personal savings.

The interviews concerning community awareness of health care fee waivers and exemptions for the poor and vulnerable found that 72 percent of the local community leaders felt that most of the residents in the study villages were not aware of waivers. Ten percent opined that only a few residents were aware while 18 percent were of the opinion that all the residents in the study villages were aware. However, 100 percent of the community leaders interviewed were personally aware. Sixty-one percent of the exit patients interviewed were uncertain of whether the exemption policy existed while 16 percent were not been completely aware. In contrast, government hospital staff, DHMT officers and other district-level officers said that most of the residents in Korogwe district were aware of user fees in public hospitals and of waivers and exemptions. Local community leaders regarded the poor as being mainly those who cannot work to raise money for their personal and/or family because of their poor physical health (e.g., disabled people), age (e.g., the very elderly or young children), or for other reasons. Waivers and exemptions seemed to be less commonly practiced by the private health care providers (especially for-profit providers) as 50 percent reported to have not used such mechanisms at their health facilities, 20 percent were uncertain whether the mechanisms existed, and 30 percent reported to have used them. On the other hand, 83 percent of health staff interviewed at private not-for-profit health facilities reported that the mechanisms existed in practice at their health facilities. There was a mixture of views regarding whether malaria patients deserve to be exempted from health care charges. Nevertheless, the majority of the key district-level officers opposed the idea while the majority of local community leaders supported the idea.

Concerning community assessment of the impact of user fees on the quality of care at the Korogwe district government hospital, 13 percent of patients interviewed perceived that quality increased for only some services, 21 percent perceived quality decreased in all the services, and 41 percent perceived that quality increased on all the services. Eight percent of all the exit patient interviewees said that they could not make any comparison between the period prior to and after user fee introduction. Eighty-three percent of district government health staff, 80 percent of other district-level officers, and 100 percent of DHMT members perceived that user fees had been accompanied by improved quality of care for at the Korogwe district hospital. Low quality of care was perceived in terms of inadequate drug availability, inadequate facilities for patient admissions such as beds, and inadequate patient-provider interaction/communication; this was also found in recent health facility surveys in other regions in Tanzania (Mmbuji *et al.* 1996; Msamaga *et al.* 1996).

Cash was the most preferred means of payment for health care by all (100 percent) of the health staff interviewed at both public and private health facilities and the majority of health care users. In-kind payment mechanisms such as cash crops, animal products, and casual labor were also but less frequently suggested as alternative means for those who lack cash. The mechanisms were suggested proportionately more by the users than by the providers of health care. However, the majority of the users (community members), including those who suggested them, were doubtful about the viability of such in-kind payment mechanisms. Their doubts were about the ease of in-kind payments. To most of the health staff and district-level health managers interviewed, doubt was on the ease of collection and the amount that could be charged per patient case and per attendance at a health facility.

In addition to other results and analyses, several recommendations for policy action are hereby presented. Some are strictly applicable to Korogwe district; others are directed to the Ministry of

Health for consideration of applicability to other districts in Tanzania. Other readers of this report may use it to reflect what is or can/could be the case in their own country contexts:

- > More public campaigns are essential to educate communities on objectives and structure of cost recovery programs in the public health sector. This could be done through mass media, posters, local public meetings, and health staff especially while patients are waiting for the services so that for those who did not know in advance of their attendance to hospital, they could prepare to pay during their later trips to hospital.
- > Involving local community residents in the design and establishment of low-cost prepayment schemes could reduce the risk of communities running bankrupt during the time they are in need of essential health care.
- > Offering loan agreements to people who fail to pay promptly would increase coverage of the poor even if the scale of the application of this payment system might be limited and might vary by type of health facility organization. The follow-up of claims from the indebted could effectively be done if there is strong cooperation among health facility administration, village health workers, and local government leaders in the areas where the indebted patients reside.
- > It is essential to involve local community leaders in the identification of poor individuals eligible for payment waivers.
- > There are ways to avoid abuse of the waiver system in order to ensure public confidence in the existing formal financing system. Any decision as to who is eligible for a waiver should involve more than one local leader or community representative. Also, periodically the rest of the community members should be given feedback about those who have been waived of or exempted from fees.
- > Ensuring quality care, especially an adequate supply of essential drugs, patient bed services, patient–health staff communication, and minimal patient waiting time at health facilities would enhance community’s willingness to pay, attendance, and actual payment for health care even in public health facilities.
- > Educating and regularly reminding people to work hard and have a habit of making personal/family savings regardless of their incomes would have—even if with long-term implications—a contribution towards enhancing most people’s ability to pay for health care.

Bringing health facilities closer to the people would not only increase the geographical coverage and equity of access to health care facilities to residents, but also might reduce some extra cost people incur by paying for transport to and from seeking for health care. In some areas the introduction of mobile clinics would be helpful in reaching poor people living very far from modern health facilities.



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# 1. Introduction

This report presents data, results, and policy recommendations of a small applied research project concerning current and proposed health care financing mechanisms in Tanzania using Korogwe district in the northeast of the country as a case study. The cross-sectional research was conducted between April 1999 and April 2000. More specifically, the study looked at the existing mechanisms of payment for health care poor and vulnerable groups delivered in private and public health facilities. In addition, it assessed alternative mechanisms of payment for health care suggested by and acceptable to either the health care users or the health care providers or both.

Malaria was used as a tracer disease for the study of community health care seeking behavior because of its relatively dominant public health importance. Information was collected through various types of interviews and review of health facility day-to-day routine service records. The views presented in this report may be useful not only in Korogwe district but also elsewhere in Tanzania where the community is the target of district health management and health care delivery programs. In addition other communities within and outside Tanzania may learn from this experience.

Some of the questions asked in this study are the following: What do communities perceive to be major health problems and where do they mostly seek for care when they suffer from malaria and other illnesses or diseases? To what extent are communities aware of the public health care cost-sharing policy? Are people willing to pay for health care at public (government) health facilities? To whom are the user fees implemented at district hospitals not affordable? How do providers and users rate the quality of care provided at a district public hospital following user fees implementation in comparison with the period before hand? Are there any means of payment for health care acceptable to both the users and providers of health care as an alternative to payment by money (cash) terms; if so, which ones and, if not so, why? If cash is preferred to other means of payments, in which way do communities wish to pay for their health care needs; do they prefer prompt payment at the service delivery points or by installment or through various lending/borrowing mechanisms? How do communities perceive poverty and who is regarded as being the poorest among the many residents who might be considered generally poor? How far in theory and in practice are the people in Korogwe district familiar with mechanisms for protecting the poor and vulnerable population groups against user charge barriers of access to primary health care; and how effective and equitable have such mechanisms been; and what do communities suggest that should be done to improve the cost sharing implementation?



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## 2. Background to Health Sector Reform in Tanzania

Although to many people in the developing world the term “health sector reform” may sound like a new policy or ideological terminology, its process and practice in Tanzania are historical. A few years after the country had gained political independence from colonialism, the Tanzanian government launched the Arusha Declaration in 1967. Under this declaration, all major social and economic sectors were nationalized. In relation to health, one of the purposes of the Arusha Declaration was to ensure universal access to social services to all the citizens, the majority of whom were (as they still are) poor and rural. The people regarded as being poor were those who could hardly pay for their essential needs, such as health and education. The Arusha Declaration was followed by the Decentralization Act of 1972. This was aimed, among other objectives, at building regional, district and village capacity to effectively participate in decision making, planning and implementing activities for their own development, health in particular (Mills et al. 1990; Gilson et al. 1994). The government banned the private for-profit medical practice in 1977 and continued to finance and provide health services free of charge to all citizens seeking care from government health facilities. However, mission health facilities continued to operate as private not-for-profit organizations by charging their patient clients, as they had been doing even before independence (Newbrander and Sacca 1996; Msamaga et al. 1996; Ministry of Health [MOH] 1997). Due to poor national economic performance, escalating costs of public health care service provision, emergence of pandemic diseases such as HIV/AIDS and changes in patterns of other diseases, the government’s ability to continue providing free health services to all citizens decreased. Consequently, establishing other resource bases for financing health services was viewed as a means of improving the availability and quality of health care delivered in the country (MOH, 1994, 1996), as is also advocated elsewhere in the world (World Bank 1993; Shaw and Ainsworth 1996).

In July 1993 a cost-sharing policy was launched in the Tanzanian public health sector. User fees began to be implemented in phases at referral, regional, and district hospitals for some services that had previously provided free of charge (Newbrander and Sacca 1996; Mmbuji et al. 1996). According to the government’s health sector reform policy agenda, cost-sharing was planned to be extended to health center and dispensary levels so that communities would participate in financing their health care needs through formal and informal risk pooling mechanisms (MOH 1994, 1996).

The inadequate performance of primary health care delivery systems in Tanzania, like many other sub-Saharan African countries is a critical issue in contemporary health sector reform strategies, research, and policy debates. The key question is, what changes are necessary at the organizational and process or functional levels of the health sector in order to enhance the performance of the primary health care provision within the districts under decentralized hierarchies. There has also been concern about the contents and direction health sector reforms should take, the level to which they should extend (national, district, or village level), who will benefit from reform, and whether the primary health care guidelines developed by the World Health Organization (WHO) will be effectively and successfully implemented, taking into consideration the capacity of management at various levels in the health sector.

The primary goal of the Tanzanian health sector reform is to improve the population’s health through better health sector planning and management that would consequently contribute to a

reduction in the government's health budgetary constraints (Mwisongo et al. 2000). Despite several previous studies, little information is available concerning the real impacts or implications of the recent and current health sector reform strategies on the health conditions of the population. In any health system, the poor and high health risk groups are the most likely or sensitive groups disadvantaged by interventions that “touch” their health in any way.

Following the introduction of user fees at public health facilities in Tanzania, several studies were conducted to assess the impact of such fees on people's health seeking behavior, including their utilization of alternative health facilities (private and public). Some of the studies attempted to look at the impact that the introduction of fees in public/government health facilities had on the private health care utilization by the communities in the catchment areas (see also studies by Wyss et al. 1996; Msamaga et al. 1996; Munishi 1997). Notwithstanding variations in the results and discussions presented, the studies justify what is already reported from other studies in developing countries—that user charges have some deterrent effects on health care seeking behavior of the poor population groups. Unfortunately in Tanzania, none of the previous studies had looked at and reported on the impact of health care charges on patients suffering from specific illnesses, such as malaria, which is endemic in many areas but is not currently exempted from fee charges. According to the WHO, there is an increasing research and policy concern in sub-Saharan Africa that some malaria patients might need to be considered for exemptions from user fee payments (World Bank, United Nations Development Fund, Tropical Disease Research 1997).

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### 3. Rationale for Assessing Non-Cash Health Care Financing Options in Tanzania

According to the literature, populations living in different epidemiological, cultural, and socioeconomic settings are likely to have different preferences of health providers, different willingness and ability to pay for basic needs, and different utilization of basic and non-basic services. This is a very important point to be considered by decision makers in any social sector such as education and health. The health care sectors in several sub-Saharan African countries have traditionally used alternative options or mechanisms of payment; some have been introduced in recent years and others are still being considered as part of the strategies for reforming their health care financing policies. As was described above, Tanzania has been implementing patient user fees in government hospitals and private health facilities since 1993, and mission health facilities are reported to have been charging patients since before independence in 1961. Some researchers have found that mission health care providers sometimes accept in-kind (non-monetary) payment, such as casual labor, from patients who cannot promptly pay in cash (Mujinja and Hausmann 1997). Even if such mission providers have succeeded in mobilizing such in-kind payments, the key questions arising are (i) what kind of in-kind payments are preferred (ii) how and to what extent have they been used in Korogwe district? (iii) to what extent do communities who are the users, and health facility owners or staff who provide services, accept such payment mechanisms? (iv) how do the communities in this study distinguish the poor—from the poorest to the less poor, and from the rich—and how do they suggest the poorest could be protected from health care charges? (v) what were peoples' attitudes towards the government policy to charge for publicly provided health care, and what did they suggest as an alternative or should have been done instead? These are among the key questions this study was designed to answer. The study obtained ethical clearance by the National Institute for Medical Research on behalf of the Tanzanian Ministry of Health before it started to be implemented.

Readers may ask why the study assessed alternative means or mechanisms of payment for health care employed or preferred, and the ways these means or mechanisms would be implemented. It is because findings may be useful not only to those with academic interests, but also to decision makers at various levels in the health care system, particularly those who have little opportunity to read up-to-date research reports and publications relating to health care financing policy reforms in Tanzania. It is anticipated that the recommendations made in this report may be used to effect changes at various levels in the health sector in Tanzania.

So that readers better understand the study findings, the rest of this section describes the roots of the current formal health care financing policy and the proposed health care financing options in Tanzania.

In its “agenda for reform” policy initiated in 1987, the World Bank advised African and other developing countries to establish alternative payment mechanisms in order to increase accessibility, efficiency, equity, and effectiveness in their health care delivery systems (Green 1992; World Bank 1993). This advice originates from an economic hypothesis (sometimes empirically verified) that user fees paid in cash deter utilization of health care by the lowest-income population groups.

Following UNICEF's Bamako Initiative of 1988, various countries in Africa and the rest of the developing world started to establish alternative community financing mechanisms in their health care systems (Green 1992). In Tanzania, the most popular and traditional mechanism of payment has been user fees paid directly by patients at public and private health facility counters. Although at public/government hospitals they were introduced in recent years, evidence that user fees having some negative impact on patient attendance at public hospitals in Tanzania has increasingly been documented as will be cited later in this report. Other mechanisms considered include drug revolving funds, community health funds (CHFs), and health insurance schemes. CHFs had been advocated as a prepayment mechanism and alternative to user fees particularly for those living in rural areas and who might face difficulty in paying cash for health care services at the point of delivery. The Tanzanian government, with assistance from the World Bank, established a community health fund scheme that was piloted in several districts (Korogwe exclusive) in the country. The annual membership fee for the people who voluntarily join such a scheme is 10,000 Tanzanian shillings (Tsh) per member. However, the government and the World Bank subsidize this by contributing Tsh 5,000 for each citizen who becomes a member of the CHF scheme; members contribute the remaining Tsh 5,000. This entitles them to receive the scheme-defined package of medical care free of additional charge. The government is in the final arrangements to start implementing a national health insurance scheme for civil servants and some of their dependants (MOH 1996; MOH 1997b). This is a typical compulsory health care prepayment system under which civil servants who, according to the existing statutory requirements, automatically become members and are obliged to contribute a certain premium through their payroll salaries; the government contributes an equal amount for each member. All these schemes (direct fee for service, prepaid CHF and national health insurance) are formal mechanisms intended to involve communities in financing their health care needs, which consequently are envisioned to enhance efficiency, coverage, and equity of the existing health care delivery systems. In the public sector context, the new payment mechanisms established would contribute towards reducing the government's burden of being the sole provider and financier of public health services.

