



Save the Children



The Unbearable Cost of Illness

Poverty, ill-health and access to healthcare –
evidence from Lindi Rural District, Tanzania

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Abbreviations and acronyms

| | |
|------|---|
| CBO | Community Based Organisation |
| CHF | Community Health Fund |
| DMO | District Medical Officer |
| FGD | Focus Group Discussion |
| HEA | Household Economy Analysis |
| HH | Household |
| HW | Health Worker |
| LZ | Livelihood Zone (HEA concept) |
| MCH | Maternal and Child Health |
| MoH | Ministry of Health |
| PHC | Primary healthcare |
| PRSP | Poverty Reduction Strategy Paper |
| STD | Sexually Transmitted Disease |
| TB | Tuberculosis |
| Tsh | Tanzania Shillings (exchange rate approx 1,000 Tsh = \$1) |
| VEO | Village Executive Officer |

Glossary

| | |
|------------------------------|---|
| Community health fund | A prepayment scheme recently established in Tanzania, whereby people working in the informal sector are able to pay an annual premium which entitles them to free service in public facilities. |
| Chronic illness | Defined here as illness which lasts more than one agricultural season. |
| Exemptions | Categories of services (such as treatment for TB) which are free. The term is often used interchangeably with 'waivers', which are categories of people (often 'the poor', however defined) who are allowed to access services without paying charges. |
| Indirect costs | Opportunity costs of illness, such as lost production, time and income. |
| Livelihood zone | Geographic area in which the majority of households obtain their food and cash income through a similar combination of means. |
| Labour poor | A household with more dependent than economically active members. |
| Primary health | A normative care concept, as laid out in the Alma Ata Declaration, encompassing the principles of accessibility for all, community participation, the importance of health promotion and a multi-sectoral approach to the production of health. |
| Reference year | Any data set has to be grounded on a particular time frame. Within the HEA methodology, data is collected in reference to a year that represents a relatively 'normal' or typical year as defined by the community. The fieldwork generates baseline/reference data by asking how people lived during the <i>reference year</i> . |
| Regressive | Form of tax or other financing in which the proportion of income paid (eg for healthcare) falls with rising levels income levels. This means that the rich pay proportionately less than the poor, although in absolute terms they are often spending much more. |
| Social protection mechanisms | Policies and practices intended to: protect people against shocks that could push them deeper into poverty; make poor people less vulnerable to these shocks; protect people against extreme poverty and its effects on wellbeing; and protect wellbeing at vulnerable periods of the life cycle, including early childhood. |
| User fees | Direct payments for services at the point of use by the patient, which are officially sanctioned. |

Abstract

Save the Children has studied the effects of user fees in healthcare on poor households in Tanzania. We have found that:

- user fees inhibit the use of public healthcare, particularly for households coping with chronic illnesses
- fee exemptions systems are complicated and difficult to understand; frequently they do not reach target groups
- families with chronic health problems are likely to become significantly poorer.

Save the Children recommends that:

- user fees in healthcare are ended
- central healthcare spending is increased
- healthcare delivery is reformed to better suit the needs of families coping with chronic illness.

Executive summary

Tanzania, like many low-income countries, faces difficult decisions about how to pay for healthcare. In the 1990s the healthcare system, which had been free and universal, began to share costs with patients via a system of user fees. The aim was to bring in more funds and drive up standards. But the results were disappointing: fewer people used the system and revenue from user fees was less than expected. At the same time, the quality of public sector healthcare remained low.

Save the Children carried out a series of quantitative and qualitative studies in Lindi rural district in southern Tanzania in 2003-4. We collected information about the costs of healthcare, health-seeking behaviour and the impact of chronic illness on households, with particular emphasis on poor and marginalised households.

This paper summarises the results of these studies, which included a household survey (of 532 households); 22 focus group discussions; 27 key informant interviews; a Household Economy Analysis (HEA) baseline study in two livelihood zones; in-depth interviews with 14 households affected by chronic illness; and interviews with 21 health staff in six rural facilities.

Poverty estimates

According to the HEA study, 30-40 per cent of the district are classified as 'poor'. Food accounts, on average, for 70 per cent of poor families' expenditure. Once minimum non-food costs are met, this leaves little flexibility for dealing with health or other crises. In the agricultural heartland, where 65 per cent of Lindi's population lives, poor families have only 1 per cent of their income available (compared to 30 per cent for the richer group). This amounts to some 1,600 Tsh per family per year.

Episodes of illness

Families typically face between two and six cases of illness each year. This applies relatively equally across the wealth groups. However, in one zone (the coastal zone), we found a significantly higher rate of chronic illness amongst the poorest families. This may be related to living conditions, and to an inability to afford treatment for chronic illness (see below).

Health seeking behaviour

Although illness is relatively evenly distributed across socio-economic groups, the number of times members of a household seek treatment relates directly to wealth. According to the HEA study, richer households treat an average of four to six cases per year; middle ranking households three to four; and poor households two to four (in the coastal and agricultural zones respectively). There is clear evidence that ability to pay is the limiting factor. The HEA study found that poor households in some areas were spending as little as 48 per cent of the typical annual healthcare expenditure required for households of their size. Clearly rationing is occurring, especially in the more populous agricultural zone.

For acute illness, visiting public healthcare facilities is the most common strategy (45 per cent), followed by self-medication (27 per cent). The poorest families are more likely to self-treat: 33 per cent self-medicate in cases of acute illness. When an illness demands admission, public facilities are most commonly used across all wealth groups, although a surprisingly high proportion (31 per cent) are admitted by traditional healers. For chronic illness, a worrying 54 per cent reported taking no action.

Lack of money was the main reason for not seeking care. In one area, of the poorest who did not seek care, 73 per cent cited lack of funds, compared with 0 per cent for the richer group.

Women were equally likely to seek care, but were more likely to consult a traditional healer, perhaps because of the flexible payment methods they offer. According to focus group discussants, the authority to agree cash payment for healthcare lies with men (either the husband, or his relatives when he is away). This can mean that urgent care for children is delayed.

Direct health costs

All groups spend between 1 per cent and 4 per cent of their total income on healthcare. For the poor, the proportion is slightly higher, though the absolute amounts they spend are much lower at around 5,500-7,000 Tsh per year, per household. Better-off households spend two to three times as much. Overall, then, the system is mildly regressive, with evidence of rationing according to ability to pay.

The average cost per episode is 2,850 Tsh for all direct costs (fees, drugs, tests, transport, accommodation etc). According to the household survey, an episode of acute illness costs, on average, 1,590 Tsh. This is one third of chronic illness costs (4,939 Tsh) and a tenth of the cost of an admission (15,337 Tsh).

For chronic illness, self-care is by far the cheapest strategy, followed by public healthcare facilities, then traditional healers and private care. For admissions, there is little cost difference between public, private and traditional facilities.

Within public facilities, the poor appear to be paying more for each admission. Similarly, for chronic care in private facilities, the poor are being charged more on average per episode than the middle and better off groups. This is mysterious and merits further investigation.

Fees are not the most significant part of the direct costs of healthcare. For acute illness, transport, tests and drugs are the biggest costs, while for chronic illness, traditional healers, transport and drugs are the most expensive items. For admission, food and accommodation are the most significant expense.

Cost-sharing

According to our interviews with health workers, cost sharing practices are highly variable, without clear systems for setting fees, or collecting, using and reporting on them.

Fees are generally low – in the range of 200-500 Tsh – but so is community willingness and ability to pay, according to health workers. Health workers reported a fall in the use of all but one healthcare facility after fees were introduced. Ability to pay is also seasonal – use goes up during harvest time and drops in the dry season when cash is scarce. During this time, the sick are more likely to visit traditional healers who have flexible payment arrangements. People

know when health centres have drugs in – generally, early in the month – and are more likely to visit then, compared with later on when stocks have run out.

Patients' fees are used to buy day-to-day supplies and pay staff allowances. Although not large, they are highly valued by the health staff.

Exemptions

There is a lack of information and understanding of the exemption scheme by communities and even health-workers. The policy is interpreted differently by different facilities.

All facilities claimed to exempt children under five, pregnant women, chronically ill people, the elderly and the disabled. Yet according to our household survey, only 20 per cent of children under five were exempt from admissions costs, and 49 per cent from acute care costs. None had specific exemptions for poor people.

Exemptions from user fees are given to a relatively large number of people, but there is evidence that they are often going to the wrong people.

According to the household survey, 50 per cent of the poorest families were exempted from fees for acute illness. However, when it comes to more expensive interventions, such as admission, the richer group are capturing more of the benefits (23 per cent were exempt, compared with 12 per cent of the poor). According to health workers, leakages to local leaders do happen, though it is hard to track the scale of the problem as record-keeping and transparency are very poor.

Coping strategies

Nearly one third of families reported that they had been unable to pay for care in the most recent episode, according to the household survey. The most common methods of financing care are to sell crops and to borrow. The better off are also able to sell assets.

Impact of chronic illness on households

Poorer households affected by chronic illness often face a cycle of despair, increasingly unable to cover escalating healthcare costs, as incapacity erodes their ability to work. In-depth interviews revealed how households tried a series of strategies, increasingly using up resources before abandoning treatment having lost hope of finding a cure.

Households spent between 3,000 and 40,000 Tsh per year on treatment – up to three times the amount they spent on healthcare before the illness. Although all those interviewed were technically eligible for exemptions – as sufferers from chronic illnesses such as asthma and tuberculosis – only one person had received any.

Drought in 2003/4 affected households suffering from chronic illness particularly acutely. In response, they used strategies such as: reducing the area they were farming; changing their agricultural activities; calling in support from relatives; reducing expenditure to a minimum (including withdrawal of children from school to assist at home); substituting cheaper sources of nutrition and stopping treatment for the ill member of the household. All became labour-poorer as a result of the double shock. The minority were able to keep their income at

previous levels through various strategies; the majority saw income levels fall by 20-40 per cent. Some shifted from being middle-level households to being poor, and two shifted from poverty into destitution.

