EQUITY IMPLICATIONS OF HEALTH SECTOR USER FEES IN TANZANIA

Do we retain the user fee or do we set the user f(r)ee?

ANALYSIS OF LITERATURE AND STAKEHOLDER VIEWS
Commissioned by Research for Poverty Alleviation (REPOA)
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FINAL REPORT

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EXECUTIVE SUMMARY

1. Background

Early 2004, Research for Poverty Alleviation (REPOA) commissioned ETC Crystal to examine the equity implications of health sector user fees in Tanzania, with particular reference to proposed and actual charges at dispensary and health centre level. This year, Tanzania will review its PovertyReduction Strategy. With the findings of the user fee study, REPOA aims at making a valuable contribution to the review process and provide country-specific insight into one of the most debated issues in health financing.

2. Methodology

The focus and design of the study was formulated in close cooperation with the Research and Analysis Working Group of REPOA. The strategies for data collection comprised:
(1) a comprehensive literature analysis literature,
(2) semi-structured interviews with resource persons from the government of Tanzania, multi- and bilateral donors, research institutes and NGOs in Dar Es Salaam, and
(3) a case study in Kagera Region, including both document analysis and semi-structured interviews with resource persons from the MOH, NGOs, FBOs, health workers and health care consumers from vulnerable and poor population groups.

The study team developed multiple tools for data collection and analysis including:
(1) a data matrix for categorization and identification of key issues,
(2) guidelines for the interviews in Dar Es Salaam,
(3) guidelines for data collection and interviews in Kagera Region, and
(4) a tool for the analysis of poverty reduction strategy documents.

A total number of 170 user fee-related documents were assessed, including those covering the experience from neighboring countries. Seventy-nine resource persons participated in the study.

3. Main findings and recommendations

1. *Resources generated by user fees and their use at hospital, district council and PHC levels.*
The study team found that reliable, transparent user fee income data for district, hospital and PHC level were difficult to obtain. Based on what information is available, the team concludes that revenues raised from user fees at the hospital level have been lower than what has been projected. Furthermore, the data reflect huge variations between facilities and a decline in the revenues from cost sharing. The reasons of the reported decline are unclear. The data reflecting the contribution of user fees and CHF to the health budget at district council level show huge variations as well. The reported user fee income proportion for the district health budget was on average 10.5%. The study team could not establish how the income from cost

sharing and the CHF was re-distributed by the council to PHC facilities or priority areas. A worrying finding was that some councils did not spend all health resources in the health sector. The study team observes an urgent need for: (1) more accurate and comprehensive record keeping at local council level, and (2) more costing and tracking studies to obtain a better insight into cost sharing and expenditures and to adequately inform policy making.

2. *Contribution of user fees and CHFs to the health resource envelope.* The study team concludes that the national projections of the cost sharing schemes do not reflect an accurate picture, since the data are based on the inaccurate financial data received from the districts. It is likely that the actual and projected data on user fees, CHFs and HSF are underestimations of the real income collected at the different facility levels. This means that the MOH faces a loss of income that cannot be redistributed to the health sector. It also implies that people (both wealthy and poor) are likely pay more than what is officially reported. The actual potential and use of the non-reported user fees are not known. The total contribution of the cost sharing schemes (excluding NHIF) to the national health resource envelope for FY03/04 is 1.67 Billion Tshs. This equals a contribution of 0.6% to the overall budget for the health sector. In total, this is US$ 1.56 million. Given the size of the total health budget (US$ 260 million), it can be concluded that the *officially* reported user fees contribute a small proportion only. The actual revenue generated does not meet the initial expectations.

3. *Contribution of revenues generated to improved services*. The study team found limited positive evidence that user fees in Tanzania have in general achieved their original objectives of sustainability, drug availability, quality of care, equity and access for the poor. More specifically, the study team found that government-run PHC facilities appeared to face severe shortages of drugs and supplies. In addition, user fees were not always retained at PHC level, but deposited in the HSF account which mainly benefits the purchase of supplies for the district hospital. Positive results were seen for reinvestment of CHF funds. In total, 50% of the health workers and patients reported improvements in drugs availability, diagnostic facilities and maintenance. However, equity criteria for the distribution of available resources from the user fee income to PHC level are not systematically followed.

4. *Impact of user fees on access to health services*. The study team concludes that presently, the user fees in Tanzania are regressive and contribute to substantial exclusion, self exclusion and increased marginalisation. The team has collected evidence which shows that user fees have disproportionally affected access to health care for poor and vulnerable population groups, more specifically: (1) pregnant women from poor households, (2) under-five children from poor households, (3) orphans and especially double orphans, (4) widows, (5) people older than 60 years, (6) people with disabilities, and (7) AIDS patients.

5. *Further extension of fees to dispensary and health centre level*. Also at the PHC level, the study
team found that fees have negatively impacted the use of health care by the rural poor population, particularly women and children. Given the importance of the public PHC facilities for poor people (government health centres are the main choice for out-patient care for the poor), the study team expects that the further extension of user fees to PHC level without effective exemption and waiver mechanisms will contribute to further exclusion and self-exclusion.