Non-monetary means of payment (payment in kind) proposed by some Tanzanians include farm crops, casual labor, animal products, and other household property, depending on what the persons concerned would wish to dispose. In Tanzania, for example, it had been reported that some mission health facilities have accepted in-kind payment from poor people, particularly those who claimed and seemed to have no ability to afford the cost of their medical care needs by paying in cash terms. Other poor have been given piece of work (casual labor) estimated to be equivalent to the cost of care they had been provided (Mujinja and Hausmann 1997).

There are those who strictly prefer payment in monetary terms to non-monetary payments but suggest that such cash payments be made by installment by those with low ability to pay. The idea behind this suggestion is that, if people who face difficulties in paying the full charge of their health care needs in money terms were allowed to pay by installment, few people would complain of not affording fees on medical services.

This background has tried to show readers why study researchers attempted to study population's perceived alternative mechanisms of payments for health care for poor and vulnerable groups in Korogwe district. Their interest was on means or mechanisms of payment for health care that were perceived to be feasible (affordable) and desirable both by the providers and users of health care, and that are viable (effectively put into practice). These views or opinions were collected from respondents who were able to suggest alternative payment mechanisms.

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## 4. Study Objectives

The main objective of the study was to assess the means/mechanism(s) of payment that could enable the poor and vulnerable population groups in Korogwe district to meet the cost of essential their health care needs in relation to on malaria.

Specifically, the study was aimed at assessing the following:

- > Community knowledge, attitudes, beliefs and practices (KABP) towards cost-sharing policy in the public health sector, particular focus being on user fees implemented at the Korogwe district government hospital
- > Means and/or mechanism(s) for payment for health care preferred by the study populations
- > Socioeconomic status of the study populations
- > Comparative cost of malaria case management between public and private health facilities and its implication on people's health care seeking behavior in relation to malaria

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### 4.1 Study Methodology

#### 4.1.1 Study Area and Population

This study was undertaken in Korogwe district in Tanga region in northeastern Tanzania. Rainfall there ranges from 800 mm to 1000 mm per annum. The annual temperatures range from 24 to 26 degrees celsius. National demographic statistics in 1988 showed the district had a population of 218, 810.

The main economic activity in the district is small-scale farming. The main cash crop is sisal. Other crops that families grow primarily for food but some of which are sold for the purpose of raising cash to pay for other needs include rice, maize, bananas and beans. Supplementary to this is retail trading/business. A few people are employed in the private and public sectors.

The main indigenous groups are the Wasambaa, Wabondei, Wapare, and Wazigua tribes. There is a considerable number of immigrants from other countries, especially from Rwanda and Burundi, some of whom, or whose grandparents, came as migrant laborers to work in sisal plantations and were subsequently granted permanent national residence permits.

According to the district's health profile, there are 51 formal health facilities. Malaria is the major cause of clinical attendance, admissions and deaths. Other significant diseases include measles, schistosomiasis, acute respiratory illnesses, cholera, typhoid, pneumonia, scabies, and filariasis.

## 4.1.2 Sampling Methods and Sample Sizes

The choice of the sampling approach depended on the variables that were to be studied such as people who were to be interviewed and for which type of information needed.

### 4.1.2.1 Research Methodology

In order to reach the required 30 study villages and health facilities, a multistage sampling method was adopted (Table 1). First, the district's divisions were identified using the available maps obtained from the district planning office. Then, from each division, one or two wards were selected from which a simple random sample of two villages was obtained. The study covered all the district's divisions except one and attempted to include some villages and health facilities located in urban areas and some located in rural areas. From each of the selected study villages, a simple random sampling method was applied to identify the study households. From each household selected, one head or a representative of the head of household was interviewed. During the selection of study areas, consideration was made.

**Table 1. Data Collection Methods and Sampling**

Data Collection Methods	Unit of Analysis	Sample Size and Selection	Sampling Approach
Semi-structured interviews	Households in communities	451 randomly selected heads of households in 30 villages	Multistage sampling
Semi-structured interviews with health care providers	Staff at government, not-for-profit and private facilities, administrators, pharmacists, and cashiers	44 staff at private health facilities (12 at not-for-profit and 32 at the for-profit), and 6 staff from the government hospital  20 retail drug antimalarial drug shops	Purposive sampling of 1 district hospital, 3 not-for-profit, 1 voluntary (non-mission) facility, and 5 private for-profit health facilities  Deviant sampling of health staff  Convenient sampling
In-depth interviews with key informants	Community leaders (village chairpersons, village executive officers, religious leaders, teachers, and traditional healers)	39 key informants	Deviant sampling
In-depth interviews with key informants	District medical officer, district nursing officer, district cold chain coordinator, district maternal/child health coordinator, district government hospital medical officer in charge, district government hospital secretary	6 district health management team members	Deviant sampling

	District commissioner, district executive director, district treasurer, district planning officer, district administrative secretary	5 other district-level government officers	Deviant sampling
Focus-group discussions in villages	Women of childbearing age, male youths, elderly people	24 focus group discussions	Purposive sampling in 8 villages (4 from rural and 4 from peri-urban ) settings
Exit interviews with malaria patients	Malaria patients at government, not-for-profit, and private for-profit health facilities	442 exit patients at 11 health facilities : 1 district hospital, 3 not-for-profit, 1 voluntary and 6 private for-profit facilities	Purposive and convenient sampling of health facilities
Document review	Government, non-profit and private facilities	11 health facilities: 1 district hospital, 3 not-for-profit, 1 voluntary and 6 private for-profit facilities Sampling of facilities based on what was available in the study sites	Deviant sampling

Village government leaders assisted in the mobilization of village participants for focus group discussions (FGDs). Overall, 261 village residents participated in the FGDs. The villages in which these discussions were conducted are mentioned in the appendix section of this report. Participants included men age 35 years and above (referred to in this report as senior adults), men between 18 and 34 years (referred to in this report as junior adults or young men), and women. Most female participants were married. Those who were not yet married but had reached a childbearing age of 15 years, who had already completed seven years of primary school, and who could confidently participate in the group discussions were invited to participate. Each group was interviewed independently to allow for more freedom of expression among participants in relation to the questions posed. The analysis presented in this report with regard to FGDs is based on the data obtained from eight groups of women, eight groups of senior adult men and eight groups of junior adult men.

The study intended to interview one retail antimalarial drug source from each study village but unfortunately in some villages there was none. Therefore, a convenient sampling method was adopted, including in the sample only retail drug sellers who were available in the study sites.

The selection of health facilities for the study was both purposive and convenient: purposive, because researchers were interested in studying private health facilities and only one public (Korogwe) hospital where user fees were implemented; convenient, because the distribution of private health facilities was not even in the selected study sites. The district government hospital was selected as a reference point in the assessment of aspects relating to cost-sharing policy in the public health sector. At each private health facility surveyed, several health staff responsible for day-to-day patient cases were selected using a deviant sampling method. The health staff targeted included: nurses, medical officers, cashiers or account officer (responsible for collection of patient payments), and pharmacists. Researchers had planned to do exit interviews with 40 patients (most of them outpatients) at each health facility surveyed, but in the end interviewed 442 patients, i.e., two extra interviewees. In primary-level health facilities, a rural medical aide or assistant clinical officers were interviewed instead of medical doctors who normally are not employed to work at such a level. Some of the health facilities, such as the private for-profit dispensaries and health centers, were still in

infancy of their operation since they had been established recently following reintroduction of private for profit medical practice made in the early 1990s. Therefore only those health staff who were found at the health facilities at the time of interview were interviewed.

Some of the district health management team (DHMT) members are professional health staff who also deal with patients in the district government hospital. Thus, those were not included in the interview with other hospital staff to avoid double interviews of the same individual.

The most important questions in each of interview are explained in detail below.

#### 4.1.2.2 Household Survey

The survey asked heads of households about major community health problems in their own villages, where people often sought for care when they suffered from malaria and/or other diseases or major injuries, and about the poorest residents who could not afford the cost of their treatment from various health care providers. It also asked whether the heads of households themselves or their fellow village residents knew of the existence of user fees at the Korogwe district public hospital. Their attitudes and suggestions towards such a fee policy were also assessed. In addition, they were asked about their views on whether or not waiver and exemption mechanisms had been implemented in their district and how effective the mechanisms were in protecting the poor from payment barriers to modern health care access. Other aspects investigated were their perception of the quality of care provided in the Korogwe hospital following the introduction of user fees, if they personally felt that there was a lack of quality, and what they themselves suggested could be done to improve the implementation of such fees. Also, they were asked to express their opinions concerning the means and/or mechanisms of payment for health care they personally would prefer if they were given an opportunity of paying for their health care needs in the way they liked. The focus was on alternative payment mechanisms such as payment in cash at the health provider’s counter (i.e., paying at the point of service delivery), payment in cash in advance of facing health problems (*prepayment*), and payment in non-monetary items (*in-kind payments*) such as farm crops, animal products, casual labor or other personal/household property. Households’ socioeconomic status was assessed considering their background characteristics such as family size, education, monthly income, and sex distributions (Table 2).

**Table 2. Socioeconomic Characteristics of Household Respondents**

Characteristic	Frequency (% of the respondents) N = 451
<b>Sex</b>	
Males	65%
Female	35%
<b>Education</b>	
No formal schooling	11.4%
7 years of primary school	78.1%
“O”-level secondary school	8.5%
Higher than form four	2%
<b>Occupation</b>	
Small-scale farming	84.8%
Formal employees	6.5%
Petty business	4.5%
Artisan	2.9%
No specific employment	1.3%

### 4.1.2.3 Health Facility Survey

At each of the 11 health facilities surveyed, the following aspects were studied.

#### *Interviews with Exit Patients/Escorts*

Exit patients interviewed include those who had already contacted a health provider and who were leaving the health facility. Escorts include adult people/relatives who accompanied patients to the health facility. Most escorts accompanied young patients (children). Some of the questions asked were similar to those posed to heads of households and other interviewees. Among other questions, patients were asked to express their views concerning where they sought for health care when they suffered from malaria and/or other diseases or injuries.

They were asked whether or not they had known of the poorest residents who had no ability to afford the cost of their health care needs in various health facilities. They also were asked whether or not they knew of the existence of the waivers and exemption mechanisms according to the government's cost sharing policy guidelines, and whether such mechanisms existed in practice in Korogwe district. In addition, their perception of the quality of care at the Korogwe district public hospital following user fee introduction and their attitudes and suggestions towards such a fee policy implementation at such a hospital were investigated. Also, they were asked to mention the sources of money they used for paying fees for the care at the health facilities on the day of the interview. Asked also were their opinions regarding the mechanisms of payment they would have preferred if they had been given an opportunity to choose how to pay for health care. Like what was assessed for households, characteristics such as family size, education, monthly income, and sex distributions were examined in order to determine the socioeconomic status of exit patient interviewees (Table 3).

**Table 3. Sociodemographic Information of Exit Patient/escort Respondents**

Characteristic	Frequency (%) of respondents
<b>Sex</b> (N = 442)	
Males	33%
Female	67%
<b>Religion</b> (N = 434)	
Christian	44%
Moslem	55%
Traditional	1%
<b>Education</b> (N = 433)	
No formal schooling	13%
7 years of primary school	72%
Secondary school	12%
Higher education	3%
<b>Occupation</b> (N= 425)	
Small-scale farming (peasants)	68%
Formal employees	19%
Petty business	6%
Artisan	7%

### ***Interview with the Korogwe District Hospital Health Staff***

Survey questions were designed to assess the attitudes of the government hospital health staff regarding the implementation of user fees at such facilities as theirs. Their knowledge of why the government established the cost-sharing policy at public health facilities was examined. Other aspects investigated were on how and to what extent the implementation of user fees had affected the attendance of patients at such facilities, compared with the period beforehand, whether the existing user fee rates were affordable to patients (particularly the poor and vulnerable ones) seeking care from such a hospital, and how the health staff rated the impact of user fee system on the quality of care provided at such a facility. There also was a question on how the hospital staff used waivers and exemptions to protect poor patients from user charges. Other issues investigated are as stated in other sections in this report.

### ***Interview with Health Staff at Private Health Facilities***

Questions included: How long have you been working at this hospital? What are the main health problems facing communities living within or around in this area? From your experience which population groups categorically by age and sex usually seek for care at your (this) health facility? From your experience, what can you say about the quality of care and attendance of patients at this health facility after the introduction of user fees at the Korogwe district government hospital in comparison with the period prior to the introduction of such fees? Have you ever met patients who complained of having no money for paying user fees at this health facility; if so how often? Were there any malaria patient among those claiming of having no money to afford the charge for the care they needed from this health facility, and if so what measures were taken regarding such patients? What alternative ways (means/mechanisms) of payment would you think that health care providers including owners of this health facility would accept from people who complain of inadequacy of cash for paying for their health care needs? These are the most important questions asked towards collecting the required information from the interviewees.