Recommendations

- 1 User fees bring in little revenue and are perceived as a barrier to healthcare, particularly for the poorest families. They should be abolished, thus emulating the success of the free primary education policy in Tanzania and the free public healthcare policy in Uganda.
- 2 Exemption mechanisms are not effective. They should be replaced by free access to primary healthcare and essential life saving services (such as emergency obstetric care).
- 3 If cost-sharing initiatives are considered in the future, they should be thoroughly tested and their impact on the poor assessed before becoming national policy and practice. Creating a sustainable healthcare system is important, but not at the cost of deepening inequalities and vulnerability.
- 4 A system of social protection should be established for vulnerable households suffering from chronic illness and other shocks, to prevent them falling into long-term destitution or being forced to compromise their children's fundamental rights to shelter, food, health, education and protection.
- 5 To improve services, the health budget, which declined to 9 per cent of government expenditure in 2004, should be increased, with defined strategies to bring it up over the longer term to the level recommended by the Sachs Commission (World Health Organisation, 2001).
- 6 Healthcare facilities are currently unable to deal flexibly with minor expenditures. This problem should be addressed by reforming budgeting and cash-flow in the public health sector to improve efficiency, enhance users' perceptions of quality and increase take-up.
- 7 The quality of primary healthcare services and the availability of drugs need to be improved. This will lead to a decline in self-treatment and self-referrals and a fall in opportunistic costs like transport and accommodation which fall particularly hard on the poorest families.
- 8 Monitoring Tanzania's poverty reduction strategy should include access and utilisation of quality healthcare by the poor as indicators to measure the impact of interventions.
- 9 The use of traditional healers is very high and they play a particularly important role in chronic and recurrent illnesses such as HIV/AIDS. The traditional health service should be recognised and linked to the conventional health service, and its quality should be regulated. More information needs to be collected about the traditional health system.

Introduction

After independence, Tanzania developed an extensive public healthcare infrastructure. The quality of public healthcare has, however, fallen since the late 1980s as a result of economic problems (volatile world commodity prices, worsening terms of trade and the build-up of debt), structural adjustment and funding constraints. These led in the early 1990s to the introduction of cost-sharing (first at the hospital, but later at lower levels) and the legalisation of private providers.

A number of recent studies testify that problems of quality and access remain, though there is a thriving market for alternative providers offering varying quality and effectiveness (Green, 2000). Poor people face a number of barriers to access including poor health worker attitudes, transport costs, cost of drugs, user fees, informal charges and uncertainty about charging and exemptions. User fee revenue for the sector has also been low. These problems have led in turn to the development of alternative health financing mechanisms since 2001, including a National Health Insurance Fund (NHIF) for public employees and a Community Health Fund (CHF) for the informal sector. The aim of these is to spread risks between consumers and increase revenue for the public health sector. However, coverage by these funds remains low (the CHF, for example, was estimated to contribute 0.7 per cent of the health budget in 2003/4 (Laterveer, 2004).

An underlying constraint is that poverty has remained stubbornly high. Over a decade there has been only a small decrease in income poverty of about three percentage points and an increase of the population below the poverty line. Some 36 per cent of Tanzanians now fall below the basic needs poverty line and 19 per cent below the food poverty line, compared with 39 per cent and 22 per cent respectively in 1991/92 (<http://www.tanzania.go.tz/statisticsf.html>). Two-thirds of Tanzanians perceive a decline in living conditions and a widening gap between rich and poor, and three-quarters believe that the cost of healthcare has increased over the past few years (Research on Poverty Alleviation, 2003).

One of the priority areas of Save the Children's Tanzania programme is increasing children's access to, and quality of, basic services, particularly health and education (Save the Children, 2004). In Lindi rural district, one of the poorest in Tanzania according to the Poverty Reduction Strategy Paper (PRSP), Save the Children has been developing a district health programme. As a component of this programme and in order to inform the national debate about health financing alternatives, Save the Children initiated a series of studies in 2003 to investigate health seeking behaviour and how communities cope with the costs of illness. This paper summarises the main findings of the studies and discusses their implications for public policy.

Background

Study objectives

The studies aimed to carry out the following tasks:

- 1 measure the financial (direct) costs of illness, and the production and wage losses (indirect costs) resulting from illness
- 2 describe the types and sequence of strategies adopted by households to cope with direct and indirect costs of illness (cost prevention or cost management strategies)
- 3 evaluate the impact of illness costs and coping strategies on different dimensions of household livelihood, focusing on material assets, social networks and obligations, and debt levels
- 4 describe people's treatment seeking behaviour and the factors influencing this behaviour, including decision-making processes within households and the implications of these processes for women and children's access to health services
- 5 examine the availability and allocation of resources within the household to pay for different individuals' treatment, and factors influencing intra-household resource allocation
- 6 identify (and where possible measure) household and community social capital/resources
- 7 identify the factors influencing exemption policy effectiveness (coverage of the poor; leakage to non-poor).

The component studies

In order to fulfil these objectives, a series of studies, using quantitative and qualitative methods, were carried out between February and September 2003. They are summarised in table 1.

| Study | Type | Output |
|----------------------------------|--|---|
| Phase I (February 2003) | A quantitative cross-sectional household survey; focus group discussions and in-depth interviews | Database and report describing: <ul style="list-style-type: none"> • access to healthcare • households' health seeking behaviour • direct costs of healthcare • affordability and coping strategies |
| Phase II (a) (August 2003) | Household Economy Analysis baseline for two livelihood zones | HEA database and report describing food, income, expenditure and problem specification for different wealth groups in each livelihood zone |
| Phase II (b) (September 2003) | Individual interviews with households affected by chronic illness | Individual case studies with two components: <ul style="list-style-type: none"> • Health report: analysis of the timeline, cost and health seeking behaviour in relation to illness for each case • HEA report and database of case studies that describe food, income and expenditure for households affected by chronic illness. Each case describes the situation before they were affected, during the reference year and in the drought year |
| Phase III (January 2004) | Case studies with primary health facilities in Lindi rural district | A report on cost sharing and exemption practices in six primary health facilities |

Table 1: The three phases of studies in Lindi

Six wards in Lindi rural district were included in the household survey in phase I. Five hundred and thirty two households were selected using a sample proportional to size approach. A total of 2,510 people were reported to live in those households. Most of the analysis was carried out on the 91.5 per cent of the sample who lived in the coastal and agricultural zones. The HEA study was carried out in these zones, and so the household health-seeking behaviour information could be correlated with the income and expenditure data from the HEA study.

A structured household questionnaire was used to collect information on household livelihood, illness, care-seeking patterns, costs, cost management strategies and perceived impact. Qualitative information on similar topics was collected through focus group discussions and in-depth interviews. The interviewees included village government leaders, community based organizations, leaders and traditional healers. Focus group discussions included adults (men and women) and children (9-12 year olds, both in and out of school). A total of 22 focus group discussions were conducted and 27 individuals were interviewed. (For more detail on the methodology and results see: *Save the Children & Ifakara Health Research and Development Centre, 2003*)

This was followed by a HEA baseline study in zones one and four (Grootenhuis, 2003b). The agricultural zone (zone four), in the central part of the district, is characterised by deep, fertile soil and is the district's dominant farming area. Most households here are dependent on crop production as their main source of income. Households in the coastal zone (zone one) have access to the sea. In this area the collection of sea products, fishing and crop production are the most important sources of income (see figure 1 for the livelihood zones map of Lindi).

Finally, a total of 17 health workers and four chairpersons of facility health committees or boards were interviewed in six of Lindi's primary care facilities, using a key informant interview guide. These looked at cost-sharing and exemption practices from the supply side to complement the other studies which focused on the consumer point of view (Mbuyita, 2004).

The findings: household survey and focus group discussions

Household livelihoods

Households were classified by wealth group, as identified by the community, according to their land holdings and other productive assets. A breakdown by livelihood zone and wealth ranking of the participating households is given in table 2. The proportions falling into the 'poorest' category agree with the Household Budget Survey for 2000/1 which shows 39 per cent of rural Tanzanians under the basic needs poverty line.

| Category | Livelihood zone | | Total N=487 |
|---------------------------------|-----------------------------------|--|----------------|
| | Coastal Zone (Zone 1) N=139 | Agricultural Zone (Zone 4) N=348 | |
| Poorest | 36.0 | 42.8 | 40.9 % (199) |
| Moderate | 41.0 | 43.4 | 42.7 % (208) |
| Better off (wealthy) | 23.0 | 13.8 | 16.4 % (80) |

Table 2: Distribution of households by wealth groups within livelihood zones

Annual income of typical households varies substantially between different wealth groups. In zone one, where the distribution is less extreme, income doubles on average between the wealth groups. In zone four, it trebles on average between the 'poorest', 'moderate' and 'better off' (see table 3).

| | Coastal Zone | Agricultural Zone |
|----------------------|-----------------------|-----------------------|
| Poorest | 274,000 – 335,405 | 85,850 – 215,000 |
| Moderate poor | 400,790 – 535,300 | 298,900 – 801,600 |
| Better off | 1,000,000 – 1,243,300 | 1,145,500 – 1,822,800 |

(\$1 = Tsh 1,000)

Table 3: Annual household income by wealth status and livelihood zone (in Tsh)

There is roughly an equal proportion of households in the three wealth categories, and this applies to both zones. However, when it comes to households headed by a woman, significantly more fall into the poorest wealth group. Most female-headed households (60 per cent) in both zones were in the category of the poorest (see table 4). Overall, 28 per cent of the households in this sample were female-headed.

| Wealth group | Coastal Zone | | Agricultural Zone | |
|-------------------|--------------|----------------|-------------------|----------------|
| | Male N=97 | Female N=42 | Male N=253 | Female N=95 |
| Poorest | 25.8 | 59.5 | 35.2 | 63.2 |
| Moderate | 44.3 | 33.3 | 47.4 | 32.6 |
| Better off | 29.9 | 7.1 | 17.4 | 4.2 |

Table 4: Distribution of household headship by sex within the livelihood zones and wealth group

Illness

Respondents were asked about any incidents of illness in the household in the previous two weeks, either acute or recurrent (meaning an illness which had lasted more than one agricultural season). They were also asked whether any household member had been admitted to hospital within the past year. The results are shown in table 5.

