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BRIEFING

The Cost of Coping with Illness

Tanzania

Health financing, access to healthcare, health costs and household impacts: a summary of Save the Children UK's research in Lindi Rural District, Tanzania, 2003

Background

After independence, and alongside rapid economic growth, Tanzania developed an extensive public-healthcare infrastructure and followed a policy of free healthcare for all at government facilities. By the 1980s, due to harsh economic policies, such as structural adjustment, the economy had plunged into crisis. This led to under-funding of the health sector and severe deterioration in health facilities and the quality of health services.

In the 1990s, the Tanzanian government introduced a series of heath reforms including decentralisation, the introduction of user fees, the promotion of public-private partnerships, and the development of pre-payment insurance schemes: the National Health Insurance Fund (NHIF), which is compulsory for civil servants, and the community-based pre-payment Community Health Fund (CHF).

However, the results to date from these reforms have been disappointing. Despite Tanzania allocating almost 15 per cent of its budget to health in 2002, over a third of national health spending was in the form of out-of-pocket expenditure. This is regressive, perpetuating the vicious cycle between ill health and poverty. Spending only $13 per capita per year is a long way from the $30–40 estimated in 2001 by WHO as the minimum needed to deliver a basic package of healthcare. This long-term under-funding has led to poor quality services which reduces utilisation. The government is facing enormous challenges and demands, and costs are increasing. Fewer people are accessing healthcare, revenue from user fees is less

Table 1: Selected health-expenditure indicators

Selected indicators	Tanzania	Sub-Saharan average
Population (2003)	35.9 million	
GNI/capita ($) (Atlas method) (2003)	310	490
Official development assistance/capita ($) (2002)	35	28
% population living on less than $1/day, 2000-01	19.9	
Total health expenditure per capita (current $) (2002)	13	29
% GDP spent on health (2002)	4.9	6
Health expenditure, public (% of GDP) (2002)	2.7	
General government expenditure on health as % of total government expenditure (2002)	14.9	
% of total health expenditure that is public (2002)	54.8	41
% of total health expenditure that is private (2002)	45.2	
% of private payments that are out-of-pocket	82.5	
Life expectancy at birth (years) (2002)	43	46
Under-5 mortality rate/1,000 (2002)	165	174

Sources: HNP stats, 2003; WHO statistics for 2001; World Bank development data 2002, WDR 2005, WDI 2004; Save the Children UK reports

than anticipated (about 4 per cent of the total health budget), enrolment in the CHF is reported to be low (less than 30 per cent of the population in CHF areas), and the exemption system is inconsistently and often ineffectively applied. In March 2005, the Tanzanian Ministry of Health convened a stakeholder meeting to debate national health financing options, as a first step in addressing many of the challenges highlighted in this paper.

Save the Children's research: methodology

Save the Children carried out a series of quantitative and qualitative studies between 2003 and 2004 in Lindi Rural District in southern Tanzania, one of the poorest districts in the country. Using a household survey, household economy analysis, focus-group discussions, in-depth interviews of households affected by chronic illness, and key informant interviews,[1] information was collected on the costs of healthcare, health-seeking behaviour, and the impact of chronic illness on households, with an emphasis on poor and marginalised households. The CHF was not operational in Lindi District at the time of the research and therefore was not included in the study.

Save the Children's research: findings

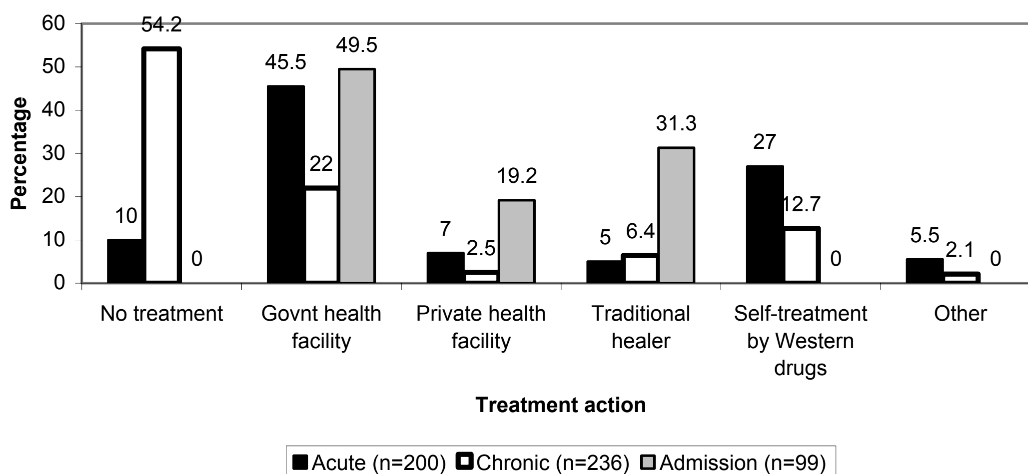
Cash availability across all those surveyed was low.