### ***Interview with the Korogwe District Government Hospital Administrative Personnel***

Most of the questions asked in this case were similar to those applied to members of the DHMT. They covered a range of issues concerning community knowledge of, beliefs and attitudes towards user fee policy implemented at district public hospitals, the quality of care at the Korogwe district public hospital after user fee introduction, and community ability to pay for health care. In addition, an assessment was made on these officers' knowledge or views of criteria used in identifying the poor who could not afford the existing user fee rates and measures taken or that could have been taken to protect them. Alternative ways of payment for health care they thought would be feasible and desirable to the Korogwe district's residents and to the health care providers were assessed as well.

### ***Health Facility Documentary Review***

Researchers reviewed records at the Korogwe government hospital and several private health facilities surveyed. At the government hospital, the aim was to assess the trend of patient attendance for several years before and after the introduction of user fees, with the focus on malaria patients. Malaria was chosen as a tracer disease because it is the predominant public health problem, leading to greater proportion of patient attendance, admissions, and deaths in the district and the rest of Tanzania. The amount and trend of revenue collected from user fees at the district government hospital over several years was recorded and analyzed. At each of the facility surveyed, a document review was made to determine whether and to patients of what characteristics were waivers and exemption mechanisms practised. The cost of managing/treating a single (complicated or uncomplicated) malaria case was estimated based on the available records supplemented by direct interview with key health staff informants. Some of the data collected through this approach were used to countercheck or supplement other data collected using other research instruments.

#### **4.1.2.4 Interview with Retail Drug Sellers**

Retail drug sellers were asked about what they perceived to be the major community health problems and why, where people usually sought for care when they suffered from malaria and other health problems, which type of antimalarial drug was more frequently bought and why they were bought that way. In order to justify what is usually reported in literature and technical research reports concerning the malaria vulnerable population groups, retail drug sellers were asked to estimate the age and gender proportion of customers who bought antimalarial drugs from them most frequently. They also were inquired about whether their customers often showed certificates from authorized medical officers for the drugs they came to buy and what such business dealers did when no certificates were shown. There were questions posed in order to assess the knowledge of retail antimalarial drug sellers concerning the implementation of user fees at the Korogwe district public hospital and their attitude concerning the appropriateness and affordability of such a system to the poor and vulnerable groups in Korogwe district. They were also investigated on whether they have ever met people coming to ask for antimalarial drugs from their sources whilst claiming to have no money to pay for them and if so what measures they take for such people. Aspects concerning the existence and practice of health care fee waivers and exemptions in the district were examined. Drug sellers were also asked to express their opinions regarding the means/ mechanisms of payment for health care they preferred for the drugs they provided their clients especially those who might find it difficult to pay promptly in cash at the counter.

#### **4.1.2.5 Interview with Local Tax Collectors**

The survey asked local government revenue officers the criteria used by in planning and implementing taxes to local people in the catchment areas, the problems they faced when collecting taxes, and measures they took to protect some people from tax charges. It also assessed how they perceived of the poor at the individual and household levels, how exemptions from community-oriented payments should be administered, and who should be eligible for such exemptions.

#### **4.1.2.6 Interview with Other District-level Government Officers**

District officials were asked their personal views on various aspects of community participation in financing their health needs, the socioeconomic status of the district's residents, and their awareness of and attitudes to the cost-sharing policy in the public health sector. Researchers also asked their views of the impact of the recently introduced fees on the quality of care provided at the district government hospital, community knowledge of waivers and exemption mechanisms according to the existing cost sharing policy guidelines, and how such mechanisms were implemented. In addition, researchers asked if officials personally had ever heard of any complaints from the community against various local tax-related payment systems such as the local government development levy, and, if so, which types of community groups complained most and against which specific issue of the tax charge system. Alternative means and/or mechanisms of payment for health care officials thought could be feasible, affordable, and possibly acceptable to the consumers of health care in comparison to payment in cash at the point of service delivery were also looked into among other aspects investigated.

#### **4.1.2.7 Interview with DHMT Members**

DHMT were asked their views on various aspects concerning community participation in financing for their health care needs, their socioeconomic status, and their knowledge of and attitudes to the cost-sharing policy programs recently established in the public health care sector.

Other aspects assessed were their views of the impact of user fees on the quality of care provided at the district government hospital, community knowledge of waivers and exemption mechanisms in accordance to the existing cost-sharing policy guidelines, and the way such mechanisms were implemented. In addition, they were asked problems faced in the course of implementing user fees, if they personally had ever heard of any complaints from the community against such a fee system, and if so which community groups had complained most and against which specific aspect of the fee system. Which alternative means and/or mechanisms of payment for health care they thought could be feasible, acceptable and effective both to the consumers and providers of health care in comparison to cash collected at health facility counters were also examined.

#### **4.1.2.8 Interview with Local Community Leaders**

As was mentioned before, community leaders at village and ward levels were given in-depth interviews. The questions posed were intended to obtain information on what they perceived were the major community health problems in their areas and where usually people sought care when they suffered from malaria or other health problems. Leaders were asked their views regarding the impact of user fees on community health seeking behavior to the district public hospital. They also were asked whether, as community leaders, they felt it was appropriate to charge fees for health care services in a government health facility. They also were asked community knowledge of the cost-sharing policy introduced by the government in the public health sector, whether fee waivers and exemptions were in practice in the district and how well they were protect the poor and vulnerable groups. Alternative means/mechanisms of payment for health care that could be feasible, affordable, and sustainable to the poor were also assessed.

#### **4.1.2.9 Interview with Traditional Healers**

Before 1961, traditional health practice in mainland Tanzania (Tanganyika at that time) was not recognized by the modern curative care-oriented colonial state (Collins 1994). The post-independence government recognizes traditional healers, however, as they act as substitutes or complements to the public health care service process (MOH 1997).

In this study traditional healers were asked what they perceived to be major health problems facing the residents in the catchment area and what they thought were the causes of such problems. They also were asked about specific health problems they dealt with and the population groups that seemed to attend most frequently (vulnerable groups) in relation to such problems. They were also asked about the average rate they charged to their customers, whether they had ever met patients claiming to be unable to pay their charges, and, if so, how often and what measures they took with such type of patients. They also were assessed on their knowledge of user fees implemented in the district government hospital, their perception of such fees in relation to the socioeconomic status of the communities surrounding them and aspects relating to waivers and exemptions for the poor and vulnerable groups. They were asked the extent to which they accepted in-kind payments, which types of in-kind payments, the frequency with which they accepted such payments, and their preferences to alternative payment mechanisms.

#### **4.1.2.10 Focus Group Discussions**

While on one side FGDs are useful community-based information seeking approaches, on the other side they are one of the most difficult type for qualitative data collection and analysis. Except for very different views or comments from individual FGD participants that sounded important to be

noted, researchers focused on answers expressed by the majority of participants and these were regarded as being the group answer. Discussions used interview guides with most open-ended questions. Participants were interviewed on their perception of the major community health problems in the study areas, where they sought for care, the types of care they got when they faced malaria or other health problems, and whether they perceived malaria could be effectively prevented if appropriate strategies were in place. They also were asked their own and community's knowledge of cost-sharing policy program in the public health sector, affordability of the current user fee rates at the district government hospital, their perception of the poor, and what should be done to effectively protect the poor and vulnerable groups from health care charges. Other aspects discussed will be elaborated in the corresponding section in this report.



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## 5. Results

As discussed above, this study used different data collection methods applied to different interviewees and through a review of health facility documents. This report, illustrates and interprets relatively or comparatively the results obtained, how the responses given by different interviewees were similar or dissimilar, and why that was the case.

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### 5.1 Perceptions about Major Community Health Problems and Health Care Seeking Behavior

Although this study used malaria as a tracer disease, it is important to note that different persons may have different perceptions to health problems facing them or other persons in their community. Willingness to pay for health care and health care seeking behavior may also differ from one person or group to another because of their different perceptions.

#### 5.1.1 Disease Prevalence

Table 4 lists the five most prevalent diseases expressed by all survey respondents.

**Table 4. Five Major Diseases Reported by All Types of Respondents (average %)**

Disease	Proportion (%) of the interviewed
Malaria	86
Diarrhoea	52
Helminthic (worm) infestations	46
Tuberculosis	31
Gonorrhoea and syphilis	30

Table 5 lists major diseases reported by FGD participants. Other important but less frequently mentioned diseases include measles, infant respiratory illnesses, coughing in young children, filariasis and anaemia, especially in young children, though the latter might have been associated with malaria. Also, HIV/AIDS and other sexual transmitted diseases (gonorrhoea and syphilis) were mentioned by 33 percent of the participants respectively.

**Table 5. Five Major Diseases Reported by FGD Participants**

Disease	Proportion (%) of the interviewed (N = 261)
Malaria	100
Diarrhoea	67
Cholera	54
Helminthic (worm) infestations	46
Typhoid	46
Tuberculosis	46

Table 6 lists major health problems reported by traditional healers. Other but less frequent health problems reported by them include tuberculosis and schistosomiasis. When they were asked about where they themselves usually sought for care when they suffered from malaria, they mentioned to have either gone to modern health facilities or used drugs bought from retail shops and/or to have used local herbs.

**Table 6. Five Major Health Problems Reported by Traditional Healers**

Health Problem	Proportion (%) of the interviewed (N = 17)
Malaria	94
Helminthic (worm) infestations	88
<i>Zongo</i> or <i>juju</i> (disabilities caused by witchcraft)	47.1
Impotence	41.2
Gonorrhoea and syphilis	41.2

Table 7 lists major diseases reported by community leaders. Other problems reported by these leaders but at lower frequencies include schistosomiasis and filariasis.

**Table 7. Five Major Diseases Reported by Community Leaders**

Disease	Proportion (%) of the interviewed (N = 39)
Helminthic (worm) infestations	72
Diarrhoea	54
Malaria	39
Gonorrhoea and syphilis	31
Scabies	21

Table 8 lists the major diseases reported by 10 (50 percent) of the retail drug sellers interviewed. Their responses were based on the frequency at which the various drugs were bought from their retail sources.

**Table 8. Five Major Diseases Reported by Retail Antimalarial Drug Sellers**

Disease	Proportion (%) of the interviewed (N = 20)
Malaria	95
Diarrhoea	55
Helminthic (worm) infestations	45
Gonorrhoea and syphilis	25
Schistosomiasis	20
Scabies	20

Quinine was obtained from pharmacies rather than in the ordinary retail shops or kiosks where antimalarial drugs were sold. This data on drug utilization corroborates with some of those reported from other studies in other parts of Tanzania (see Alilio et al. 1997; Mnyika et al. 1995). Note that in the analysis each type of drug mentioned was estimated separately as a percentage of all the respondents.

Further, assessment was made to collect the views from these respondents as to why they thought the mentioned drugs were the commonly used antimalarial items by the residents in the area. Of those interviewed, 15 (75 percent) of the interviewed thought it was because of the widespread and recurrence of malaria episodes to among the people, while eight (40 percent) thought that chloroquine and fansidar were relatively more available than other antimalarial drugs (Table 9).

**Table 9. Main Antimalarial Drugs Reported by Retail Drug Sellers**

Type of Drug	Proportion (%) of the interviewed N = 20
Chloroquine	90
Fansidar	40
Metakelfin	30
Amodiaquine	25
Quinine	20

Regarding the main buyers of antimalarial drugs from retail shops, the following groups were mentioned by the drug sellers: children 18 (90 percent), women 10 (50 percent), pregnant women 7 (35 percent), and female and male youths 12 (60 percent). Although according to literature young children (mostly under five years) are among the most vulnerable to malaria (the other group being pregnant women), it is important to note that this evidence could not be supported directly by this study finding. The reason for the high frequency of children mentioned could be that children in most of the households were sent by their parents or adult relatives only as agents for buying drugs and not necessarily for use of such drugs by themselves. Sending children to shops or markets to buy domestic items is a common practice in many Tanzanian communities as it is perhaps the case in some other African countries.

In response to the question on whether or not antimalarial drug buyers show prescriptions (i.e., certificates) from authorized medical practitioners, nine (45 percent) of the respondents agreed that customers had been showing prescriptions. Four (20 percent) said most of the buyers had done so, meaning that some did not. Five (25 percent) said that only a few did. Poor or inadequate community compliance to standard medical prescriptions has increasingly been reported and debated in scientific

meetings and literature as one of the factors contributing to the increasing trend of malaria parasite resistance to antimalarial drugs (especially for chloroquine). The concern on this drug resistance issue in sub-Saharan African countries including Tanzania has increased following liberalization of medical practice whereby it is common to find drugs being sold on the open markets (including retail shops/kiosks some of which are of sub-standards) with inadequate regulation and monitoring or control.

Table 10 lists the five major diseases as reported by private health facility staff. Infant respiratory infections, amoeba, and schistosomiasis were also pointed out by four (9.1 percent), six (14 percent), and five (11 percent) health staff respondents respectively. Other diseases mentioned but with relatively lower frequencies include *kwashiokor*, typhoid and scabies. A non-disease problem mentioned was the low ability to pay as expressed by some of the patients who sought for care at private health facilities.

**Table 10. Five Major Diseases Reported by the Private Health Facility Staff**

Disease	Proportion (%) of the interviewed (N = 44)
Malaria	100
Diarrhoea	52
Helminthic worm infestations	46
Anaemia	32
Pneumonia	18.2

### 5.1.2 Health Care Seeking Behavior

Although evidence indicates that children under age five years and pregnant women are mostly vulnerable to malaria, the following population groups (see Table 11) were identified as being attended most frequently at private health facilities surveyed.

The numbers in Table 11 justify the above mentioned evidence that children are among the most vulnerable groups to malaria. Among other groups, there was a comparatively balanced proportion of male and female patients reported to have been attended at private health facilities.

**Table 11. Types of Patients Most Frequently Attended in Private Health Facilities**

Age and Gender of Patients	Proportion (%) answers of all private staff N = 44
All young children	91
Female children	91
Male children	73
Middle-aged adult males	36.4
Middle-aged adult of both sexes	30
Middle-aged adult females	30
Youths (18-39 years) of both sexes	36.4
Female youths	34

<b>Age and Gender of Patients</b>	<b>Proportion (%) answers of all private staff N = 44</b>
Male youths	34.4
Elderly (over 50 years) of both sexes	14
Female elderly	14
Male elderly	9.1

Table 12 lists the providers from which key survey interviewees sought care. Of these health staff respondents, 97 percent reported that most of the residents sought care mainly from modern health facilities, 83 percent mentioned that the community also used traditional medicines, and 72 percent mentioned retail drug shops.