| Category of illness | Total reported cases | Prevalence (%) | | |
|--------------------------|----------------------|----------------|------------------|-----------------------|
| | | All | Coastal Zone (n) | Agricultural Zone (n) |
| Chronic/recurrent | 236 | 9.4 | 8.3 (57) | 10.0 (160) |
| Acute | 200 | 8.0 | 7.3 (50) | 8.5 (136) |
| Admitted | 99 | 3.9 | 5.4 (37) | 3.4 (55) |

Table 5: Illness prevalence and admissions

The prevalence of reported illness within the previous two weeks (both acute and chronic) was 17 per cent, which is consistent with national figures. Malaria was the leading cause of morbidity and admission. About 24 per cent of reported chronic/recurrent illnesses were perceived as asthma, chest pain and tuberculosis. There were no reported cases of sexually transmitted disease (STD) or HIV/AIDS. However, the qualitative data revealed that STDs and HIV/AIDS are among the major problems in the community. Chronic illness was more prevalent among women aged between 15 and 44 (9.4 per cent), compared with men of the same age (4.4 per cent). In the coastal zone, the poorest reported a significantly higher prevalence of chronic illness ($p < 0.05$) (see table 6).

| Type of illness | Livelihood zones | | | | | |
|------------------|------------------|----------|------------|-------------------|----------|------------|
| | Coastal Zone | | | Agricultural Zone | | |
| | Poorest | Moderate | Better off | Poorest | Moderate | Better off |
| Chronic | 12.1 | 7.8 | 5.2 | 10.1 | 10.8 | 7.6 |
| Acute | 7.1 | 8.5 | 5.7 | 8.5 | 9.3 | 6.4 |
| Admission | 6.1 | 4.4 | 6.2 | 4.0 | 3.0 | 3.4 |

Table 6: Illness prevalence by wealth group within livelihood zones

A total of 370 (69.5 per cent) households reported at least one person ill within the past two weeks or admitted in the last year. Eleven households had at least one person in each of the three categories of illness (figure 2).

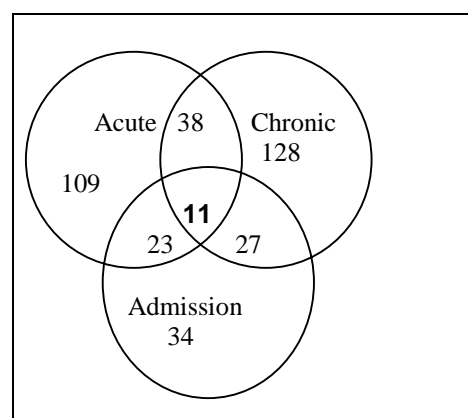


Figure 2: Illness and admissions in households (both zones)

Care seeking

Figure 3 shows the care seeking adopted for acute illness, chronic illness and hospitalisation. For acute illness, the most common approach is to go to a public facility (45 per cent), followed by self-medication (27 per cent). For chronic illnesses, however, 54 per cent took no action. This may reflect problems of affordability, and the perception that there is no cure. For admissions, public facilities were again the most popular (49.5 per cent), followed by traditional healers (31.3 per cent).

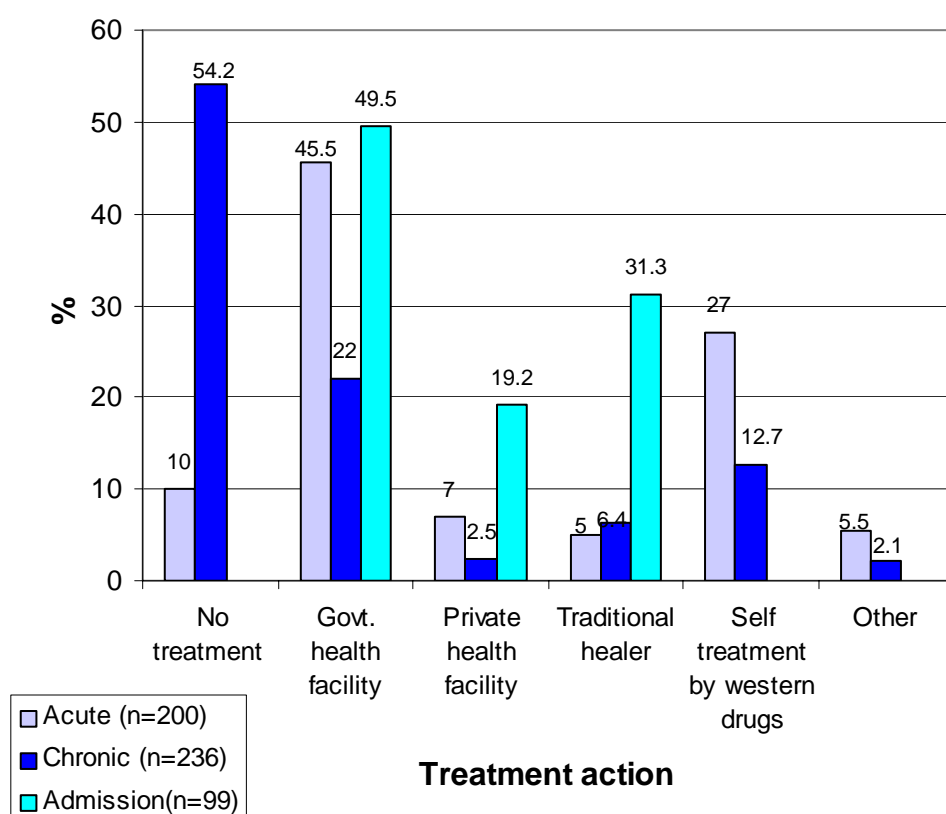


Figure 3: Treatment action by type of illness

For the poorest, the lack of cash was reported most frequently as the reason for not seeking care, particularly for chronic illnesses which are more costly. In the coastal zone, amongst the poorest who did not seek any treatment for chronic illness, 73 per cent stated lack of cash as the reason compared to 0 per cent among the better off (see table 7). This problem was confirmed by the focus group discussions.

| Wealth categories | Chronic (n) | |
|-------------------|--------------|-------------------|
| | Coastal Zone | Agricultural Zone |
| Poorest | 72.7 | 46.9 |
| Moderate | 41.7 | 41.3 |
| Better off | 0.0 | 25.0 |

Table 7: No care sought for chronic illness due to lack of cash by wealth groups within zones

Rates of overall care seeking showed no difference between the wealthy and the poorest. The poorest, however, were more likely than the wealthy to buy drugs from shops and treat themselves. This makes sense: self-treatment is a low-cost option. Private facilities were used more by the better-off group. Government services were heavily used by households from all three wealth categories, with a higher proportion of the better off using them for acute illness. (Neither the poor nor the wealthy use much care from traditional healers for acute illness.)

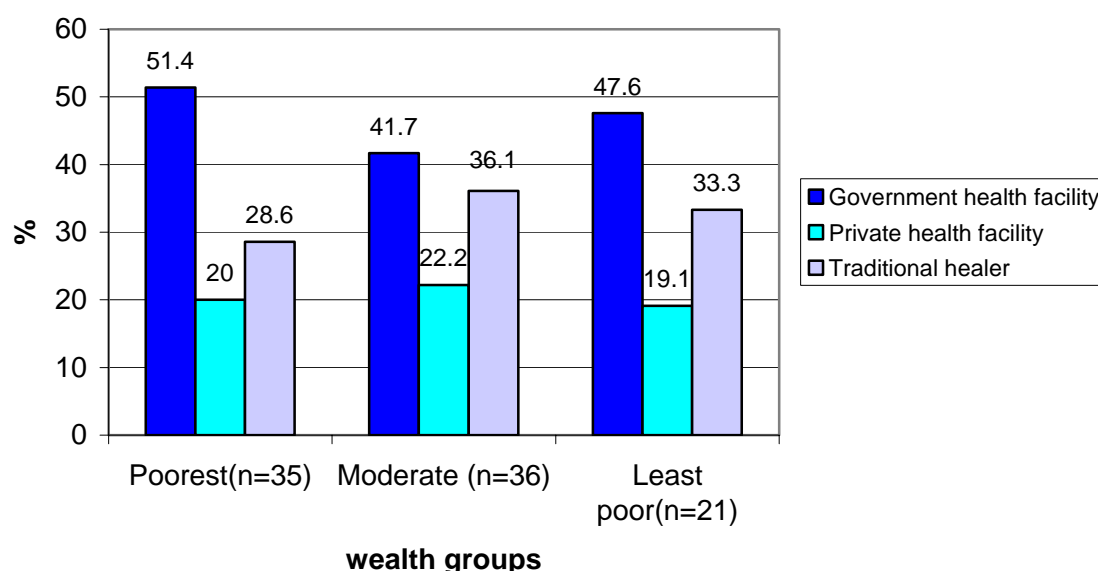


Figure 4: Place of admission by wealth groups

Traditional healers' services were popular for specific illnesses seen as linked with 'evil spirits'. Flexible payment methods for these services were cited as an advantage in focus group discussions. Surprisingly, a very high rate of admission to traditional healers' centres was reported across the wealth groups (figure 4). Although results did not provide evidence for an overall gender imbalance for care seeking, women used traditional healers' services more than men (see table 8). This may be related to cultural beliefs or to the fact that cash is not required up-front by traditional healers.

| Care sought | Wealth group | | | | | |
|----------------------|---------------|-----------------|---------------|-----------------|--------------|----------------|
| | Poorest | | Moderate | | Better off | |
| | Male N= 39 | Female N= 43 | Male N= 43 | Female N= 62 | Male N=14 | Female N=16 |
| Government facility | 15.4 | 20.9 | 23.3 | 24.2 | 14.3 | 37.5 |
| Private facility | 2.6 | 4.6 | 7.0 | 0.0 | 0.0 | 0.0 |
| Traditional healer | 0.0 | 4.6 | 2.3 | 11.3 | 7.1 | 18.7 |
| Medication from shop | 15.4 | 25.6 | 9.3 | 6.4 | 7.1 | 18.7 |
| No action | 66.6 | 41.9 | 55.8 | 58.1 | 64.3 | 25.0 |
| Other | 0.0 | 2.3 | 2.3 | 0.0 | 7.1 | 0.0 |

Table 8: Care seeking (treatment action) by sex across wealth categories for chronic illness

Treatment choices also varied between the two livelihood zones (figure 5). People in the coastal zone were more likely to use public facilities, compared with the agricultural zone where private facilities, traditional healers and self-treatment were relatively more common. This may reflect the available infrastructure.