6. *Effectiveness of exemption and waiver mechanisms.* The study team identifies the ineffectiveness of the present exemption and waiver mechanisms as the core problem in the user fee debate in Tanzania. A functional exemption and waiver system is actually non-existent putting vulnerable and poor people at risk by practically denying them access to public health services. This applies both to (1) the exemption and waiver system in health facilities and (2) the exemption mechanisms instituted for the CHFs. In both situations, poor people just do not receive the exemptions to which they are entitled to! Revenue collection appears to prevail over protecting the poor and vulnerable. Some hospitals have even tried to hide the waivers in their

statistics in order to have, on paper, a better performance with their user fee income. The study team recommends that, should the government of Tanzania decide to maintain its user fee policy, priority is given to the design of an effective exemption and waiver system combined with: (1) sufficient resources to compensate for the unknown money lost (since it not recorded properly), and (2) a serious effort to make it work. However, there is substantial evidence that exemption and waiver systems do not guarantee increased access to health services for poor people unless major adjustments in the design, implementation and funding for adequate exemption and waiver systems take place. In the light of recent developments in Uganda and Kenya, it seems a much more realistic approach to compare the costs of (1) the suspension of user fees at PHC level against the required costs for (2) improved exemption and waiver systems or (3) improved NSHIF approaches in the contest of abolishment of fees and to opt for the most pro-poor and cost-effective approach within the shortest possible time frame.

7. *The potential and impact of Community Health Funds.* The introduction of the CHF has not provided the expected benefits for poor people. There are a number of constraints the study team thinks should be urgently addressed, including the delays in the introduction of the CHFs and the weak management at the district and lower levels. More importantly, the study team found that poor people often cannot afford to pay the CHF premium because it is too high and has to be paid at once. If membership of the CHF becomes compulsory and poor people are not effectively exempted from paying CHF premiums and co-payments, the impact of the CHF can be disastrous and lead to double exclusion of poor people. Another issue of concern is related to the link between user fees and the CHF. According to the CHF Act, the user fees paid at public health centres and dispensaries form a source of income to the CHF. The premium paid to the CHF will receive WB matching funds, putting pressure on the PHC facilities to raise income through user fees. This indicates a complicated dilemma since it means that if user fees will be suspended or abolished at PHC level, the CHFs will not be able to take off as planned and will not receive part of their required resources. This points to the need to assess the mix of financing mechanisms and their interactions, rather than look at them as stand-alone policies. Tanzania has opted for a system of multiple risk-pooling schemes for the health sector. There is an urgent need to review the ongoing processes and assess their impact on the overall health system and the vulnerable members of the population.

8. *Scenarios*. Reviewing the available literature, the study team observes that the abolition of user fees for education in Tanzania, and for health in South Africa and Uganda, has had impressive results in terms of attendance and access. Recently, Kenya also decided to abolish user fees for health. However, when reviewing the stakeholder's attitudes towards abolition, the study team concludes that the necessary support for such a decision seems to lacking in Tanzania at present. The study shows that Tanzania is at a cross road. Tanzania can opt for two strategic directions. One strategy can be to continue on the road of the multiple risk pooling strategies. The other strategy can be to follow the abolishment of user fees at either (1) all levels or (2) at PHC levels. Both strategies will require substantial support from external donors and will require major adjustments in the current funding mechanisms. However, given the negative equity implications for poor people with the multiple risk pooling systems and the complicated, time consuming, costly and unreliable administration that is required for user fee systems and CHF, evidence indicates that it seems a more pro-poor and pragmatic strategy to abolish the user fees for poor people either (1) temporarily till improved exemption and waiver systems have been designed and introduced or (2) as long as the poverty situation in Tanzania requires. In case Tanzania will opt for the continuation of a multiple risk pooling system, then a number of key conditions will have to be met in order to ensure access to health services for poor people. It will be crucial to assess the mix of financing mechanisms and their interactions rather than look at them as stand-alone policies.

Considering the severe poverty situation in Tanzania, it is concerning to find that many stakeholders continue promoting and supporting user fees in the absence of effective exemption and waiver systems. This does not correspond with the commitment to reducing poverty in Tanzania as articulated in the PRS. Consequently, immediate political action is

required. Abolition of user fees can be considered as a pro-poor option to reduce exclusion and self-exclusion among the poor and vulnerable. The studies illustrate, that the abolition of fees needs to be combined with considerable efforts in other areas, such as changed levels of funding (internally and externally), improvements in the allocation and disbursement of funds, improved human resource development, improved incentive schemes for health workers and improved quality of services. This indicates the importance of a broad, strong political support and donor support.

9. The developments in Uganda and Kenya might have created a momentum for Tanzania to rethink the current multiple risk pooling strategies in the context of the PRS Review and to opt for more pro-poor health strategies. It should be noted that in the current political situation strengthening the existing exemption and waiver systems seems to be the most preferred scenario at this moment. However, in the light of all the constraints mentioned and in the context of positive developments in Uganda and recent decisions taken in Kenya, the study team would like to recommend to include the suspension of user fees at PHC level in the next PRS document for Tanzania as a real pro-poor health strategy for Tanzania. The study team considers the Poverty Reduction Strategy Review Process as an excellent opportunity to lobby the government and the development partners on these issues, and to demand that a specific Plan of Action is included in the second Poverty Reduction Strategy Paper. The study team hopes that the findings of this study will contribute in such a positive and constructive way to the Tanzania PRS Review Process. The outcomes of this study confirm that in Tanzania, user fees are an issue to be carefully (re)considered when designing national pro-poor health policies in Poverty Reduction Strategies.
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