**Table 12. Sources of Care for Those Suffering Malaria and Other Diseases According to Key Informants**

<b>Source of treatment</b>	<b>Proportion (%) of the interviewed</b>			
	<b>FGD participants</b>	<b>Community leaders</b>	<b>Retail drug sellers</b>	<b>Traditional healers</b>
Modern health facilities	72	97	100	-
Retail drug shops	72	51.3	75	-
Local herbs	100	56	-	-
Traditional healers	-	49	10	47.1

Note: dash (-) indicates that the corresponding point has not been mentioned by respondents. The sample sizes for each group of the respondents are as shown in table 3 above.

Of those who reported to have suffered from malaria in the last six months (Table 13), 70.3 percent said they had sought care from modern health facilities, while 19 percent reported to have bought antimalarial drugs from retail drug stops. Also, 23.4 percent reported to have used a combination of these sources. A few of the respondents reported to have relied on other measures such as religious spiritual healing and some reported to have contacted traditional healers. Some individual respondents mentioned to have adopted more than one measure and that is why the total percentage presented here exceeds 100. Also, 366 (81 percent) of all the household interviewees asked about where they usually sought for care when they suffer from any health problem (not necessarily malaria) said they went to public health facilities.

**Table 13. Households that Suffered Malaria in Six Months Prior to Study**

<b>Response</b>	<b>Proportion (%) of respondents N = 445</b>
Suffered	67.3
Not suffered	32.2
Couldn't remember	0.5

## 5.2 Malaria Control Measures Taken by Communities

Table 14 presents the causes of malaria perceived by different types of respondents.

**Table 14. Reasons for the Prevalence of Malaria as Given by Different Respondents**

Cause/Reason	Proportion (%) of all Interviewed, by group		
	FGD participants	Traditional healers	Retail drug sellers
High mosquito densities	89	41.2	60
Widespread mosquito breeding sites perpetuated high mosquito densities	63	-	60
Low use of preventive items such as mosquito nets as most people cannot afford to buy them	40	18	20
Low community knowledge of preventive measures	-	40	-
Negligence by most people of taking preventive measures	-	29	-

It was reported that various antimalarial drugs were sought either from modern health facilities or retail drug sources while bed nets and mosquito coils were obtained from retail shops and/or mobile net vendors.

Another assessment made to FGD participants was whether they felt malaria could be effectively prevented if appropriate measures were available (Table 15). Participants in 21 groups (88 percent of all the participants) felt that malaria could be effectively prevented if appropriate measures were undertaken at community level while three groups (13 percent of all the participants) did not. Those who did feel so argued that mosquitoes were multiplying every day and were so widespread in the country that they could not be eradicated.

**Table 15. Measures Used for Malaria Prevention According to FGD Participants**

Measure	Number of groups answered	Proportion (%) of participants
Insecticide treated nets and/or insecticide treated curtains	18	78
Swallowing antimalarial drugs every week	17	72
Burning or boiling of various tree leaves such as Mvumbasha, mwembe (mango tree), mwarobaini, fevi and Mzugwa and other types of mosquito coils	14	58
Regular cleaning of residential sites	8	33
Burning of cow dung	4	17

### 5.3 Community Knowledge and Beliefs about User Fees and Other Cost-sharing Policy Schemes in the Public Health Sector

The strength or effectiveness of any system such as a district health care delivery system depends, among other factors, on the resources available for it to operate optimally and how such resources are organized and managed. The resources include personnel (human resources), buildings and other physical infrastructure, and communication. If a system is not well known, it may not adequately be accepted, implemented, and protected or defended by those responsible for its implementation or by those it is intended to serve.

As was mentioned earlier in this report, the phased implementation of user fees on some health care services delivered at district, regional and referral public hospitals in Tanzania started in July 1993. Despite the time elapsed since then, little information is available concerning the extent to which Tanzanians, especially those living in rural and/or remote villages, know about the reasons for or implementation of such fees. This section reports on the views elicited from the interviewees concerning the existence, practice and community attitudes towards cost sharing in the public health care sector, with a particular case study of the Korogwe district in Tanzania. The methodology elaborated above presents most of the questions posed in order to collect the required information from different types of interviewees. The results obtained from different types of respondents are indicated in Tables 16, 17, and 18.

**Table 16. Awareness among Community Groups Interviewed about the Introduction of User Fees in Public Hospitals**

Awareness reported	Proportion (%) of the respondents			
	Traditional healers N = 17	FGD participants N = 261	Household heads N = 446	Community leaders N = 39
Self-aware	100	79.2	78	100
Not self-aware	0	20.8	22	0

**Table 17. Community Awareness of Cost Sharing in Public Health Sector According to Public Employees Surveyed**

Awareness reported	Number and proportion (%) of the respondents		
	DHMT members	Other District-level officers	Government hospital staff
Most (> 50% but < 100%) are aware	5 (100%)	5 (100%)	6 (100%)
Few (< 50%) are aware	-	1 (20%)	-
The majority are aware of the existence of the policy but not the reasons why it was introduced	-	-	-

Note: Dash (-) indicates that the respective point was not mentioned by the concerned.

**Table 18. Other Interviewees’ Awareness of Reasons for Cost Sharing in Public Health Facilities**

Reported knowledge by those who stated at least one reason	Proportion (%) of the respondents			
	FGD participants N = 261	Households N = 413	Govt. Hospital Staff N = 6	Traditional healers N = 17
Knowledgeable	17	44	100	100
Not knowledgeable	83	56	0	0
No answer given	0	0	0	0

Of household respondents who gave reasons, 24 percent stated that the government intended to ensure adequate and reliable supply of drugs and other services. Sixty three percent stated that the aim was to mobilize additional revenue for financing the health sector and that the government did so due to the economic difficulties. The remaining 13 percent of the respondents thought that the government just decided as it usually did on various other aspects.

Thirteen traditional healers (76.5 percent) appreciated that the government had made an appropriate decision to charge for some public health care services in order to recover some of its costs due to economic hardship that faced it. In contrast, four healers (23.5 percent) felt that the policy decision was inappropriate since the majority of citizens were poor and their income earnings are not reliable.

A cross-tabulation of data on household knowledge of the reasons for the government’s cost-sharing policy for the public health sector and their levels of education (for those who responded) was made. It was found that the level of knowledge of the reasons was higher among the respondents who completed many classes of schooling than rest who had completed few classes (*p-value = 0.006* at 95 percent confidence interval).

Similarly, the cross-tabulation of the data on household respondents’ gender and their knowledge about waiver and exemption mechanisms indicated that men were at a greater chance than women of being knowledgeable (*p-value = 0.017*). The possible factors contributing to this are discussed in detail in other sections in this document.

Only 84 (19 percent) of all household interviewees reported to have attended the Korogwe district government hospital in six months prior to this study, whilst 358 (81 percent) reported to have not sought care.

In response to the question on whether there was any problem or difficulty facing the district managers in disseminating (communicating) information to local communities on various aspects concerning their development, two main problems were mentioned by the district development director. These include the reluctance or stigma of some local government leaders in communicating the right messages to their people. And that even if some of them such as ward councillors understood well the issues in question, they sometimes feared to tell their people the truth in order to avoid being directly challenged especially by members of opposition political parties. Another problem mentioned is the inability of the local people to correctly interpret the messages given by their leaders or community representatives.

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## 5.4 Information Sources for Those Aware of the Cost-sharing Policy

Those who reported to be aware of the implementation of user fee in public hospitals were asked where they had obtained information about the cost-sharing policy. Most obtained information through Radio Tanzania announcements, health staff and posters at the district government hospital, newspapers (not specifically pointed out), and public political meetings. Table 19 illustrates answers obtained and the percentage of the responses for each source of information given.

**Table 19. Sources of Information about User Fee Policy in Public Health Sector**

Source of information	Proportion (%) of interviewees who answered	
	FGDs N = 261	Exit-Patients N = 442
Posters at health facility (e.g. district hospital)	50	50
Other people in the streets	8	-
District hospital staff	79	-
Political meetings (e.g. MPs, PPLs)	21	7
Radio Tanzania and others	38	41
Newspapers	29	6

Notes: MPs = members of parliament, PPLs = political party leaders

Percentages exceed 100 percent because some respondents mentioned more than one source of information.

However, in one FGD, a participant reported that newspapers sometimes arrive late in remote areas and that many persons could not afford to buy a newspaper everyday; others had no custom of reading newspapers even if they were freely provided. Three local community leaders (8 percent) made this point when explaining why health care fee waivers and exemptions are not widely known to the population in the study villages.

DHMT members were asked about measures taken by the district health management authority to inform the public about the cost sharing policy. Four of the five managers felt that general awareness is high since the public was informed through mass media, posters and hospital staff. One manager, however, felt that public awareness of the policy in Korogwe district was not high because the policy was not adequately advertised.

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## 5.5 Fee Waivers and Exemptions in Theory and Practice

The literature demonstrates problems with the efficacy of the design and practice of waivers to protect the poor against user fee barriers.

*There are problems in the area of equity with user fees. The clause providing exemption for the poor and treatment of emergencies, whether they are to immediately pay or not, is hardly used and people are sometimes denied the care they need. In part, the no-use of the clause exempting the poor is because the costs of exemption are to be borne by the health facility out of the surplus it generates. People are reluctant to watch their surplus being eroded in a way which brings no obvious benefit to the health facility or the*

*workers. There is also extra “ social work” involved in verifying that a person is indeed unable to pay since if just a statement of inability to pay is used, everyone will become “too poor to pay. (Agyepong 1999 p 60)*

*Exemption policies aimed at increasing the access of marginalized groups to health services do not seem to be working, and further work is needed to determine how best these groups can be assisted. (Hunson and McPake 1993 p 273)*

*User fees have some potential to be progressive if they are biased in favor of the low income/more vulnerable through a sliding scale or exemption mechanism. Whilst the need for exemption mechanisms is common, there is still little evidence of their effective implementation, and increasing evidence of political and managerial difficulties of effective targeting. (Gilson & Mills 1995 p 224)*

*Exemptions are rarely, if ever, implemented where the primary objective of the fee system is financial sustainability, as the Bamako Initiative-type of scheme, because they necessarily lower revenue generation levels. (Gilson 1997 p 276)*

*We learnt two lessons about exemptions. First, rules have to be very clear. Stating that the “poor people” should be exempt is too vague. You need to decide who should identify poor people and what definition of “poor” should be used. (Waddington & Asiana 1994 p 8).*

One of the critical issues in contemporary research and policy debates is how to determine or develop appropriate criteria for identifying people eligible for exclusion from health care charges on the basis of their inability to pay. This situation has been discussed in a variety of texts (published and unpublished): Gilson 1997; Ensor and San 1996; Newbrander and Sacca 1996; Gilson and Mills 1995; Leighton 1995; Creese 1995; Russell 1996 are a few. The concern focuses on the contradiction between waivers and exemptions in theory and what is actually practised. One reason for poor implementation in Tanzania is the paucity of information about how waivers and exemption mechanisms should be designed and/or practised (Newbrander and Sacca 1996; Mubyazi 1998). How to determine the waiver eligibility of an individual is indeed complex, especially where individual or family incomes are not known, and, because of this, decisions may be made subjectively depending on who is carrying out the assessment (Green 1992). Another question is whether the decision on eligibility should be made in advance of people’s contact with health care providers or at the health facility counter (Green 1992). Based on several research studies, the Tanzanian Ministry of Health developed several cost-sharing guidelines regarding the implementation of waiver and exemption mechanisms in the health sector. Despite this, it was found that very few waivers and exemptions were granted by health facilities, that letters from community leaders were not required, and that the process of approval of waivers for the poor was done by health personnel at the local facility level (Newbrander and Sacca 1996). Mwabu et al. (1995) had similar findings regarding the government leaving the decision of who is to be waived from health care fee charges to the discretion of health staff in Kenya.

All the district level government officers and government hospital staff believed that the majority of residents in the district were aware of the waiver and exemption policy (Table 20). However, answers from 433 exit patient respondents concerning whether they personally had got a fee waiver indicated that 41 (10 percent) had been waived while 392 (91 percent) had not.

**Table 20. Awareness of Waiver Policy**

Awareness indicator	Proportion (%) of the respondents			
	Community leaders N = 39	Government hospital staff N = 6	Exit patients N = 429	Other district govt. officers N = 5
Yes, the policy exists	100	100	23	20
Uncertain whether the policy or not	0	0	61	0
No, the policy doesn't exist	0	0	16	80

The elderly, children under five years, people suffering from diseases such as cancer, leprosy, and women for maternal child health/family planning services were mentioned by the district government hospital staff as eligible for exemptions in accordance to the Ministry's cost-sharing guidelines. When asked on whether they have experience with patients that ask for waivers, all the six respondents said "yes". In response to the question on whether waivers and exemption mechanisms existed in practice at the district government hospital, four (67 percent) of the six staff interviewed said "yes" but two said "no". Then, they were asked to mention the measures they personally had undertaken when, for example, a patient complained to them for having no money for paying user fees and asked for a waiver. All the six staff said that such patients were forwarded to the hospital administrative authority which then forwarded the respective patients to contact the social welfare officer for final assessment and decision. Also, according to the health staff, some patients were advised to seek financial assistance from their friends or relatives instead of deciding immediately to come for help at the district government hospital. It also was reported that sometimes health staff volunteered to pay for the patient directly or later by allowing the administration to cut their salaries an amount equal to the cost of care provided to the patient in question. It was added that some patients were allowed to get treatment credit. But following those who delay to pay seemed to be difficult thus discouraging such an exercise since most of the patients indebted were not honest enough to keep their promise with the health provider.