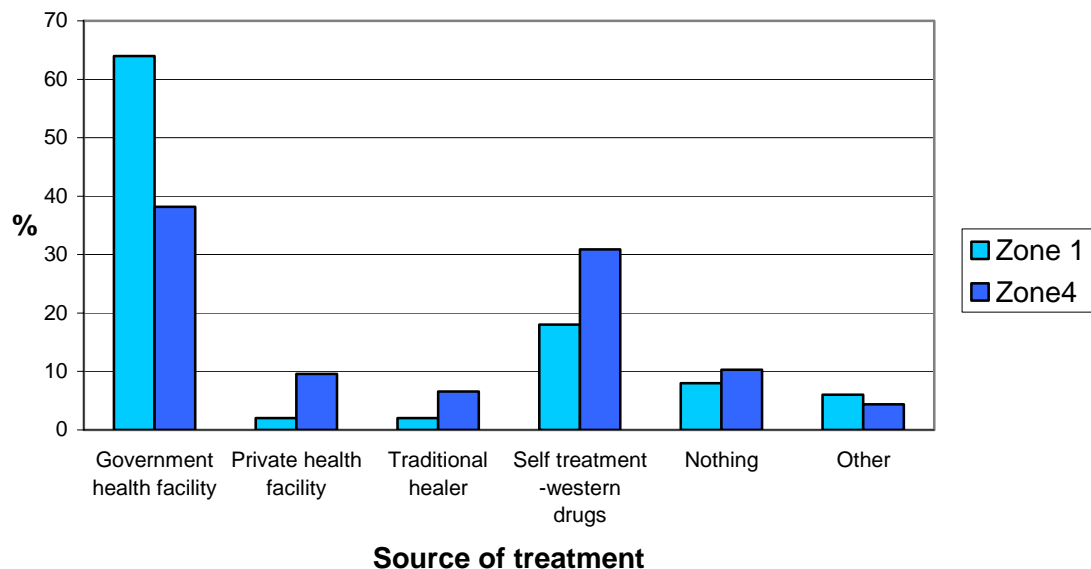


Figure 5: Source of treatment for acute illness by livelihood zone

Twenty per cent of those who reported an acute illness sought care from a second source.

Decision-making about care seeking

Qualitative data showed that men (fathers and husbands) are most central in making decisions about care seeking for household members. Although women are involved in discussions, men have authority over the decision. This posed problems when men were absent. Women were expected to consult their husband's family before incurring any expenditure, and this sometimes delayed treatment.

Exemption awareness and practice

Like many developing countries with user fees, Tanzania has a complicated list of exemptions, which includes children under five, pregnant women, people with chronic illnesses, and the elderly and others 'unable to pay' (Laterveer, 2004). The studies looked at how well known these categories are, and whether they are being observed in practice.

Results suggest that the exemption scheme is not functioning efficiently. Qualitative data revealed that many people saw exemptions as a special favour rather than a right. In the household survey, some 50 per cent of the poorest households had been exempted from paying for acute care. Moreover, leakage of the scheme benefits to the better off was also found, particularly for chronic illness and admissions (see table 9), which are, of course, the highest cost items.

| Wealth categories | Acute illness N= 88 | Chronic illness N= 51 | Admission N= 44 |
|----------------------|------------------------|--------------------------|--------------------|
| Poorest | 50.0 | 26.7 | 12.5 |
| Moderate | 40.5 | 10.7 | 20.0 |
| Better off (wealthy) | 19.1 | 22.2 | 23.1 |

Table 9: Exemptions at public facilities (as reported by households), by wealth categories

A break-down by age and gender (table 10) suggests that blanket exemptions for children under five and pregnant women are only partially realised. Only 20 per cent of under-fives were exempted from admissions costs, and 49 per cent from acute care costs. According to focus group discussions, interpretation of the exemption for pregnant women is very varied: in some cases, it is taken to mean exemption for maternal and child health (MCH) services only; in others, exemption from delivery ; in others again, exemption from all healthcare costs during pregnancy.

| Acute illness | | | | Admission | | | |
|---------------|--------|------------|---------------|-----------|--------|------------|---------------|
| Sex | | Age | | Sex | | Age | |
| Male | Female | Under five | Five and over | Male | Female | Under five | Five and over |
| N=69 | N=95 | N=45 | N=119 | N=39 | N=49 | N=25 | N=63 |
| 24.6 | 23.2 | 49 | 14.3 | 7.7 | 16.3 | 20.0 | 9.5 |

Table 10: Exemption by sex and age

The in-depth household interviews supported these conclusions. They found that only 50 per cent of households reported being aware of the exemptions policy, and that awareness was linked to wealth. Moreover, of those who were aware, very few knew the detail of which groups were entitled to free services and under what circumstances.

Treatment costs

The direct costs of illness data were collected in the household survey. These included the costs of fees, drugs, travel and accommodation.

The cost of admission was the biggest single expense, followed by chronic illness and then acute illness. The mean expenditure per individual on chronic illness at Tsh 4,939 (\$1=1,000 Tsh) was about three times higher than the mean spending on acute illness (Tsh 1,590). Mean admission cost per individual (Tsh 15,337) was about 10 times higher than mean costs per individual for acute illness. This was true for both zones. Median costs were lower: they were Tsh 1,000, Tsh 500 and Tsh 7,200 per episode per individual for chronic, acute and admission respectively.

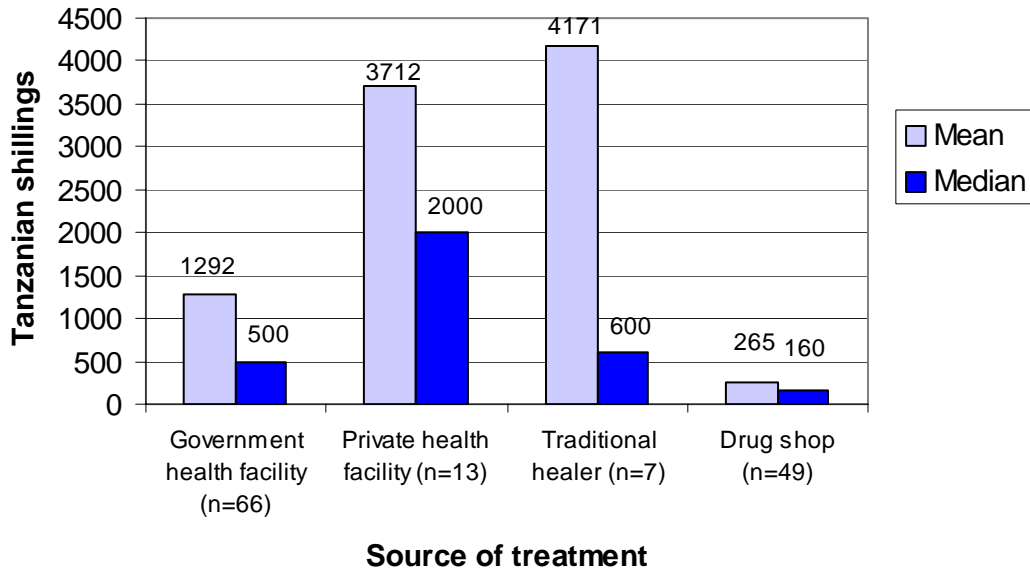


Figure 6: Treatment for acute illness: average cost by treatment source

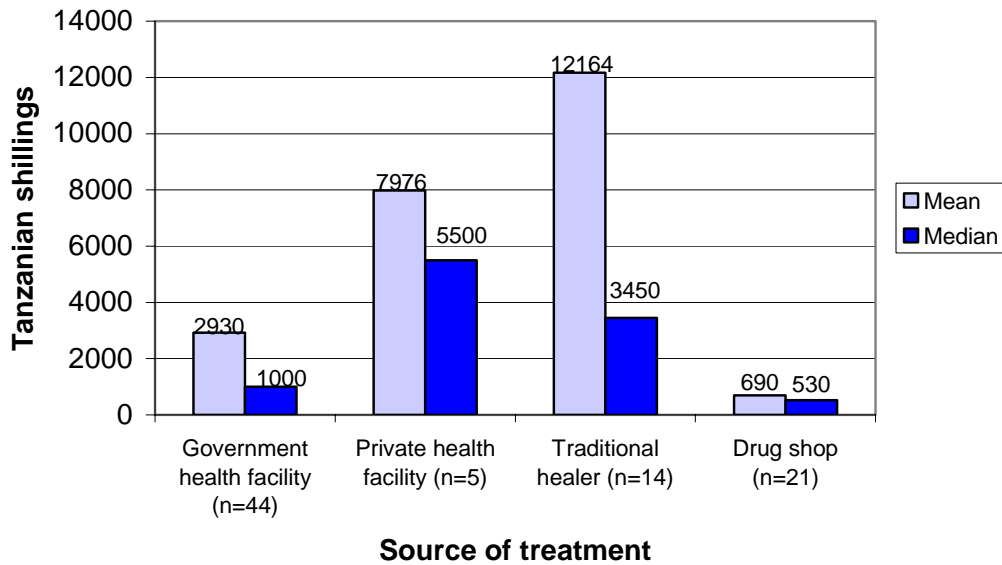


Figure 7: Treatment for chronic illness: average cost by treatment source

For acute and chronic illness, self-care is the cheapest option, followed by government health facilities (figures 6 and 7). Traditional healers' services are surprisingly expensive for chronic illness, with a median cost per episode per individual of Tsh 3,450 (compared with 600 Tsh for acute illness).

When it comes to admissions, traditional healers are the most costly on average, followed by government services and then the private sector (figure 8), but median payment is much lower. This may explain the high level of admissions by traditional healers, along with their flexible tariffs, based on perceived ability to pay (according to focus group discussions).