According to the household economy analysis, 30–40 per cent of the district population is classified as 'poor', with an annual household income between 85,850 and 335,405Tsh.[2] Sixty per cent of female-headed households, which accounted for 28 per cent of the total sample, were classed as poor. Food accounted, on average, for 70 per cent of poor families' expenditure. After minimum non-food expenditure, poor households had only 1 per cent of flexible income, approximately 1,600Tsh per year.

A high burden of both chronic and acute ill health was evident.

The prevalence of illness in the two weeks before the survey was 17.4 per cent (9.4 per cent chronic and 8 per cent acute illness). A total of 370 households (69.5 per cent) reported at least one person ill in the previous two weeks, or admitted to a healthcare facility in the previous year. Malaria was reported as the leading cause of morbidity and admission. While no cases of HIV/AIDS or other sexually transmitted diseases were reported in the household survey, both were considered to be major problems in the community during the focus-group discussions. Chronic illness was significantly higher among women aged 15–45 years (9.4 per cent) than among men of the same age (4.4 per cent).

Fig 1: Treatment seeking behaviour, by type of illness



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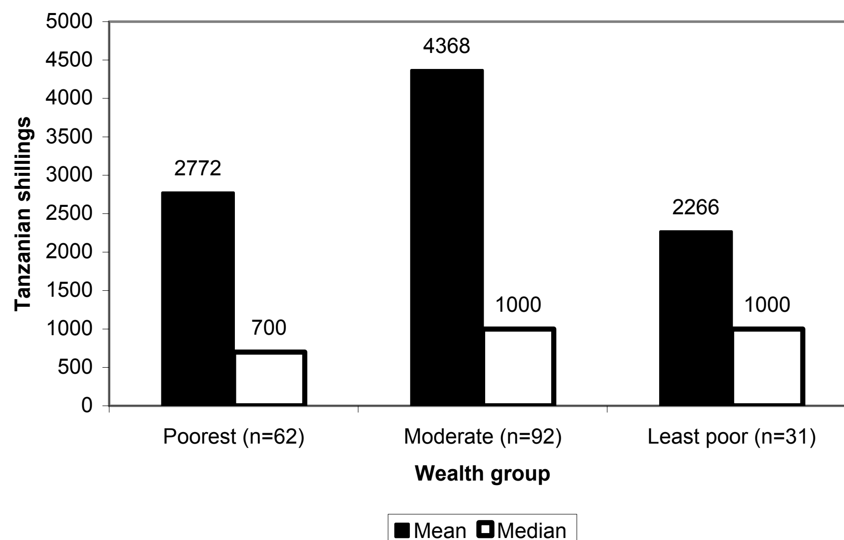
Substantial proportions fail to seek treatment. Figure 1 summarises the results for treatment-seeking behaviour by all wealth groups. Ten per cent of those reporting acute illness did not seek treatment, rising to a staggering 54.2 per cent of those reporting chronic illness. The poor were more likely to self-treat, and lack of cash was most frequently reported by the poorest group as being the reason for not seeking healthcare. The better-off were more likely to use private facilities. Traditional healer services were popular for specific illnesses seen as linked with 'evil spirits' or for illness requiring admission (31.3 per cent). Flexible payment methods for these services were cited as an advantage in the focus-group discussions. Women were also more likely than men to seek care from traditional healers

Overall, poorer households are likely to pay more as a proportion of their income, even though they are less able to buy healthcare.
All groups said they were struggling to pay for healthcare, with 28 per cent of households surveyed reporting that they had not been able to pay for the most recent episode of illness and 60 per cent unable to pay for chronic care.

The average costs of healthcare (including fees, drugs, tests, transport, food and accommodation, etc) per illness episode was 3,175Tsh (see Figure 2 for wealth group breakdown). On average, the cost for an acute episode of illness was 1,590Tsh, a third of that incurred for chronic illness and a tenth of the average cost of admission. Indirect costs, such as transport, food and loss of earnings were also significant barriers which influenced health-seeking behaviour. For acute and chronic illness, self-treatment 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 requires further investigation.

All groups spend between one and four per cent of their total income on healthcare. While wealthier households are spending two to three times more than the poorer households, in relation to the proportion of annual income spent on health, poorer

Fig 2: Average household direct costs of illness for all treatment (acute and chronic) by wealth groups



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groups spend proportionally more than wealthier groups.

Although illness was relatively evenly distributed across socio-economic groups, the number of times members of a household sought treatment was related directly to wealth. According to the household economy analysis 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 household economy analysis 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. This indicates that rationing is occurring.

Entitlements to exemptions, waivers or other social protection schemes are rarely realised and do not offer protection against the impact of user fees.

While exemptions or waivers from user fees are given to a relatively large number of people (children under five years of age, pregnant women, the chronically ill and those considered to be too poor), there is evidence that the most needy are not benefiting.

According to the household survey, 50 per cent of the poorest families were exempt from fees for acute illness. However, when it comes to more expensive interventions, such as admission, the richer group is capturing more of the benefits (23 per cent were exempt, compared with 12 per cent of the poor). Communities and health workers alike reported a lack of information and understanding of the exemption scheme. The policy is interpreted differently by different facilities, and record-keeping and transparency are poor.