When a question was posed on whether they personally were happy with the way the waiver and exemption mechanisms were implemented in the hospital, there was a balanced mixture of answers. Three of the staff (50 percent) said "yes" and three (50 percent) "no". No further inquiry was done by the investigators as to why the health staff had perceived so concerning the implementation of waivers and exemptions in the district government hospital.

### **5.5.1 Additional Community Leaders' Views Regarding Waivers and Exemptions**

The answers obtained from those who responded to the question, "are residents in this area aware of the existence of waiver and exemption mechanisms for protecting some people from health care charges?" were as follows:

- > Yes, all the people in this village are aware, 7 (18 percent)
- > Yes, but only a few people are aware, 4 (10 percent)
- > Not at all, the people are not aware, 28 (72 percent)

Community leaders were further asked whether anyone had ever recommended waivers. Eleven (28 percent) answered “yes”. Among these, one was a religious leader and two were teachers with community leadership responsibilities. Twenty-seven (72 percent) answered “no”. Unfortunately, no information was obtained from these respondents on whether the recommendations made were accepted and by which type of provider; nor was there evidence that local leaders participated in the decision making.

Further, community leaders were asked to give their views regarding whom they felt was qualifying to be given an authority/responsibility of identifying and deciding on people who deserve waivers from health care charges. The types of authorities suggested and the frequency of the opinions given are as indicated below:

- > Village chairpersons and their respective executive committees, 29 (74.4 percent)
- > Ward councillors and their respective ward committees, three (8 percent)
- > District level (central and local) government leaders, two (5 percent)
- > Health staff at fee charging health facilities, one (3 percent)
- > Ministry of Health headquarters, one (3 percent)

“Ward and village community leaders” were also suggested by 12 (71 percent) of the 17 traditional healers interviewed.

Most opinions seem to be more suggestive of local (community) leaders possibly because the latter live closer to local people and are believed to be in a better position of identifying who is poor and deserves protection than other higher-level decision authorities. This seems to be in line with the recommendation given from a study undertaken in Kilimanjaro and Mara regions in Tanzania (Msamaga *et al.* 1996).

In this study letters from local community leaders are said to be accepted at the Korogwe district hospital level but final decisions as to which patient qualified for waivers were made by the community welfare officer who sometimes obtained advice from the hospital administration.

### **5.5.2 Characteristics of Populations Eligible for Waivers**

In regard to criteria for waiver eligibility, there were variations in the number of years mentioned by the respondents regarding the elderly and children (Table 21). As for the former, some mentioned people aged 50 and above, some 60 years and above, others 70 years and above. As for the children, some respondents suggested all children, some specified children aged 17 years and others specified children aged below 10 years. Two traditional healers also suggested that every person who qualifies for a waiver provided it is proved that they have no ability to pay.

**Table 21. Respondents' Perceptions Regarding Community Groups Eligible for Fee Exemptions**

Characteristics	Frequency of (%) the respondents					
	Exit patients N = 373	Drug sellers N = 20	Community leaders N = 29	FGD participants N = 261	Traditional healers N = 17	Private health staff N = 44
Pregnant women	77	95	0	4	18	0
Children under five	15	95	80	54	53	21
Elderly	6	95	82	67	53	21
The chronically ill	6	95	15	46	18	0
Physically disabled	0	95	69	33	65	13
Street children, orphan children, refugees, old widows	0	95	39	25	71	13

Most of the suggested eligible groups are similar to those already appearing in the Ministry of Health's cost sharing implementation policy guidelines concerning waivers and exemptions (Newbrander and Sacca 1996; Mujinja and Hausmann 1997). However, the guidelines cite no specific criteria on how the poor could be identified. This issue seems to have been left to the health care providers and local community leaders to decide informally and subjectively. In 1999, the Minister for Health announced that, as of July 1999, all elderly people age 60 years and above should be exempt from health care charges at public hospitals. This announcement came out through various mass media such as newspapers and radios.

### 5.5.3 Protecting the Poor and Vulnerable from Charges in Private Health Care Facilities

*Mission hospitals have a long tradition of charging fees for services in Tanzania, and while no formal mechanisms exists for granting waivers, all patients are treated regardless of their inability to pay.*" (Newbrander and Sacca 1996)

This study sought to determine whether there was a formal system for protecting the poor and some vulnerable groups from health care charges in private health facilities or whether, in the perception of private health staff, waivers and exemptions were meant being implemented in public hospitals only. Table 22 shows responses from health staff.

**Table 22. Private Health Staff on Whether Waivers and Exemptions Were Practised in Their Facilities**

Response	Proportion (%) of the respondents by type of health facility		
	Private for-profit staff N = 32	Private not-for-profit staff N = 12	All private health staff N = 44
They exist in practice	30	83	46
They don't exist in practice	50	17	41
Uncertain whether they exist	20	0	16

“Formal system” is used here to mean a systematic or officially recognized procedure regarding the design and administration of fee waivers and exemptions. No formal training in the administration of these mechanisms was reported by the respondents to have been done for health workers in the private health facilities surveyed. Similar findings were reported from a previous study in several referral hospitals in Tanzania (Newbrander and Sacca 1996). In this study, however, it was pointed out by some health staff at mission facilities that, while there are informal eligibility criteria (Table 23), no patient was turned away without being given treatment because of their inability to pay.

The current survey of the DHMT members and health staff of private health facilities regarding the criteria actually used to identify people eligible for fee waivers, obtained the following answers:

- > When a patient admitted and seeming to be poor had stayed at the hospital too long without a relative or friend coming to help him.
- > Physical appearance, for instance, most disabled people automatically get waivers especially if they themselves asked for such waivers.
- > The way a patient asking for a waiver is dressed. Poor dressing and general personal cleanliness may reflect one’s financial status.
- > Patients who ask for waivers need to fill in special application forms which are then forwarded for consideration to the community welfare officer through the hospital administration.
- > Children under five, the elderly, people suffering from certain diseases (leprosy, HIV-AIDS, tuberculosis, diabetes) and women visiting maternal child health/family planning clinics are free of paying.

**Table 23. Criteria for Fee Waivers Used in Private Health Facilities**

<b>Eligibility criteria</b>	<b>% of private for-profit staff respondents (N = 32)</b>	<b>% of private not-for-profit staff respondents (N = 12)</b>
Patient’s request (self-expression)	28	83
The elderly and children under five	6	50
The deprived (young orphans, refugees)	3	33
Order from health facility administration	9	0
Letter from local government leaders	6	8
Patient’s physical body appearance	6	8
The way a patient is dressed (clothes)	6	0

#### **5.5.4 Do All Malaria Patients Deserve Exemptions from Fees?**

*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 system 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.* (Newbrander and Sacca 1996 p vi)

An increasing number of arguments from various research and policy debates on cost-sharing programs argue that malaria patients should be included among those exempt from health care charges (WHO/TDR 1997). In this study, different views concerning this issue were collected from interviewees.

In this study, four (80 percent) district-level government officers, disagreed and one agreed to the proposal that malaria patients deserve to be exempt from health care charges. Those who rejected the idea argued that the current fee rates, particularly in public hospitals, are modest enough for the majority of people to afford them, and that the presence of such an exemption system would cause unnecessary overcrowding at health facilities. The one in support of the idea of exempting malaria patients said that since malaria is an increasingly dangerous communicable disease, their exemption from health care charges would contribute towards effective control of malaria at community level. This ignores the potential for disturbances that may result from patient overcrowding, as well as the fact that exemptions could crowd out some private for-profit health facilities.

Despite their knowledge of a mechanism to protect poor and vulnerable groups from health care charges, four (66 percent) of the six DHMT members opposed the idea of exempting all malaria patients from fees. One manager was undecided. In contrast, all 39 (100 percent) community leaders supported the idea.

Other answers in relation to this question were obtained from the private health facility staff and are discussed later in this chapter.

### **5.5.5 FGD Suggestions for Disseminating Information on Cost-sharing Programs and Other Health Policies**

This study sought suggestions for feasible and effective ways of disseminating information concerning cost sharing and other health policy issues to target populations especially those living in remote/rural areas. In this way, it would involve local communities in evaluating the existing health care financing policy and in suggesting, where possible, means for its strengthening.

In FGDs, 16 groups (67 percent) suggested that local government leaders at ward, street/village and ten-cell levels should be briefed thoroughly before being given the responsibility of informing fellow residents about new or changed health policies through public meetings and poster announcements. One participant (then supported by other participants in his group) suggested that health staff are also responsible for informing their patients. FGD participants agreed with DHMT members on the strategy of using posters to disseminate information to the target population. Nevertheless, the scale at which it had been adopted and the degree to which it had been effective were matters to be considered by the district health care managers.

Other suggestions concerning this information dissemination aspect were discussed in the preceding sections of this report (e.g., specific section on waivers and exemption mechanisms).

## 5.5.6 Impact of User Fees on the Quality of Care at the District Government Hospital

There is mixed evidence from many African countries that user fees contribute to the improvement of the quality of care and increase patient attendance at fee-charging public health facilities. In some countries evidence indicates that fees improved quality of care and patient attendance in health facilities while in other areas fees are reported to have depressed utilization (Leighton 1995; Gilson and Mills 1995; Gilson 1997). In Tanzania, evidence is mixed (Mubyazi 1998). One of the reasons is that the domain factors for assessing the quality of care and for assessing demand for health care, and the timing of studies might have led to varied findings. The domain factors for quality of care assessment may include the availability of things like drugs, hospital bed services, foods for inpatients, the physical health facility infrastructure, patient waiting time, laboratory services, and patient-provider communications/interactions. The demand factors include the perceived or expected quality of care, rates of health care charge, availability of alternative providers, person's disposable income, and person's taste or preference to type of care. In spite of the available evidence, more details or findings are needed to inform policy makers and health care program managers of what the communities who are targeted health care users and health staff who serve patients directly (face-to-face) perceive of the existing fee system on the quality of care provided.

Table 24 presents the main findings of this study regarding the issue of the impact of user fees on the quality of care at the district government hospital.

**Table 24. Perceived Impact of User Fees on Quality of Care at the Korogwe District Government Hospital**

Impact	Proportion (%) of the respondents			
	District govt. hospital staff N = 6	Exit patients N = 428	Other district-level officers N = 5	DHMT members N = 6
Only some services improved	83	13.1	20	100
All types of services improved	17	40.65	20	-
All types of services deteriorated	-	21.5	-	-
Some services increased but some decreased in quality	-	11	-	-
No substantial change noticed	-	7.94	-	-
Difficult to judge	-	5.84	-	-

### 5.5.6.1 Patient Attendance at District Government Hospital

Five (83 percent) of the six staff interviewed at the district government hospital reported that attendance of patients at the hospital had increased while one staff viewed that it decreased following introduction of user fees. No further explanation was given as to whether or not the perceived increase in attendance of patients at the hospital was a result of the improvement in the quality of care or due to an epidemic outbreak.

All six staff were of the view that there had been an increase in the quality. Of these, five viewed that such a quality increase applied to all the services delivered while one staff viewed that the

improvement had been on a few of the services. No specific types of services were identified to have increased or decreased in quality.

Some of these answers (especially by exit patients) are quite similar to those reported by Mmbuji et al. (1996) from their evaluation of the impact of cost sharing (user fees) on the quality of care at 13 hospitals in Tanzania whereby 356 exit patients and their escorts were interviewed. These authors reported that < 50 percent of exit patients noticed a little improvement in the quality of care in terms of drug availability, buildings situation, hospital beds, laboratory services, time spent to get service, and how they were listened to by the health staff.

### 5.5.7 Affordability of Existing Fee Rates at the District Hospital

Different respondents answered about whether or not they had ever heard of or met people complaining as being unable to afford user fees at the district government hospital (Table 25).

**Table 25: Perceived Complaints about User Fees in the District Government Hospital**

Response	Proportion (%) of the respondents					
	DHMT members N = 6	Other district-level govt. officers N = 5	FGDs N = 261	Comm. leaders N = 39	Drug sellers N = 20	District hospital staff N = 6
Heard complaints	17	100	79.2	82.1	75	100
Never heard complaints	83	0	20.1	17.3	25	0

According to district-level government officers, most complaints were experienced during the first few years after the introduction of user fees, a period during which reasons for user fees were not yet known. However, concerning the affordability of user fee at the district government hospital, three (60 percent) of these respondents and four (66 percent) of the six DHMT members felt that the majority of people in Korogwe district had ability to pay fees at the existing rates. In contrast, two (40 percent) of the officers and one (17 percent) of the DHMT members felt that even if the existing rates were absolutely low, many people in the district would face difficulty in paying. One of the two officers who felt that many people would hardly afford the fees argued, however, that most of the residents in Korogwe district did not work hard and that is why they perpetuate poverty among themselves. A view similar to this was obtained from one primary school teacher.

One of the DHMT member among those who reported to have heard complaints against user fees clarified that it was believed that there were some nurses who received payments from some patients without giving them receipts and that was one of the reasons for the complaints. People paying health staff under the table at formal public health facilities seemed to have existed even before the introduction of user fees as was reported from a previous study in Tanzania (Shaw & Ainsworth 1996; Abel-Smith 1992). According to the district medical officer, some patients who attended the Korogwe district government hospital had complained against the Tsh. 300 fee rate that was initially charged to cover the annual cost of registration card. To most of patients, this rate seemed to be comparatively higher than the Tsh. 100 charged for registration on each trip a patient made to private health facilities.

FGD participants who seemed familiar with their communities confirmed that some people have little ability to afford fees. Some FGD participants identified the poorest people as those who either couldn't afford to feed their families or those who did not earn a monthly income of at least Tsh. 1000-2000. Some respondents perceived the poor as being those who had income less than the monetary value of one sack of maize.

Although all the six government hospital health staff primarily appreciated that charging fees for care might have a potential of recovering some of the medical care costs of provision, they argued that the burden of charging was greater to those who had limited access to cash. They referred to people aged 60 years or above and young children from poor families. When asked whether they personally were happy with the recently introduced fees at the government hospitals, four staff said "yes", one staff said "no" but one staff said, "I can't say anything". Much could be said regarding those who said "yes". Probably these were of the view that the existing fee rates at the district government hospital were modest enough for most people to afford or that fees had contributed to the improvement in the quality of care provided at such a hospital. Also, apparent decreased overcrowding at the hospital might have advantageously reduced workload of the part of health staff.