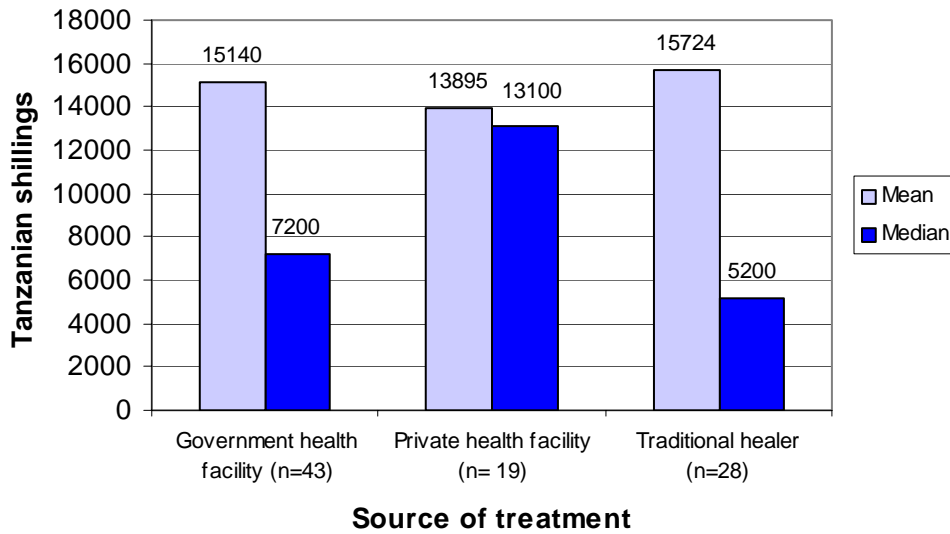


Figure 8: Average cost by place of admission

Figure 9 presents costs per episode, disaggregated by wealth group and illness type. It seems that the poor groups pay more than wealthier groups for admission to public facilities. This supports the evidence from health centres that waivers for the poor are not working. In the private facilities, poorer households are paying more for chronic care. Wealthier groups are paying more for admission in private facilities.

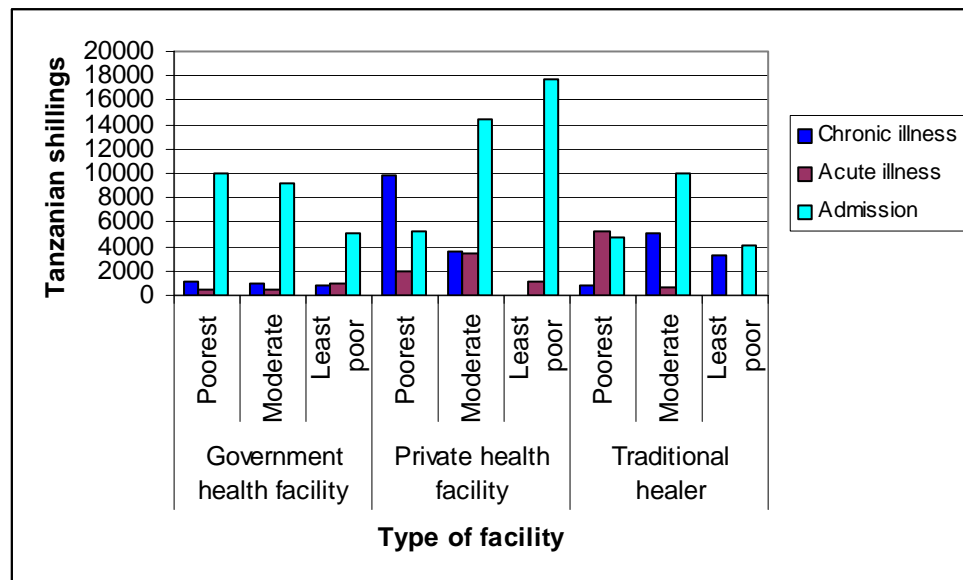


Figure 9: Median costs by source of care and wealth groups

The poorest households had a slightly lower median cost for combined chronic and acute illness compared to the other two wealth groups (Tsh 700 against Tsh 1,000) (figure 10).

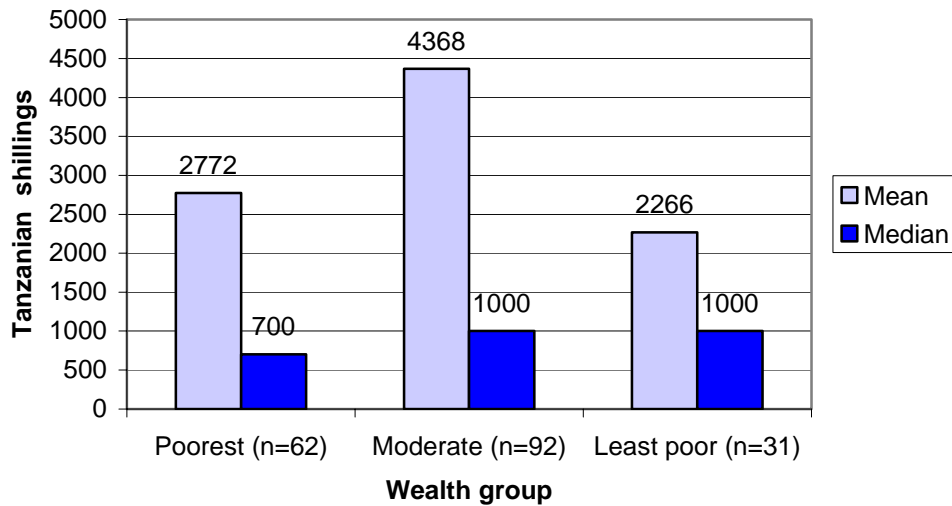


Figure 10: Average household direct costs of illness for all treatment (acute and chronic) by wealth groups

Most costs for acute illness were incurred on transport, laboratory tests and drugs. For chronic illness, the main cost items were traditional healers, transport and drugs. For admission, non-medical costs such as food and accommodation were most significant (figure 11).

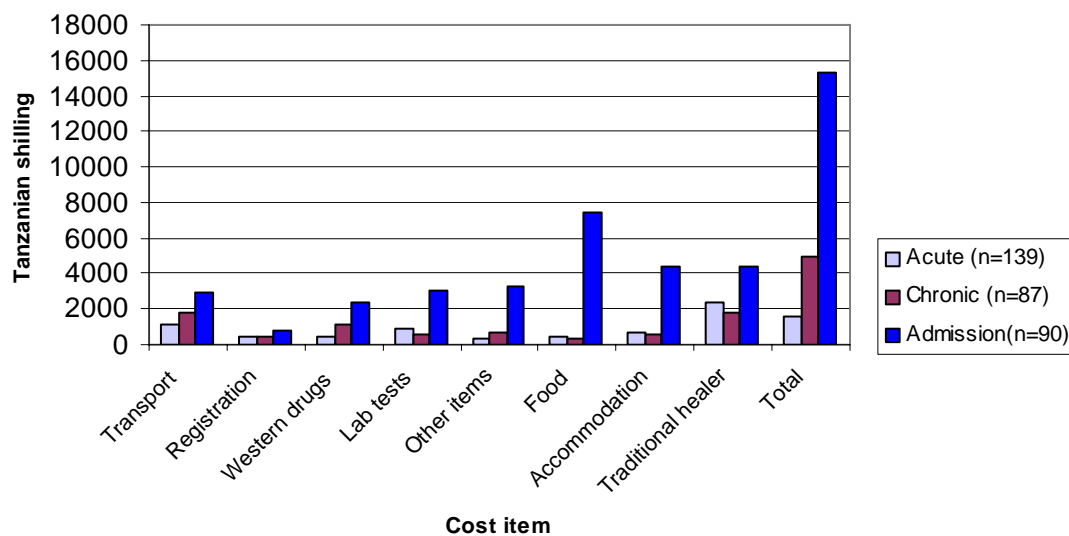


Figure 11: Mean spending on specific expenditure by individuals on treatment actions

Source of cash and coping strategies

For those with acute illnesses, 72 per cent overall said that they were able to raise funds to pay for treatment. For chronic illness, the proportion paying for treatment in the previous fortnight dropped to 40 per cent. The main way of funding treatment, both for acute illness and admissions was by selling crops and doing petty trade. This held across all wealth groups, though the better off were also able to call on salaries for assistance (table 11).

| Source of cash | Illness category | | | | | |
|-------------------------------------|------------------|------------------|--------------------|-----------------|------------------|--------------------|
| | Acute | | | Admission | | |
| | Wealth groups | | | Wealth groups | | |
| | Poorest N=27 | Moderate N=42 | Better off N=14 | Poorest N=19 | Moderate N=24 | Better off N=15 |
| Selling crops | 29.6 | 35.7 | 21.4 | 42.1 | 54.2 | 53.3 |
| Petty trade | 40.8 | 47.6 | 57.1 | 42.1 | 20.8 | 20.0 |
| Contributions from relatives | 11.1 | 7.1 | 0.0 | 5.3 | 0.0 | 6.7 |
| Fishing | 0.0 | 7.1 | 0.0 | 10.5 | 12.5 | 6.7 |
| Salary | 7.4 | 0.0 | 21.4 | 0.0 | 8.3 | 13.3 |
| Manual labour | 11.1 | 2.4 | 0.0 | 0.0 | 4.2 | 0.0 |

Table 11: Household sources of cash to pay for treatment costs by wealth categories

Coping strategies include selling household assets (commonly bicycles and radios); borrowing money from relatives, neighbours and friends; selling household livestock (commonly chickens, ducks and goats); selling out labour (commonly on other peoples farms); putting household assets in pawn (locally called *rehani* or *poni*); and in a few cases asking for assistance from the village government. The choice of strategy depends on the severity and type of illness. In severe or acute forms of illnesses, speed is important so selling household assets or pawning them are common. With long-term illnesses, a strategy of labouring in other peoples' crop fields to earn money is often applied, according to focus group discussions. Table 12 lists the most common strategies used by different wealth groups.

| Source of cash | Illness category | | | | | |
|-------------------------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|
| | Acute | | | Admission | | |
| | Wealth categories | | | Wealth categories | | |
| | Poorest N=8 | Moderate N=18 | Better off N=7 | Poorest N=13 | Moderate N=11 | Better off N=3 |
| Borrowing | 62.5 | 38.9 | 42.9 | 15.4 | 54.5 | 0.0 |
| Contributions from relatives | 25.0 | 22.2 | 0.0 | 61.5 | 27.3 | 33.3 |
| Selling assets | 12.5 | 11.1 | 42.9 | 15.4 | 18.2 | 33.3 |
| Other | 0.0 | 27.8 | 14.2 | 7.7 | 0.0 | 33.3 |

Table 12: Coping strategies used to access cash by wealth group

The findings: HEA baseline study

The HEA baseline study distinguishes three main wealth categories: the poor, the middle and the better off. It covers two different livelihood zones, agricultural and coastal fishing. The majority of the population in both zones fall into the middle group making up 40-45 per cent of the total population. Second is the poor group with 30-40 per cent of the area's population. The better off group make up 12-16 per cent of the population.