Charges at the point of service – for registration, drugs and commodities like gloves – have had a negative impact on utilisation. While consultation fees are generally low – in the range of 200–500Tsh – so is community willingness and ability to pay, according to health workers. Health workers also reported a fall in the use of all but one healthcare facility after fees were introduced.

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

"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."

"Delays in reporting cases to health facilities are very common nowadays, and when you ask why they are coming late to the facility, 'no money' is the common answer."

From key informant interviews with health workers

According to interviews with health workers, there are no clear systems for setting fees, collecting them and using them. Poor transparency also makes tracking and accountability difficult.

Healthcare expenditure can have serious negative consequences on household economy and long-term welfare, particularly for the poor.

The most common methods of financing care are to sell assets and to borrow money. Households with members with chronic illness, especially HIV/AIDS, are particularly disadvantaged. Spending on healthcare for all the case studies increased substantially for the duration of a chronic illness. The range of increase varied from 9 per cent to 54 per cent to over 300 per cent.

The indirect costs of illness due to loss of labour were considerable for all wealth groups, with destructive consequences such as withdrawal of children from school and abandoning treatment. Chronic illness can also cause households to shift wealth groups: 17 per cent of households affected by chronic illness had become destitute.

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> "When my elder sister was sick, first of all she paid for her own medical care with the money she earned from where she used to work in Dar es Salaam. Her condition didn't improve. She was then brought here from Dar es Salaam. Our family 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 was used up, but my sister didn't recover. My father put his coconut plantation in pawn and we took her to a traditional healer but she still didn't recover. Finally, we just took her home and waited for her days to finish, as there was nothing left to sell to help her. In the end, she died and my father lost his plantation as he couldn't afford to reclaim it within the agreed time."
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> *From the focus-group discussions*

Key conclusions

The evidence presented from this research indicates that:

- The majority of people are unable to afford the high costs incurred when seeking healthcare, particularly for chronic illness and admission to hospital. The community cannot cope with the impact of the high levels of out-of-pocket expenditure on health.
- There are inequalities in accessing and utilising healthcare between socio-economic groups and geographical areas.
- The current exemption system does not offer protection against the impact of user fees or reduce the inequalities that result.
- The direct and indirect costs of accessing healthcare can lead to delays in health-seeking behaviour, often with devastating impacts on household economy and health outcomes. Payments charged at the point of access are seen to be real barriers to healthcare utilisation.

Presently there is a plethora of health-financing mechanisms in Tanzania; none of them is sufficiently regulated, standardised or equitable. The government and donors need to review the efficiency of these mechanisms and, in line with their vision and strategy, consolidate and regulate these programmes, focusing on how they can be more equitable or pro-poor.

Actions need to include:

- increasing government expenditure on the health sector (which declined to 9 per cent of government expenditure in 2004), with defined strategies to increase it to at least 15 per cent, as agreed by African Heads of State at Abuja in 2001 and reaffirmed in Gaborone in 2005[3]
- ensuring that donors, as pledged in the Gleneagles G8 statement, invest in more long-term, predictable funding to enable developing country governments to increase the health sector budget, while supporting increased allocative efficiency in the use of health sector expenditure
- an explicit commitment to moving away from out-of-pocket payments at the point of service for public-sector health services over time, given that this is the most regressive form of financing, and to moving towards more progressive financing mechanisms, as agreed in the May 2005 WHA resolution 58.31.[4] This would support the move towards an increased focus by the Tanzanian government on poverty reduction, as set out in the National Strategy for Growth and Reduction of Poverty (NSGRP). Including access to and utilisation of quality healthcare by the poor as indicators for measuring the success of the NSGRP may be one way of ensuring links between health and poverty strategies
- support from WHO and donors so that Tanzania can develop a long-term strategy to replace current exemption systems with services that are free at the point of access, to ensure that the poor (who make up 30–40 per cent of the population) can be protected from further poverty as a result of paying for healthcare
- support from donors to carry out operational research into establishing a system of social protection for poor and 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.

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References

Save the Children UK (2005) *The Unbearable Cost of Illness: Poverty, ill-health and access to healthcare – evidence from Lindi Rural District, Tanzania,* Save the Children UK, London

Notes

[1] Household survey, representative study of 532 households (2,510 individuals); household economy analysis, 2 food economy zones; focus-group discussions, 22 groups; key informants, 27 interviewees; in-depth interviews with those affected by chronic illness, 14; interviews with health staff, 21 in 6 facilities.
[2] $1 = 1,000Tsh (Tanzanian shillings).
[3] The Gaborone African Ministers of Health Declaration, October 2005, can be found at www.africa-union.org
[4] WHO (2005) *Working Towards Universal Coverage of Maternal, Newborn, and Child Health Interventions*, resolution WHA 58.31 WHO, Geneva. Available at www.who.int

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