Community leaders also were asked about whether they knew any person in their villages who could not seek for care from the Korogwe district government hospital because of lack of money. Twenty-eight (72 percent) of the leaders said "yes" and most of them insisted, "many of them". Eleven (28 percent) of the respondents said that they did not know of any.

Heads of 448 households were asked about whether they knew of any person who had failed to go to seek for care from a modern health facility because of lack of money. Answers obtained from 301 (67.2 percent) said "yes" indicating that they knew someone, and 147 (32.8 percent) said "no", indicating that they did not. Those who answered "yes" were also asked to state what happened thereafter to such patients. Table 26 illustrates the answers obtained from 301 respondents.

**Table 26. Household Responses on What Happened to Patients Who Could Not Afford Treatment Costs**

Outcome	Frequency (%) of 301 respondents
Died	63
Was assisted later by friends/relatives	25
Used local herbs/traditional medicines	10.2
Don't know	13.6

### 5.5.8 Affordability of Fees at Private Health Care Facilities

*In practice it is an unacceptable for a health provider to turn someone away for lack of either funds or an exemption certificate, this being so, it is very difficult to isolate the health professional from process of exemption. (Green 1992 p 115)*

*Before cost sharing (in Kenya), 0.4 percent of patients who sought for treatment from the modern health sector could not afford the fees charged by non-government facilities. This percentage rose to 1.5 percent after introduction of fees in the public sector, and fell to 0.9 percent when the fees were waived. Health facility managers had no uniform way of dealing with such patients because there was no formal system on*

*exempting the poor from the fees. The Ministry left fee exemption to the discretion of health facility managers. As a result, some of the facilities treated patients on credit, others treated them free of charge and others turned them away. (Mwabu & Mwanzia 1995 p 168)*

As an alternative or supplement to public health care providers, traditional healers, private health staff, and retail antimalarial drug sellers were asked their views regarding the affordability of the rates of their medical care costs. In particular, the question posed (though formulated slightly differently) concerned whether they (as health care providers) had ever seen people coming to seek for their service whilst complaining to be unable to afford the cost. Those who said “yes” were also asked about whether among those poor patients there were malaria patients. Sixteen (94 percent) of the interviewed said “yes” and of these, 15 (88 percent) reported to have seen them many times. Two respondents (12 percent) said to have never seen such patients.

In general the data shown in Table 27 indicate that 42 (96 percent) of all the private health staff interviewed reported to have seen patients coming to seek for care from private health facilities while complaining of not having money to meet the existing medical care fee rates. The first two rows indicate reports of patients complaining of being unable to afford private medical care charges in general. The last two rows show answers about malaria patients asking for waivers in private health facilities.

**Table 27. Private Providers with Patients Complaining of Being Unable to Afford Fees**

Response	Proportion (%) of responses			
	Traditional healers N = 17	Retail drug sellers N = 20	Private for-profit staff N = 32	Private-not-for-profit staff N = 12
Yes, saw them	94	75	94	100
No, never seen	6	25	6	0
Yes, saw malaria patients	-	75	87	100
Not never seen malaria patients	-	25	16	0

Private health staff were asked which measures they took when they met patients who had no ability to pay for care at their health facilities. Table 28 summarizes the results obtained.

Concerning deferring payments by those patients who may face financial shortages, 20 percent of private not-for-profit health facility staff anticipated a problem with such a system. According to their experience, it has sometimes been difficult to follow up the indebted patients and most of them have either not settled their debts in time or not settled them at all, thus causing a loss to the health care providers.

**Table 28. Measures Taken by Private Health Care Providers for Patients Who Failed to Pay**

Measure	Proportion (%) of health staff respondents		
	Retail drug sellers N = 20	Private for-profit staff N = 32	Private not-for-profit staff N = 12
Treat them on loan (debt) agreement	65	56	50
Treat them free of charge	20	22	75
Tell them to ask help from friends or relatives	0	41	42
Give service equal to the money they have	5	0	8
Do not give them any service	5	0	0
Forward them to administration to decide but do not know what happens thereafter	0	0	0

## 5.6 General Attitudes towards Cost-sharing in the Public Health Sector

Different interviewees were asked to give their opinions regarding the government's decision to introduce cost sharing in the public health sector. Tables 29 and 30 present those opinions:

**Table 29. Attitude toward the Government's Cost-sharing Policy**

Interviewees	Supporting (%)	Not supporting (%)	Sample Respondents (N)
Private for-profit health staff	100	0	32
Private not-for-profit health staff	100	0	12
DHMT members	100	0	5
District government hospital staff	80	20	6
Traditional healers	76.5	23.5	17
FGD participants	75	25	261
Community leaders	72	28	39
Household heads	52	48	447

Those supportive of the policy argued that the policy is good provided the poor are exempted, fees are lowered, and quality of health care services improved. Those not supportive were of the view that the policy is not appropriate because the quality of care had not improved, because fees are not affordable, and because they already pay taxes to the government and therefore should not be charged more.

**Table 30. Perceived Willingness to Pay for Public Health Care**

Interviewees	Willing (%)	Not willing (%)	Sample respondents (N)
Household heads	83	17	447
FGD participants	50	50	261

FGD participants made several suggestions for strengthening the implementation of the cost-sharing policy in the public health sector. Table 31 illustrates their answers.

**Table 31. Suggestions for Improving Cost-sharing Policy in the Public Health Sector**

Suggestion	Proportion (%) of answers given	
	FGDs	Community leaders
Acceptable to pay provided drugs and other services are good	50	72
Charge but waive the poorest	50	-
Charge but lower fee rates	4	-
Charge but bring services closer to the people	33	-

Although many respondents supported fees in return for better services closer to the people, one FGD participant remarked, “We can’t pay for bus fare and afford to pay for services at a government hospital.” A similar complaint was heard from several participants in eight different groups and in different study villages that were far from the Korogwe district government hospital. One respondent in the FGD claimed that, “even if the formal system of charging patients is in place, we are still making informal payments to some health personnel in order to get quick treatment”. (Referred to as under-the-table payment by Mujinja and Mabala in Tanzania [Shaw and Ainsworth 1996]).

Patient waiting time, availability of drugs and other hospital facilities such as inpatient beds and food were identified as key indicators of the perceived quality of care by the FGD and local community leaders.

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## 5.7 Effect of User Fees on Utilization of Private Facilities

The private health facility staff gave their opinions regarding the trend of patient utilization of their (private) health facilities following the implementation of user fees at the district government hospital. Table 32 presents the findings.

Overall, 32 percent of health staff perceived that attendance increased, 18 percent perceived that attendance had decreased, 39 percent perceived that there has not been any noticeable changes, whilst 11 percent said that they could not compare between the two periods. Possibly those who could not compare are the ones that have no long period of working at such private health facilities.

**Table 32. Perceived Impact of Public Health Sector Cost Sharing on Patient Utilization of Private Health Facilities**

Trend of attendance	Frequency (%) of the responses given	
	Private for-profit health staff	Private not-for-profit staff
No substantial change	41	33
Increased	28	42
Decreased	22	8
Can't compare	6	11

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## 5.8 Effect of Seasonal Variations in Disposable Income on Ability to Pay for Health Care

*Public health debates have always recognized that income, and thus living standards, is important as a determinant of health. In the literature on mortality change and health improvements it is generally accepted that within populations there are mortality differentials on other available health indicators, related to socioeconomic class status of individuals. (Barker 1992 pp 109-10)*

*Ill health and poverty, and strategies required to address them are inter-linked. A concern for health thus requires a concern for poverty, and evaluation must specifically include consideration of the impact of policy on the low income groups who are vulnerable to both ill-health and poverty. But as the causes of vulnerability are complex, the equity assessment needs to explore the impact of reform across a range of groups: e.g. categorized by socio-economic status; age; gender; and place of residence, urban vs. rural. (Wilson and Mills 1995 p 217)*

As those familiar with health financing-related literature may appreciate, a person's or a household's income expenditure pattern depends, among other factors, on disposable income that may vary with time and place. Experience from developing countries (Green 1992) has shown that the period in which income is lowest (especially for subsistence farmers) is also the one in which ill health is at the peak.

In the light of this information, assessment was done to several study population groups on whether they might have experienced any change of people's incomes by season of the year and how this might have influenced their ability to afford essential items such as health care. The approach used in this assessment varied depending on the interviewees.

For instance, local community leaders were asked to give reasons for the answers they gave concerning village residents' ability to pay for health care in modern health facilities. Fifty-six percent of the respondents reported that most of the village residents were small-scale farmers (mainly subsistence farmers/peasants) growing mainly maize, rice, and beans to meet both the food and cash of their needs. They added that, unfortunately, sometimes crop harvests were not reliable due to weather unpredictability and damage from pests, especially the army-worms (*viwavi jeshi* in ki-Swahili). Eleven (22 percent) argued that some households were facing some economic hardship because of relatives being laid off work. One respondent proclaimed that, even if the existing rates of charges at the district public hospital were modest and affordable, the time wasted and the cost of travel to and from the hospital is a barrier to many people. Nevertheless, one teacher pointed out that the majority of the village residents were lazy and prioritized too much drinking of local brews known as *mnazi* (palm wine) and *boha* (sugar cane wine). The *mnazi* is a drink processed from coconut trees widely grown along the coastal belt and the *boha* is locally manufactured from sugar cane. So, the teacher believed that even with the little money they had, such extraordinary drinkers would be able to meet some of their basic (health care) needs if they planned for and actually expended their income well.

The health staff interviewed at the district government hospital also stated their general view of the seasonal ability to pay. It was specified by all the six staff that between January and June every year, most residents had very limited access to cash because it is first a period of heavy rains and then

of planting and weeding of crops. Concurrence was expressed by slightly more than half, 17 (59 percent) of the local government tax revenue officers.<sup>1</sup>

The study assessed the criteria that were used by the local tax revenue officers to waive or exempt some residents from paying local development levy and other local taxes. Nineteen (66 percent) mentioned children under 18 years and the elderly age 60 years or above who seemed to be poor and had asked for a waiver. Six (21 percent) said that all types of pupils and junior students should be included in the fee waiver category. Other community groups mentioned by the tax officers as being eligible for tax waivers: two (7 percent) reported some old widows and some separated women, 11 (38 percent) mentioned people who may fail to make crop harvests equal to the cost of two sacks of maize due to natural calamities such as pests and/or drought, and five (17 percent) mentioned people suffering from psychiatric and other chronic diseases. (The *El-Niño* catastrophe that occurred recently was cited as an example of natural calamities that exacerbated poverty through loss of farm production among the majority of the residents.) It can be seen that the criteria used to exempt the poor and vulnerable population groups from local tax charges are almost the same as those identified or suggested by other groups interviewed in this study. Some of such criteria are similar to those stated in the current Ministry of Health's cost-sharing policy guidelines on waiver and exemption in the health sector.

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## 5.9 Patient Health Care Financing Sources

### 5.9.1 Existing Sources of Financing

Those patients who reported to have paid for their health care needs at the health facilities surveyed were asked to mention where they obtained the money for such payments. Answers obtained from 400 exit patients are as follows.

- > Personal savings, 36 (9 percent)
- > My fundraising activities, 121 (30 percent)
- > Sale of my home property, 16 (4 percent)
- > Sale of farm crops, 158 (40 percent)
- > Loans
- > Help from friend/relative, 59 (15 percent).

Of course, the clauses “my fundraising activities” and “personal savings” may have the same meaning. A similar survey in Kenya found that people paid for medical care costs with wage income, with loans from friends and relatives and with proceeds from sale of food assets (Mwabu et al. 1995). Also, similar evidence was reported from a recent study in Vietnam (Ensor and San 1996).

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<sup>1</sup> According to the District Executive Director and other local government leaders interviewed and from investigators' personal knowledge, it is important to note that except for civil servants and business women, all other women are currently exempt from local government development levy throughout Tanzania.

## 5.9.2 Alternative Means of Payment

*The basic requirement of any financing system is that it can be made to work.*  
(Green 1992 p 108).

All interviewees were asked to give their opinions or suggestions regarding alternative health care payment mechanisms they would choose if they were given an opportunity to do so. One alternative suggested was in-kind payment, such as cash crops, animal items, or other valuable items (Table 33).

**Table 33. Alternative Non-monetary Payment Mechanisms**

Alternative payment option	Proportion (%) of the respondents				
	Households N = 448	FGDs N = 261	Community leaders N = 39	Drug sellers N = 20	Traditional healers N = 17
Farm crops	19	58	49	20	88
Animals or animal products	2	33	20	20	88
Other household property	1	0	18	0	88
Casual labor	10	8	8	20	0

However, most of the FGD participants and local community leaders felt that in-kind payments could prove problematic to a health care provider. Thus, they felt that cash is most efficient means in terms of portability, although it is not the cheapest means since it is difficult for most rural residents to access. Table 34 lists various monetary mechanisms cited by respondents.

**Table 34. Alternative Monetary Payment Mechanisms**

Alternative payment option	Proportion (%) of respondents					
	Govt. hosp. staff	House- holds	FGDs	Comm. leaders	Drug sellers	Trad. healers
Cash but in advance of illness (prepayment)	17	79	79.2	0	10	0
Cash at point of service only (no more specification made)	67	42	0	0	10	12
Cash only but lower fee rates	0	0	0	5	10	0
Cash by installment	0	0	4	0	0	0
People pay more taxes but nothing to public health care	0	0	17	0	17	0
Cash only but allow people to defer payment	0	0	0	21	10	0

*Note:* In some cases, total number of responses exceeds sample number of interviewees, because respondents suggested more than one mechanism.