In both zones the main source of food is the household farm, supplemented by purchase. The poor households spend the majority of their income, about 70 per cent, on food while the better-off households spend 15-45 per cent on food. The better-off households also invest in productive assets that cost them 15-30 per cent of their income per year.

The HEA study gathered extensive data on households' health expenditure. It included both 'normal' expenditure on healthcare, and the minimum expenditure households resort to during difficult times. Better-off households spend about three times as much on health as the poor households in the agricultural zone; in the coastal zone they spend twice as much. It was estimated, based on field interviews, that households have between two and six episodes of illness a year, of which half are treated locally, and half transferred to a health facility outside the local area. This would cost a household about 11,350 Tsh a year.

However, based on the information gathered from interviews, the poor households in the coastal fishing zone spent about 7,000 Tsh; while in the agricultural zone the same category of households spent about 5,500 Tsh per year. This demonstrates that poor households are unable to cover the typical annual healthcare cost of 11,350 Tsh and compromise on their health expenditure. The middle households in the coastal zone and agricultural zone respectively spent about 10,000 and 20,000 Tsh annually on healthcare, while the better off spend about 15,000 and 20,000 respectively. This shows that they spend enough on health to cover the typical costs of four cases per year.

The poor are forced to leave their sick without treatment. For example, in the coastal zone, poor households treated on average two cases of illness in the reference year; middle households treated about three cases and the richer households treated about four cases per year. The average cost per case is 3,500 Tsh.

This shows that 30-40 per cent of the population – the poor wealth group of the coastal zone and agricultural zone in Lindi rural district – cannot cover the costs of minimum healthcare needs, even in good years.

The HEA assessment reveals that households' expenditure on healthcare for all wealth groups is between 1 per cent and 4 per cent of their total income. Middle and better-off households spend a slightly lower proportion of their income on healthcare compared to the poor wealth group.

The ecological nature of each zone predetermines the level of vulnerability to different shocks. The agricultural zone, which houses 65 per cent of Lindi rural district's population, depends on farming and so is most vulnerable to any climatic changes like drought and flooding, or any negative changes in the price of cashew nuts, the main cash crop. In this zone, households have less access to disposable income than in the coastal zone, and they are therefore less able to absorb negative changes in their livelihood.

In the last drought year, March 2003 to February 2004, the whole region was affected. In both zones, households lost between 50 and 60 per cent of their harvest. The loss of harvest forced

households to increase their expenditure on food to cover 100 per cent of their food needs. In order to cover this increase they adapted their spending patterns and resorted to the minimum expenditure on household items, clothes, education and healthcare. Households in both zones sold more of their livestock assets. In the agricultural zone, households are more affected by the drought than in the coastal zone. In order to cover their additional losses they tend to expand their petty trade activities, mainly by selling wild food and brewing coconut wine.

The poor are more deeply affected by shocks because of their small margin of flexible income. According to the HEA baseline, the poor in the coastal zone have 10 per cent of their income beyond minimum food and non-food requirements. This can be used flexibly in a good year. The middle-income households have 20 per cent and the better off 30 per cent flexibility. In the agricultural zone, however, where most of the population lives, the poor have insignificant income flexibility of about 1 per cent, which indicates that in terms of income, their coping options are very limited.

Besides climatic changes affecting agricultural production and agricultural labour, households are also vulnerable to changes in market prices. Poor households in the coastal zone buy 45 to 50 per cent of their food; in the agricultural zone, the proportion is 25 to 35 per cent. This accounts for 70 per cent of income for poor families in both zones. Any changes will force them to change their food and non-food expenditure patterns, leaving little income for basic social services such as health and education.

Middle and better-off households are more vulnerable to changes in the price of cashew nuts and *simsim* (sesame) as, unlike the poor, the majority of their income comes from sale of these cash crops.

The findings: in-depth household interviews

The most common impact of acute illnesses and admissions are increased household debt and reduced assets and consumables (most often food crops). Focus group discussions also mentioned conflicts between individuals or households when money is not repaid; and children suffering neglect and malnutrition when their mother is preoccupied with a sick family member (especially if they have been admitted).

However, it is chronic illness, especially HIV/AIDS, which most depletes a family's assets, as illustrated by this case study from a focus group discussion:

“When my elder sister was sick, she first paid for her own medical care with the money she earned from where she used to work in Dar es Salaam. There was no relief from her condition. She was then brought here from Dar es Salaam. It was later decided that our brother should go to Dar es Salaam and sell all her belongings so that we could get money to take her to Ndanda Hospital. The money brought got finished and yet she did not recover. My father put his coconut plantation in pawn and we took her to a traditional healer but again she did not recover. Finally we just took her home and waited for her days to finish as there was no more to sell to help her. In the end she died and my father lost the plantation as he could not afford to reclaim it within the promised time.”

From in-depth interviews with households, the following sequence of events (figure 12) is common, when households face chronic illness.

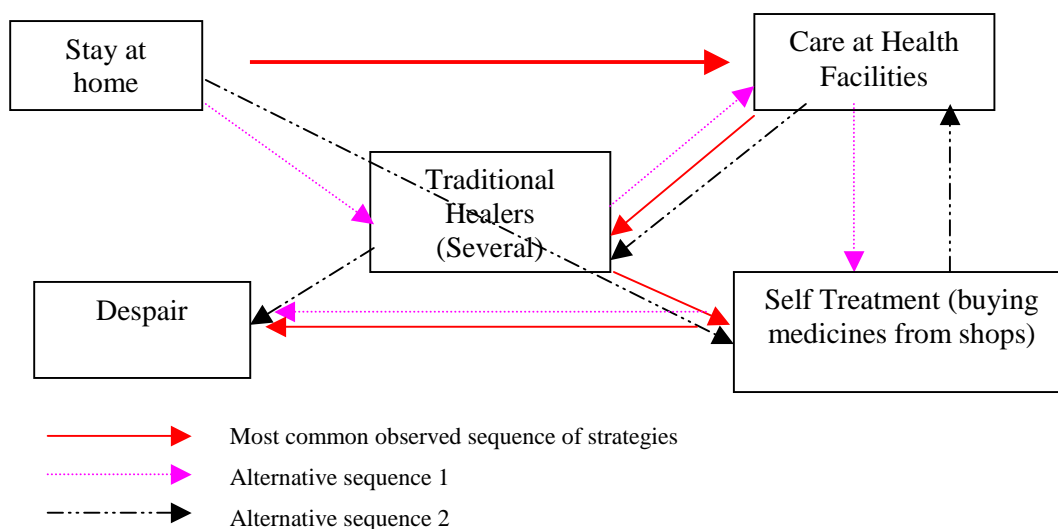
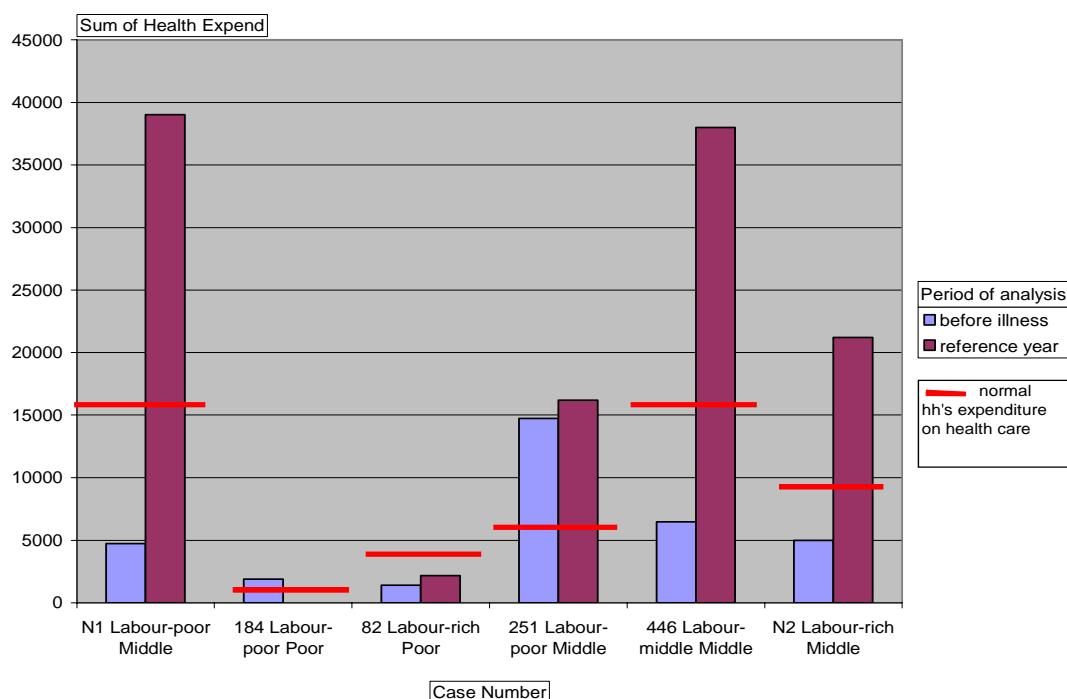


Figure 12: Common sequence of strategies in dealing with chronic illness

At first families delay seeking treatment while they assess the nature of the illness and wait for, or try to assemble, some money. This was seen even in middle-income families. They may then seek care from public facilities or a traditional healer. (Recurrent illnesses, by their nature, are more associated with evil spirits.) Often, after several visits to different practitioners, and still without achieving a cure, they end up taking herbs at home and hoping for ‘a miracle’.

Each household spent between 3,000 and 40,000 Tsh per year on the direct costs of chronic illness. Of this amount, the largest items were food, transport and traditional healers' fees.

Only one of the households reported receiving (or even being aware of) any exemptions, despite the fact that 'chronic illnesses' were always listed as an exempt category by the facilities interviewed.



Source: France & Grootenhuys, 2004

Figure 13: Change in direct expenditure on healthcare

Spending on healthcare for all the case studies increased substantially for the duration of a chronic illness (figure 13). The range of increase varied from 9 per cent to 54 per cent to over 300 per cent. The red line shows typical households' expenditure on healthcare. This has been calculated per household member¹, which is why the level of the line is different for each case study. Note, however, that the poor households are spending about 50 per cent of the minimum health costs and do not increase by the same extent as the middle. This is presumably because of their inability to afford these costs. Four out of the six case studies had increased their expenditure on healthcare by 3 to 15 per cent of their income. One household reduced its spending on healthcare from 5 per cent to 0 per cent of their income because they couldn't afford the cash and resorted to self-medication with herbs.

Indirect costs were harder to estimate, and were mitigated by extended social networks. In Lindi rural district the drought of 2003/2004 had aggravated the plight of poor families with chronic illness. In the drought year they were dealing with the 'double shock' of chronic illness and drought. In addition to the direct costs of illness and the loss of food and income as a result of the drought, the loss of labour assets was a significant constraint. The interviews revealed that households reacted in different ways to this double challenge. They developed a variety of strategies, including a reduction of the area farmed, a shift from agricultural

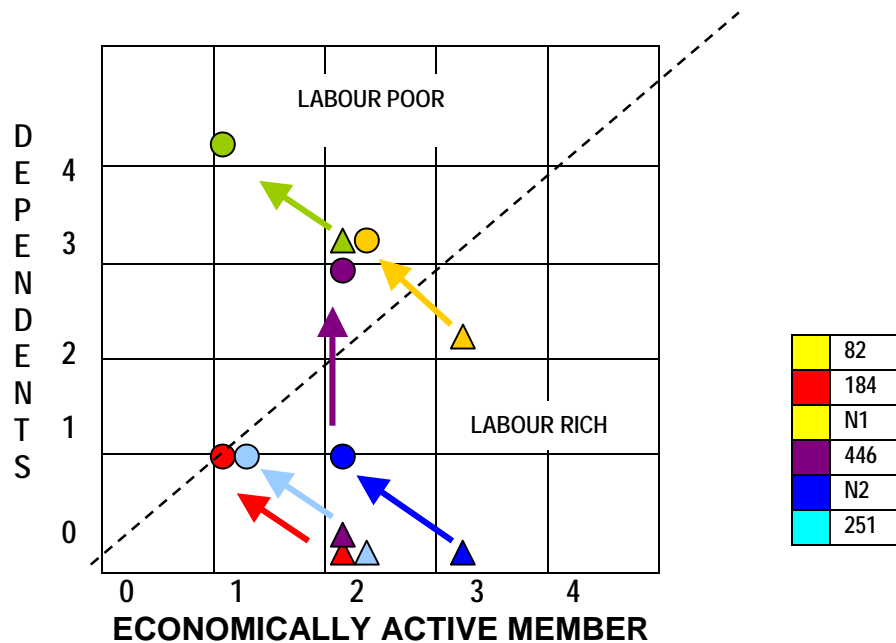
¹ A typical poor household in the reference year spent 5,675 Tsh annually on healthcare for a household of 6. Therefore the cost of healthcare per person is about 950 Tsh. A typical middle household spent 19,400 Tsh annually on healthcare, this amounts to about 3,250 Tsh per person. For each case study this amount (the red line equivalent) was calculated according to their household size.

activities to other income sources, calling in financial support from relatives, reducing spending to a minimum and/or stopping the treatment of the disease.

The case studies demonstrated other coping mechanisms.

- During the reference and drought years, the labour-poor families chose to cultivate only 65 per cent of their land due to loss of labour assets, whereas the families that had not been affected by illness did not reduce the area of land cultivated. (Labour poor is used here to indicate households with more dependents than active members.)
- The case study households consumed all of their own production (as prices of staples increase during drought) unlike families not affected by chronic illness which still managed to sell a small proportion of their staple crops for cash income.
- Some labour-poor affected households coped with these two shocks by relying on remittances to meet food and cash needs.
- Affected households relied more on purchase for their food needs.
- One labour-poor affected household reduced its expenditure on non-food items to the extreme minimum – prioritising soap and collecting firewood rather than purchasing fuel. Affected poor households commonly reduce their expenditure on non-food items and luxury food like rice, fish, beans and sugar. In some cases households stopped spending money on clothes. Middle households also reduce expenditure on agricultural inputs.

A number of the households had shifted from ‘middle’ to ‘poor’ categories as a result of the long-term illness, and in two cases had become destitute (one woman with tuberculosis having also been abandoned by her husband on account of her illness).



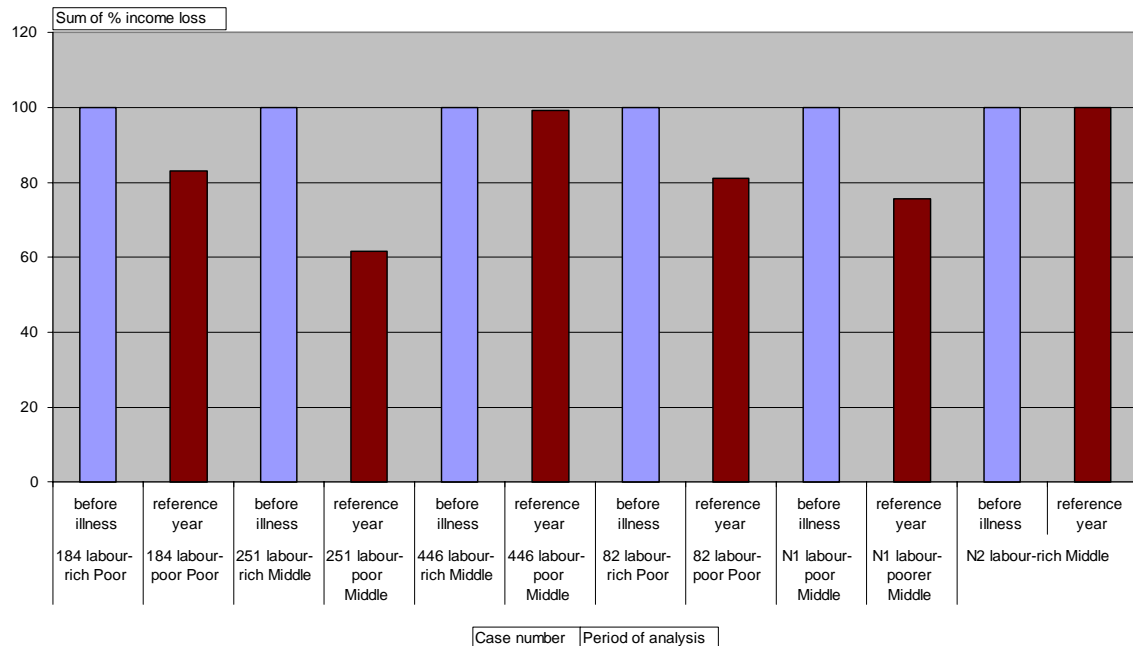
Note: each triangle/circle represents one household
 Source : France & Grootenhuis, 2004

Figure 14: Changes in labour assets

Figure 14 illustrates that all case study households became labour poorer over the period of illness, with approximately 60 per cent of the households moving from labour rich before the

impact of chronic illness to labour poor in all wealth groups. In most cases, households' coping strategies fail to maintain their income levels, and income falls as a result of the illness and the associated changes in labour.

Figure 15 illustrates this: only two households are able to maintain their income level after the shock (one by gaining the help of a relative; the other by substituting less labour-intensive but equally lucrative activities).



Source: France & Grootenhuis, 2004

Figure 15: Percentage loss of income during illness

The main findings of this research phase were that:

- The indirect costs of chronic illness due to loss of labour are considerable for all households and lead to destructive consequences, such as withdrawal of children from education.
- Indirect costs can impact on other households that offer labour or money to assist the affected household (in other words, vulnerability can spread).
- The case studies demonstrate the ability, or in some cases the inability, to cope with compounding negative shocks – in this case, chronic illness and drought.
- Households seem to be unable to cover the costs of healthcare when suffering from chronic illness.
- Poor households in both zones, when faced by a shock of chronic illness, are unable to continue to take care of themselves and become dependent on others.
- Chronic illness can cause households to shift wealth categories: for example, from a middle to a poor group, or from the poor to the destitute. Seventeen per cent of households affected by chronic illness in this sample had become destitute.

The findings: information from health workers

Interviews were held with 17 health workers (four clinical officers, one assistant clinical officer, seven auxiliary nurses, three public health nurses and two midwives) in three health centres and three dispensaries across Lindi rural district. They revealed that cost-sharing practice varies from one health facility to another, in terms of the fee rates, mode of collection, revenue banking, expenditure, supervision and reporting system. Even the start date for cost sharing varied, with some facilities introducing the scheme before the district medical officer's instruction was issued.

User fee rates, which are set by facility health boards together with the village governments, range from 200 to 500 Tsh (for adults). School children are charged between 100 and 200 Tsh in some facilities, and nothing in others. These payments are valid for two weeks to one month. They are supposed to cover the whole course of treatment, from registration to drugs. If the prescribed drugs are not available at the facility, some facilities return the fees; others do not.

Community awareness of cost sharing is high, according to the health workers, though willingness and ability to pay are low. Health workers in five of the six facilities report a reduction in attendance since cost sharing was introduced.