Five (25 percent) of the retail antimalarial drug sellers interviewed felt that no Tanzanian citizens should pay for public health care. Traditional healers gave not only suggestions but also what they

practically had been charging their customers. Fifteen (88 percent) reported that they had either been charging their customers in cash terms or receiving in-kind items depending on what their customers were willing to dispose. The in-kind items identified include farm crops such as maize, chicken, chicken eggs, goats, and sheep. One hundred and fifteen (26 percent) of household respondents proposed that people should not pay anything for public health care.

One district-level local government officer suggested that prepayment might be made in cash or in-kind terms particularly during crop harvest seasons (Table 35). The district medical officer and the District Development Director cited an example of the community health fund scheme that had been piloted in several other districts in the country (not Korogwe) as a prepayment community health financing mechanism and as a form of insuring the informally employed people’s unforeseen health problems. The reason given by these and several other respondents was that access to cash by the majority of residents in Korogwe district was a big problem. Therefore, they believed that this would not have been the case if payment were made in advance of their illnesses. However, some respondents felt that people could prepay only to be disappointed later by bureaucratic and poor accountability tendencies at health facilities.

As the data illustrate, in-kind payments such as casual labor and cash crops were not favored by either the private for-profit or the private not-for-profit health staff. The disposal of household property as an alternative means of financing health care was favored over other in-kind payment mechanisms such as casual labor and farm crops but it was not known to the investigators which household property was meant in this context. All the 44 private health staff interviewed perceived that (*data not shown in table*) regardless of the poverty facing most people in Korogwe district, it would be better to continue charging patients directly in monetary terms than in non-monetary terms.

**Table 35. Alternative Payment Options Proposed by Other Health Care Providers and District-level Managers**

Payment Mechanism	Number or proportion (%) of respondents			
	Private-for-profit staff	Private not-for-profit staff	DHMT managers	District/local govt. council officers
Farm crops	22%	17 %	1 member	1 staff
Animal products	6.3%	1 staff	1 member	0
Casual labor	1 staff	0	0	0
Other household properties	42%	42%	0	0
Defer payment but in cash	13%	1 staff	0	0
Prepayment in cash	1 staff	0	1 member	5 members
Don't charge the poor	16%	67%	0	

### 5.9.3 Experience of Local Tax Payment by Installment

It is recommended that the assessment of public or community health needs would be more meaningful and representative if a multisectoral perspective looking at key actors, stakeholders, contexts and other aspects were considered (Green 1992; Barker 1994; Collins 1994; Robinson and Elkan 1996). That is why in this study, various interviewees directly or indirectly having a role to play for the health sector were included.

As explained before, among other people interviewed were the local tax revenue collectors. One of the key experiences that were intended to be shared with these respondents on whether payment by installment was accepted for people who complained to have no money to pay the local taxes at a full rate of the existing development levy. The answer obtained was “yes” from nineteen (66 percent) and “no” from 10 (34 percent) of all the 29 officers interviewed. Those who said yes added that, however, the allowance for payment by installment was not formal and was not standard throughout all the wards or villages in the district. They argued that such a provision depended on the agreement between the responsible local revenue officers and the person who asked to pay that way provided s/he was able to fulfil the required annual rate of pay and was trusted by the tax collector who confronted them.

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## **5.10 Additional Study Findings**

### **5.10.1 From FGDs**

#### ***Major Public Health Problems***

Fourteen focus groups (78 percent) argued that it is common for the majority of people in the areas to use unboiled water for drinking and untreated water for washing which contribute to such diseases as diarrhoea, typhoid, worm infestations, and scabies.

Various reasons were given by the FGD participants regarding the causes of what they perceived to be major public health problems: abundance of stagnant water that contributes to high mosquito densities and malaria (12 responses, 52.2 percent), low community knowledge of preventive measures (eight responses, 35 percent), widespread dirty water used by many people for drinking, which contributes to diarrhoea and typhoid (seven, 30 percent), and was low ability to pay for preventive items such as insecticide-treated bed nets (five, 22 percent).

### **5.10.2 From Households**

#### ***Age Profile of Study Households***

The mean and median household ages were 46 and 45 years respectively. The maximum age of the interviewed was 98 years. When asked to mention the ages of their household members, 261 (78.4 percent) of the respondents did not mention any elderly aged 65 years or above. For households with people of such an age, 61 (18.3 percent) of the respondents reported to have only one person, 10 (3 percent) mentioned to have two persons, and one (0.3 percent) mentioned to have three persons. Also, data indicates that 59 percent of all household respondents reported to have no teenagers currently living in their households.

#### ***Gender Profile of Study Households***

Household interviewees were also asked to give count of the number of members in their households by gender. It was found that 1452 (48 percent) of the household members were male while 1525 (52 percent) were female. Even if by proportion of the female household population is greater than that of the male, the data indicate that the majority of household heads in Korogwe district are male. This is likely to have been a result of most of the communities being patrilineal in customs, norms and traditions.

### ***Mean Size of Study Households***

The mean household size was six people. The mean monthly cash income of the household members interviewed was Tsh 42, 887, the median income Tsh 19,852. The individual monthly cash income reported ranged from Tsh 2,000 to Tsh 100, 000. This shows a big income gap between individual households, although it is not certain whether the reported income represents actual earnings.

### ***Ownership of Study Households***

Concerning who was the owner of each household, 343 (77 percent) households were owned by the respondents themselves.

### ***Perceived Willingness of Households to Become Members of Health Care Prepayment Schemes***

In response to the question about whether they would be willing to join prepayment scheme so that at the time of illness/injury they would be able to get treatment without having to pay again, responses were obtained from 448 of the 451 households surveyed. An example of health insurance was given whereby members pay in advance of facing health risks/problems. Of the respondents, 354 (79 percent) felt willing to participate in such a scheme; 94 (21 percent) did not.

Only 84 (19 percent) of all households reported to have sought care at the Korogwe district government hospital in the six months prior to this study; 358 (81 percent) did not seek for care.

### ***Patient Source of Health Care Financing by Gender***

In this case, a significant statistical difference was found between individual patients of different types of sex and their reported sources of money they used for paying the health care at the health facilities surveyed. Table 36 illustrates the results of the cross-tabulations made on sex and source of money data (see the p-value). Not that all frequencies are calculated based on the 400 number of patients who responded to the question posed with regard to this issue.

**Table 36. Health Care Financing Sources by Patient Gender**

<b>Financing Source</b>	<b>% of male respondents N = 133</b>	<b>% of female respondents N = 267</b>
Personal) savings	2.5	6.5
Several of my fundraising activities	13.3	17
Sold home property	2.3	1.8
Sold farm crops	12	27.5
Borrowing	0.01	2
Helped by friend/relative	2.8	12
P-value = 0.004		

From a question posed concerning who were the main customers to traditional healers by age and sex, 16 (94 percent) of the healers reported that there was no specific age and sex group that seemed to had more frequently been seeking for care from them. However, based on her experience, one traditional healer reported that there were some variations in specific types of care sought by men and women. For instance, concerning pregnancy and childhood illnesses women were the most customers while men were the main customers with regard to impotence and gonorrhoea. Concerning witchcraft illnesses, one respondent revealed that the level of education did not matter, both the

educated and non-educated were attended and among the educated some were very highly educated civil servants.

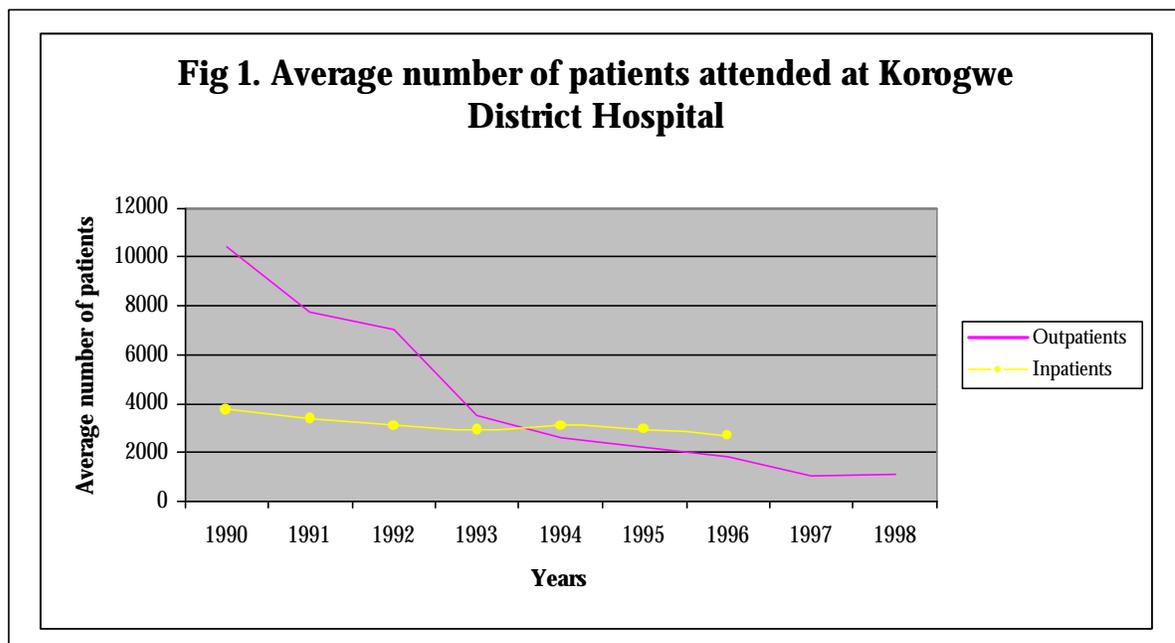
### 5.10.3 From Review of Health Facility Documents

#### *Patient Utilization of Korogwe District Government Hospital Before and After Introduction of Cost-sharing Policy*

**Table 37. Patient Utilization of District Government Hospital Before and After the Introduction of User Fees (laboratory-based diagnosis only)**

Year	Outpatients	Inpatients
1990	124823	45148
1991	93031	40671
1992	84681	37512
1993	42044	35572
1994	3130	37323
1995	26692	353384
1996	22232	32145
1997	12751	-
1998	13278	-

**Fig. 1: Patients Utilization of District Government Hospital Before and After the Introduction of User Fees**



### **Waivers and Exemptions**

There was no reliable information on waivers and exemptions at the district government hospital. Nevertheless, according to the available records only nine patients were granted user fee waivers at the district government hospital in the year 1999. And it was also mentioned that estimates show that 2 percent all patients attended at the district government hospital on the first visit need to be granted fee waivers according to the current Ministry's cost-sharing guidelines. Also, there were no reliable data (in figures) regarding waivers and exemptions in private health facilities surveyed.

### **Cost of Malaria Case Management in Private and Public Health Facilities**

#### **Uncomplicated Malaria Case Management**

Chloroquine was found to be the most frequently used prescription for uncomplicated malaria cases both in children under five and pregnant women attended in all the health facilities surveyed (Table 37). In private health facilities, chloroquine tablets were mostly prescribed to children under five rather than in injection form. However, it was reported by the health staff interviewed on this issue that the choice of prescription depended on the types of drugs available, and that antimalarial drug tablets are relatively more available than drugs in injection form. It was also reported that sometimes there are patients who specify the drugs they liked to be prescribed for them, there are those who preferred injections to tablets and those who preferred certain types of drugs to others regardless of such drugs being in tablets or injection forms. In general it was found that the cost of treating a malaria case varied with the type of treatment used and between private and public health facilities, although the difference in absolute terms was little.

The proportion of underfive uncomplicated malaria cases attended in private for-profit health facilities was 64 percent of all underfive patient cases attended in the month of January 1999. On the other hand, the proportion of underfive malaria cases attended in the private not-for-profit health facilities was 90 percent of all the patient cases attended in the same period.

**Table 38. Average Cost of Antimalarial (full course) Drug per Single Episode (in under fives)**

Type of drug	Private for-profit health facilities		Private not-for-profit health facilities	
	Tshs.	US \$	Tshs.	US \$
Chloroquine tablets	170	0.2	140	0.18
Chloroquine injections	900	1.14	700	0.9
Fansidar tablets	250	0.32	117	0.15
Metakelfin tablets	383	0.49	300	0.38

#### **Severe/complicated Malaria Case Management**

Staff at three mission health facilities reported that all the severe and complicated malaria cases reported to them had been referred to the district government hospital. However, a report from another mission hospital indicated that the cost per admission day of an child under five was Tsh 1,750 (US\$ 2.22) while according to reports from five private for-profit health facilities indicated the average cost of admitting an underfive patient of Tsh 2,470 (US\$ 3.13). The average number of days of admission of a severe malaria case was reported to be 2 in private not-for profit health facilities while it was three in private for profit health facilities.

Quinine was reported by the private for-profit health staff as being the third-line drug for patients who developed into complicated malaria situation.

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## 6. Discussions

Results of this study show that differing opinions from interviewees who were assessed on the same study aspects. This is normal in social research on public opinions whereby individuals may differ in perceptions even if they live in the same catchment area or in the same environment and even if they belong to the same sex category, age or occupation or have the same level of education. It is indeed these different characteristics that allow researchers to assess community perception or behavior to health policy interventions among other things. For example, whilst the majority of respondents in the group discussions were aware that user fee implementation at the Korogwe district public hospital, the views of those who thought that some village residents were not aware of such a policy implementation was substantial and cannot be underrated or ignored. Of course, the way the questions were posed might have influenced the way interviewees responded. This is a bias, which can be difficult to avoid in social research.

We have seen from the data presented above that the majority of residents were aware of fees implemented at the Korogwe district government hospital, as it is the case in other public referral hospitals in Tanzania. We have also seen that the majority of the residents showed a positive attitude towards the government's cost-sharing policy at public health facilities although they suggested that this should be accompanied with improvements in the quality and equity of the services provided at fee charging health facilities. But the majority of household respondents especially women seemed to have relatively little knowledge about waivers and exemption mechanisms. Therefore, more strategies are required to enhance public knowledge of waivers and exemptions, including eligibility criteria for people who are to be protected by such mechanisms. Also, the significant number of respondents who did not know the reasons for the cost-sharing policy and about waivers and exemptions indicates that much effort is needed to advertise the policy if the community is to effectively participate in its implementation.