“We get so many problems here. Community members are still pro-free; they need services free of charge. They perceive themselves to be poor and unable to pay.”

“Delay in reporting cases to health facilities are very common nowadays and when you ask them why they were late coming to the facility, ‘no money’ is the common answer.”

“Generally, attendance has decreased significantly, and it is even worse during the hard times of the year.”

“You know, there is a perception in the community that since this is a public facility, service should be free: and thus there is an element of reluctance in abiding to cost sharing.”

Health workers report that attendance is highest during the harvesting period, when people have money from sale of crops, and lowest during the dry season. During the dry season, patients are said to visit traditional healers, where they can pay in kind or get treatment on credit. Attendance also varies with drug availability. Early in the month, when the health centres still have drugs, there are more clients. Fewer come later in the month as they know when the drug stocks have run out.

Some facilities have a volunteer appointed by the village government to collect the revenues from cost sharing. Some volunteers are not paid anything for the collection they make, while in other facilities the volunteers are paid a little money (between 3,000 and 5,000 Tsh per month) from the cost sharing collections. In other facilities a health worker – the clinical officer in charge, for example – makes the collection. Of the six facilities visited, only one facility has a bank account. The rest keep the money at the facility.

Supervision arrangements are unclear. Cost sharing is supposed to be supervised by facility health committees. However, the clinical officers in charge of the facility are in reality

responsible for everything and in some health facilities the committees are extinct. The district medical officer's office is not involved in supervising or monitoring the scheme.

Financial reports should be prepared every three or six months, but only one health facility met this requirement. The rest of the facilities had not presented any financial reports to the facility health committee, village government or community at large for the previous year.

There are no general guidelines on how to implement the cost-sharing scheme available in the facilities, and neither health workers nor the facility health committee members interviewed had a clear understanding of cost-sharing and exemptions policy.

Funds are retained at the facilities and generally used for day-to-day supplies and for paying allowances to staff and committee members. Health workers reported an average monthly income from fees of 20,000-50,000 Tsh.

At one facility syringes were sold at a profit to clients to add to their cost-sharing revenue.

Health workers at all six facilities say they provide exemptions and waivers to children below five years, pregnant women, the chronically ill, the aged and people with disabilities such as the blind. The definitions of these categories vary however. While in some facilities pregnant women are fully exempted, in other facilities only maternal and child health services are free, while others also exempt delivery services. Similarly, some of the facilities define 'aged' as 50 years and above, while other facilities start at 70 or even 80. 'Chronic illness' usually includes asthma, diabetes, TB, and high blood pressure, but not HIV/AIDS.

None of the six facilities waive fees on the basis of poverty. To the extent that the poorest are benefiting from exemptions, it is by virtue of their meeting other criteria (such as being a pregnant woman, or being elderly). Some facilities give credit if people are unable to pay, with village committees assisting in enforcing repayment.

There is no clear exemption mechanism in any of the six facilities. Exemptions for the aged or people with disabilities are either directly sought from the clinical officer in charge or through village executive officers. While some facilities accept letters for exemption from village executive officers, others do not. The officer in charge has a final say on whom to exempt. However, in one health facility it was reported that there are people who seek exemption from the district commissioner and are given letters that enable them to seek healthcare in any health facility in the district. There is less complication on exemptions for children under five, pregnant women and people with chronic illnesses.

Leakages in exemptions were reported, especially to community leaders such as ward councillors, village executive officers and village chairpersons, though this was not thought to be very common.

The general opinion of the health workers is that cost sharing is a good scheme which provides valuable flexible income. It should, they believe, be maintained and improved.

Policy implications of findings

Exemptions

A number of studies have documented that exemptions and waivers generally do not operate properly in Sub-Saharan Africa (Gilson, 1997; Bitran & Giedion, 2003). The most common reasons for this include lack of funding (health facilities are expected to provide services for free, and the missing revenue is not reimbursed); lack of clarity about categories and processes, especially for waivers; lack of monitoring of implementation; problems identifying the poor; and issues of stigma for users.

The Lindi study illustrates a number of these issues. There are no targets for providing waivers and exemptions and no system for reimbursing facilities for lost revenue. The complexity of categories and lack of guidance for health workers mean that both providers and clients are unclear about who is entitled to free services. Generally speaking, characteristic-targeting – such as exempting children under five or pregnant women – works better than targeting the poor, who are harder to identify. However, even within the categories (such as ‘pregnant women’), there were some uncertainties. Children under five appear to benefit most from the exemptions, according to the household survey, but even here fewer than half are being treated without charges for acute illness and only 20 per cent for admissions. At the same time, health workers admit that there is leakage to local leaders, and poverty does not even appear as a targeting characteristic (despite the official existence of waivers for people ‘unable to pay’ in the national guidelines). These findings are consistent with other studies that have looked at exemptions for user fees in Tanzania (Newbrander & Sacca, 1996; Mubyazi, 2000).

Unless the exemptions and waivers can be made more transparent and effective, there is no hope of improving access to healthcare for the poor, either under a user fee regime or a Community Health Fund regime. If cost sharing is continued, the contributions are likely to rise, in order to improve quality, and the exemption mechanisms will then become even more important.

User fees

User fees in Tanzania have been set at a low level which means that, relatively speaking, they are not the main barrier to service use by the poor. On the other hand, they make very little contribution to the costs of running health services, once administrative costs are deducted, and they do not appear to enable quality improvements which would widen access. Fees are seen as yet another barrier by users.

According to a recent study, user fees contribute around 4 per cent of the total health budget (Laterveer, 2004). If they were to be raised, an effective waivers and exemption scheme would be needed (with funding, targets, monitoring etc) and systems for administering and using fees clarified. The Lindi study suggests that accountability for funds is almost non-existent.

Alternatively, the government could follow the Ugandan route of abolishing user fees and implementing supply-side reforms, such as encouraging more donors to channel funds through the Ministry of Health. This would enable the government to increase direct funding for primary healthcare and make quality improvements at the grassroots. This combination has led to a sustained increase in access to healthcare since 2001 by all segments of society and especially the poor (Yates, 2004; Deininger & Mpuga, 2004).

Given the small amount of revenue being brought in by user fees (and the fact that the Ministry of Health budget appears to be under-spent (Laterveer, 2004), the removal of user fees should not cause large cash flow problems. More significant at the local level is the fact that fees provided flexible funds for facilities. This points to the need for reform of the budgeting system so that facilities are able to deal with small items without undue bureaucratic restrictions.

Reducing direct costs and increasing access for the poor

The poor are using public health facilities, but the main access costs they face are for transport, drugs and tests. It should therefore be a priority to improve the drugs supply at public facilities so that clients are not forced to buy drugs privately (or from health workers selling supplies such as syringes which should be free).

Quality improvements will reduce direct costs as they decrease the number of visits needed.

The fact that poor households appear to pay more for each admission or episode of chronic care in public facilities, compared to other groups, needs further investigation.

According to these studies, 54 per cent of households are not treating chronic illness and poor households are under-spending on minimum healthcare, demonstrating that financial barriers are serious constraints. Any alternative to user fees, such as a community health fund, must deliver quality improvements and accommodate the fact that ability to pay is strictly limited. Poor households are currently paying around 5,500-7,000 Tsh per year for healthcare (for all members), and any premium above this level will reduce coverage and increase hardship. Payments should also be made at harvesting time, when income is higher.

Indirect costs of illness

It is clear from this study that chronic illness can push a household into poverty or even destitution. Pro-poor policies therefore require more than efforts to mitigate the direct costs of healthcare: support for household economies in times of crisis (or double-crisis – for example, in a drought year) should be available at the community level. All effective rural development and poverty alleviation interventions will increase the margin of flexibility of income of poor families (currently between 1 per cent and 10 per cent) and so increase their likelihood of being able to afford treatment.

These studies show the importance of social networks – borrowing and receiving contributions are the main coping strategy of poor families, and additional labour is also important in time of hardship. However, at a community level these networks can only absorb a certain amount of strain before cracking, and taking a wider group into chronic poverty.

The informal health market

The extent and popularity of the informal health market, especially traditional healers, is highlighted by these study results. The existence and flexibility of these healers increases access to healthcare, but raises important issues of training, quality and regulation. In the case studies reported here, people with chronic but curable illnesses such as tuberculosis were impoverishing themselves seeking a cure, without success.

Recommendations

- 1 User fees bring in little revenue and are perceived as a barrier to healthcare, particularly for the poorest families. They should be abolished, thus emulating the success of the free primary education policy in Tanzania and the free public healthcare policy in Uganda.
- 2 Exemption mechanisms are not effective. They should be replaced by free access to primary healthcare and essential life saving services (such as emergency obstetric care).
- 3 If cost-sharing initiatives are considered in the future, they should be thoroughly tested and their impact on the poor assessed before becoming national policy and practice. Creating a sustainable healthcare system is important, but not at the cost of deepening inequalities and vulnerability.
- 4 A system of social protection should be established for vulnerable households suffering from chronic illness and other shocks, to prevent them falling into long-term destitution or being forced to compromise their children's fundamental rights to shelter, food, health, education and protection.
- 5 To improve services, the health budget, which declined to 9 per cent of government expenditure in 2004, should be increased, with defined strategies to bring it up over the longer term to the level recommended by the Sachs Commission (World Health Organisation, 2001).
- 6 Healthcare facilities are currently unable to deal flexibly with minor expenditures. This problem should be addressed by reforming budgeting and cash-flow in the public health sector to improve efficiency, enhance users' perceptions of quality and increase take-up.
- 7 The quality of primary healthcare services and the availability of drugs need to be improved. This will lead to a decline in self-treatment and self-referrals and a fall in opportunistic costs like transport and accommodation which fall particularly hard on the poorest families.
- 8 Monitoring Tanzania's poverty reduction strategy should include access and utilisation of quality healthcare by the poor as indicators to measure the impact of interventions.
- 9 The use of traditional healers is very high and they play a particularly important role in chronic and recurrent illnesses such as HIV/AIDS. The traditional health service should be recognised and linked to the conventional health service, and its quality should be regulated. More information needs to be collected about the traditional health system.

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