It is important to consider that those respondents who believed that the existing user fee rates at the Korogwe district hospital were not affordable might have confused the rates of fees charged to outpatients and rates for other services, such as inpatient admissions, and for other grades of services. This might have been the case due to the ambiguity of the question posed, which did not focus on which types and rates of charges. Nevertheless, what is important to note here is that most community leaders interviewed felt that some village residents could not afford user fees.

Concerning waivers and exemptions, it was not clear whether those who said that these mechanisms did not exist actually meant that they were lacking in practice though they existed in theory, or whether the mechanisms did not exist in either theory and practice. Further investigation would be needed to clarify this point.

It is also important to note that people's perception to either health care charges or to quality of care may reflect their perceived willingness to utilize the health facility where fees exist. The question of how they assessed ability to pay remains critical.

Generally it seems from that in the period between 1993 and 1998 (immediately after the introduction of user fees), the average outpatient attendance at public facilities dropped but at a lower rate than in the period beforehand while there was an almost constant average admission of inpatients. As for the latter, the rate of admission might have not been affected by the introduction of fees either

because fees were modest enough to be afforded by the patients or because of inability to manage severe conditions, such as malaria, at lower primary-level health care facilities. The high average rate of drop in outpatient attendance before 1993 might have been caused by the reinstatement of private for-profit medical practice in the early 1990s. Since malaria was reported to be the most important public health problem, causing the highest number of outpatient attendance and inpatient admission in the district, the other factor that contributed to the drop in average attendance at the district government hospital might have been the high level of self-medication, as data on community health seeking behavior collected in this study illustrates. Self-medication for malaria using antimalarial drugs bought from retail shops was found to be highly adopted in the neighbouring Same district in Kilimanjaro region (Alilio et al. 1997). However, self-medication seems to have been a practice by the communities in Korogwe district even after the introduction of fees at the district government hospital. The high average drop in outpatient attendance before the introduction of user fees (1990-June 1993) might also have been caused by the low quality of health care provided (as perceived by the study community), although the data do not show that the quality of care improved after the introduction of fees. Studies from various countries in Africa show that the impact of fees on patient attendance could be positive if fees are used to improve the quality of care at health facilities (World Bank 1993, Shaw and Ainsworth, 1996, Gilson 1997, Leighton 1995).

It was seen that the number of patients/escorts interviewed of the female sex was greater than that of male sex. One possible reason might be that, when a health problem occurs to one of the household members, women are much more responsible than men of escorting their relatives to health facilities.

Different factors can be regarded as being the reason why the study households seemed to have a few elderly members. One reason might be the short life expectancy of the study population defined in terms of pre-mature deaths among children and deaths that occur before the age of 50 years due to disease or accidents. Based on the 1988 census, the current demographic statistics indicate that life expectancy in Tanzania is 49 years in males and 51 years in females (Bureau of Statistics, Tanzania 1998). The other reason might be the bias or error that might have risen from the sampling of the study households; this, however, is unlikely.

We have also seen the low number of teenagers in households reported. The reason might be that after their completion of standard seven primary school age, most teenagers leave their homes and move to towns in search for what they perceive as employment to sustain their lives although they end up not reaching their intentions. The situation becomes worse for the majority of girls who may end up being prostitutes after becoming jobless. The other group disadvantaged is that of elderly or widowed women who are left helpless by being overburdened by farming and other domestic activities.

Much can be argued regarding factors that might have contributed to households and other respondents who reported to have not sought for care from the district government hospital. One might be the long distance to travel to and from the hospital, associated with extra direct (e.g., bus fare) and indirect costs (e.g., time and other opportunities wasted). Another possibility might be that the respective respondents did not face any serious or sensitive health problem. A third possibility is that one objective of user fees in the public health sector in developing countries was to reduce “unnecessary demand of public hospital services as they were previously viewed to be misused making the sector partly inefficient as users did not pay for them” (Green 1992; Abel-Smith 1992). One could argue that the high proportion of people who seem to have not sought for care from the district government hospital might have been deterred by the user fee system. In this regard the policy might have succeeded to meet one of its missions of rationalizing the utilization of public health services.

Retail drug sellers mentioned chloroquine and fansidar had been bought more frequently than other types of antimalarial drugs because of the recurrence or frequency of suffering from malaria. But this reason does not sound convincingly sufficient to conclude or agree with their explanation. There might have been other factors for this such as individual preference to such a drug, availability of such drugs compared with other brands of drugs, individual perception to alternative drugs, and the like.

The data may be used to support the idea that at least some malaria patients deserve to be exempted from paying for care. But putting this proposal into practice in a country like Tanzania, where malaria is endemic, has little potential. Exclusion of all malaria patients from paying for health care would have a significant negative consequence on health facilities working either to recover costs.

Data collected on waivers and exemptions showed that more waivers were granted by the private not-for-profit health care providers than the private for-profit ones. A possible reason is that each type of these health facilities operates under different missions or objectives and likely they have different administrative/organizational systems. One of the objectives that makes the difference is that, as their name says, private not-for-profit usually known as “mission” or “voluntary,” health facilities do not primarily operate for profit. They are primarily established to provide health services based on the religious principle of assisting the poor under “humanitarian or good samaritan” belief. Also, mission health facilities receive subsidies from the government and often receive free or low-cost drugs and other medical supplies from donors within and outside the country. In contrast, most private for-profit providers, as their name sounds, primarily operate on profit motives. Most are owned by individual persons rather than companies or organizations with big capital to subsidize them when they seem to incur extra costs. For them, therefore, the granting of many waivers could have an adverse effect on their business. A recent hospital survey in Tanzania (Newbrander and Sacca 1996) revealed that little information has been disseminated about the waivers and exemptions. According to these authors, it is evident that some facilities do not want to “advertise” waivers and exemptions because of the concern of abuse, although in an attempt to generate revenue, there may be undercoverage of the poor. This argument can be supported or strengthened by answers obtained in this study. This was one way of assessing the attitudes to such protection mechanisms from a private-sector point of view. Of the 32 private for-profit health staff interviewed, 28 (88 percent) perceived that it was a loss to waive or exempt people from payments while four (12 percent) perceived that it was not. Of the 12 private not-for-profit health staff interviewed, only three (25 percent) perceived that it was a loss while nine (75 percent) perceived that it was not. However, two (17 percent) of nine health staff who perceived that it was not a loss pointed out that even if in reality it may be a loss, it would not be good to deny a patient treatment because of failure to pay.

The study found that some patients who contacted private health facilities and retail drug shops were treated free of charge because of they were unable to pay for it. If really that was the case, such an attempt by the private health staff and retail drug sellers is commendable, as it is ethical from the medical profession and social point of view. Cost recovery motives should not be used as the basis for the health care providers to disregard the poor population groups who seem to be unable to afford medical care costs. In the real (practical) situation, however, giving medical care free of charge to every patient who ask for a waiver because of lack of money might not be possible since a sustainable delivery of care needs resources among which the community users of health care are expected to contribute financially.

Despite this claim of free care, skepticism that in reality, some patients might have been turned back home without treatment. This would have been difficult for health staff at fee-charging health facilities to admit. This thinking is strengthened by 5 percent of retail antimalarial drug sellers who

openly reported to have decided not give any drug to people who failed to pay. This was supported by household heads who reported knowing of village residents who were refused care because of their inability to pay, some of whom are said to have died. No further investigation was made to identify which specific type of health facility organization had denied access to care.

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## 7. Conclusions and Policy Implications/ Recommendations

In general, community knowledge of malaria as the most important public health problem seemed to be high and the majority of the interviewees seemed to have good knowledge of various measures towards its control. Nevertheless, the belief expressed by some of the focus group participants that malaria cannot be effectively controlled unless mosquitoes were eradicated cannot be ignored. This implies that more efforts need to be made by malaria control managers in order to educate and sensitize communities about mosquitoes and malaria prevention and treatment. People should not give up or get discouraged from taking measures towards preventing malaria because of the prevalence of mosquitoes in their areas.

Another strategy towards ensuring that the control of malaria is effective at the community level is for the government and donor agencies to continue supporting studies of patterns of antimalarial drug utilization in different areas in the country.

It is important to sensitize communities about the risk of utilizing antimalarial drugs bought from unregulated commercial sources such as ordinary retail shops and kiosks without getting appropriate medical advice regarding the type of antimalarial drug for use and the standard course/dose. Health education/sensitization campaigns about drug prescriptions and utilization should be a two way process, targeting users and commercial drug sellers. The approach towards attaining this may vary from district to district depending on the socioeconomic and epidemiological environment concerned but there should also be a national essential drug program with nationwide guidelines concerning this. As for malaria, the National Malaria Control Program is the most appropriate authority responsible for this, among its other responsibilities relating to malaria control.

People should also be sensitized through mass media, public meetings and other ways of communication, about being careful with contacting traditional healers on various health problems. It is realized that traditional healers are useful health care providers to people but the doubt is about those who pretend to treat health problems that can only be effectively managed at modern health facilities. The doubt is also about those who cheat people that various health problems are a result of witchcraft, although some of those who seek for traditional medicines do so as an alternative option after they had failed to get the expected care from modern health care providers.

Health education and policy programs may reach local communities through various ways but more effectively through mass media such as radio announcements, newspapers and through local/village public meetings.

It is essential to involve local community leaders in the identification of the poor individuals eligible for payment waivers if the latter have to be effectively implemented.

There are possible ways of avoiding abuse of the waiver system where some individuals might be waived without being eligible, and as a matter of ensuring public confidence in the financing system. Any decision as to who is eligible for a waiver at local (e.g., village) level should involve more than one local leader or community representative. Also, periodically the rest of the community

members should be given feedback about those that had been waived or exempt from health care fee charges.

Not only advertisement should be increased regarding health care fee waivers and exemptions, but also more public campaigns are required to sensitize residents about the objectives behind the implementation of cost-sharing policy in the public health sector. Information can reach the targeted residents through mass media, posters, local public meetings and health workers. Health workers should not hesitate to inform patients who seem not to be aware of fees while they are already at the health facility for treatment so that they can get prepared to pay during their later trips to hospital.

Involving local community residents in design and establishment of low-cost community financing (such as prepayment) schemes could be potential for reducing the risk of people who might be bankrupt by the time they are in need for essential health care. The Bamako Initiative type of community health fund scheme implemented in several districts in Tanzania is a good example, although there might be some constraints in its implementation. People may be ready to pay if they are sensitized well of the benefits of paying for health care in advance of their facing illness or accidents. Nevertheless, there must be little bureaucracy in fulfilling the needs of the members of prepayment schemes if the latter have to maintain their members or attract additional ones and become sustainable (see also Mubyazi 1999).

Educating and regularly reminding people to work hard and have a habit of making personal/family savings would have, (even if with long-term implications) a contribution towards enhancing most people's ability to pay for health care by cash.

Treating people who fail to pay promptly by cash at health facility counters on loan agreement basis would contribute to increasing coverage of the poor even if the scale of the application of this payment system might be limited and might vary by type of health facility organization or ownership. The follow-up of claims from those indebted could effectively be done if there were a strong co-operation between and among the management personnel of the health facilities concerned and village health workers and local government leaders in the areas where the indebted patients reside.

Ensuring quality care especially adequate supply of essential drugs, patient bed services, patient-health staff communication, and shortest possible patient waiting time at health facilities, would enhance community's willingness to pay, attendance and actual paying for health care even in public health facilities.

Bringing health facilities closer to the people would increase the geographical equity of access to health care facilities among the residents and reduce the extra some cost people incur by paying for transport to and from seeking for health care from health facilities located very far from their homes. Where possible, the introduction of mobile clinics might contribute to reaching the poor residents in remote areas very far from modern health facilities and where communication by road is very difficult.

## Annex A: Divisions, Wards, Villages, and Health Facilities that Participated in the Survey

DIVISION	Ward	Village	Health Facility
KOROGWE	Korogwe	Kwamsisi	Arafa ( <i>Private for-profit</i> ) Dispensary  Upendo ( <i>private for-profit</i> ) Dispensary  St. Raphael ( <i>Anglican Church</i> ) Hospital  Neema ( <i>private for-profit</i> ) Dispensary  Manundu ( <i>private for-profit</i> ) Dispensary  Magunga (Korogwe) District Government Hospital
	Magunga/ Msambiazi Magunga	Msambiazi	
	Old Korogwe	Old Korogwe	
	Ngombezi	Ngombezi Mgambo	
	Msambiazi	Mtonga  Kwemkole  Msambiazi	
	Kwamndolwa	Kwameta	Kwamndolwa ( <i>Roman Catholic Church</i> ) Health Center

DIVISION	Ward	Village	Health Facility
	Mnyuzi	Mnyuzi	Hale-Tanesco ( <i>Voluntary</i> ) Dispensary
MAGOMA	Magoma	Makangara Makolora	
	Mashewa	Mashewa Kulasi	
	Kizara	Kwemkole Bombo/Majimoto	
	Kerenge	Kerenge	
MOMBO	Mazinde	Mazinde/Mkumbara  Mazinde  Mazinde-Ngua	Mazinde Ngua ( <i>Roman Catholic</i> ) Dispensary  Mazinde ( <i>private for profit</i> ) Dispensary
	Mombo	Mlembule	Mombo ( <i>private-for-profit</i> ) Dispensary
	Mkomazi	Mkomazi	
	Makuyuni	Makuyuni Magila-Gereza	
	Mkalamo  Chekelei Chekelei	Mkalamo Toronto Magamba/Kwelukombo	
		Chekelei	
BUNGU	Lutindi	Welei	

DIVISION	Ward	Village	Health Facility
	Dindira	Kwefingo	

**Villages in which FGDs were conducted**

DIVISION	Ward	Village
KOROGWE	Msambiazi	Mtonga
	Korogwe	Kwamsisi
	Mnyuzi	Mnyuzi
MOMBO	Mazinde	Mazinde
		Mheza
	Makuyuni	Makuyuni
MAGOMA	Kwamndolwa	Kwameta
	Magoma	Makangara



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