Poor people's experiences of health services in Tanzania: A literature review

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Summary & Comment: This is an exhaustive survey by this committed project for women's dignity. The women are concerned primarily for the problem of fistula, but the survey covers all aspects of health services for poor women. The report concludes with 7 points for reflection and action. Here are the contents, the executive summary, the conclusions, and the bibliography. For the whole document go to http://www.womensdignity.org/Peoples_experience.pdf JK

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Executive Summary:

"… the poor must be brought from the margins into the mainstream. The process must be inclusive. The weakest economies and communities need special and differentiated help." President Benjamin W. Mkapa

The Context:

Tanzania faces serious challenges to improving the health and well-being of its people. The Ministry of Health and its partners in government, the donor community and civil society have responded with concerted action, in many cases achieving significant gains. Services for prevention of mother-to child transmission of HIV are being expanded, a new protocol for malaria treatment is being implemented and evaluated, hundreds of service providers are now trained in life-saving skills for childbirth, and all districts have been oriented to the programme of *integrated management of childhood illnesses* (IMCI). These are but a few of the successes in recent years (MoH 2004a).

These achievements are particularly notable given serious funding limitations in the health sector. The allocation to health has increased only slowly over recent years, from 7.5 percent in *fiscal year* (FY) 2000 to 8.7 percent in FY03, which is low in relation to projections in the *Poverty Reduction Strategy* (PRS) and to the Abuja commitment of 15 percent. Again, despite the PRS commitments, the absolute budgetary increase year-to-year has declined from a high of 41.12 percent in FY02 down to a 5.68 percent increase in FY04 (MoH 2004b). The FY05 budget ceilings indicate that the health sector will actually have fewer resources in real terms than in FY04.

However, the low level of funding does not categorically preclude improvement of health services and ultimately health outcomes. Differentiation in government funding,including in the health sector, can better prioritise the

needs of the poor. The continuing disparities in health outcomes between the poorest and the richest Tanzanians and those in rural versus urban areas need to be addressed, along with the barriers to service experienced by the poor due to distance, formal and informal health charges, and other obstacles reported in this review (R&AWG 2003). The new resource allocation formula that utilizes equity criteria to distribute funds across districts, and the increasing proportion of funds for preventive services, are both positive developments in reaching the poor.

Nonetheless, additional actions are needed to mobilize meaningful change for Tanzanians living in poverty. To move beyond policies and guidelines. To make tough decisions about how to bring the poor into the mainstream of health services, to focus differentiated attention to their well-being, and to bring critical human and financial resources to bear in one of the most crucial areas of Tanzania's development: the health of its people.

Key issues

This literature review examines key findings on poor people's experiences of health services and includes a particular focus on the barriers to access among the very poor due to cost sharing, an issue of special interest in the current era of "pro-poor" development.

The review highlights seven key issues for reflection – and action:

Access:

Health services are often not accessed by the very poor, and by women in particular. Key obstacles are health care charges, long distances to facilities, inadequate and unaffordable transport systems, poor quality of care, and poor governance and accountability mechanisms. There have been improvements in availability of drugs which is a positive development, but some continuing deficiencies and particularly the cost of drugs still make them unavailable to many poor people. The shortage of skilled providers, while a serious concern to all actors in the sector including government, continues to persist. Discrimination against clients who are not able to pay and poor referral systems all result in low quality of care.

Health care charges:

Revenue generated by cost sharing has not necessarily impacted positively on quality of health care. User fees are not the only charges; other costs include transport costs, other "unofficial" costs including bribes, payments for drugs and supplies, and time spent away from productive activities which is particularly critical for people living in poverty. Health care charges have placed an impossible financial burden on the poorest households; many fail to access primary care when they need it most and many more fail to obtain the necessary referral for more skilled care.

People do not always know what they are supposed to pay, and which payment demands are legitimate or illegitimate. Official charges are not necessarily affordable. "Unofficial" charges are still in place, and exemption and waivers have not been effectively implemented. The quality of care in public facilities has not necessarily improved even with the additional funds generated from user fees.

The *Community Health Fund* may have improved the quality and range of services in those places where the CHF is in place. However, the scheme is not necessarily benefiting the very poor in a more equitable way. Many report they are not able to afford the joining fees and therefore pay for treatment on a case-by-case basis, which can ultimately be more expensive.

Participation and decision-making:

Community participation is very limited in regards to determining health care priorities, deciding where funds should be allocated, and monitoring expenditures. This is a problem across priority sectors, not only in health. It is due in part to a general lack of knowledge about rights and recent reforms. More importantly though, reliable mechanisms are not in place for discussing issues of concern at the village level and then raising these concerns to the district level for action.

Governance and accountability:

Health consumers express dissatisfaction with critical governance issues such as abuses of power, financial mismanagement and corruption. While there exist some cases of health users and authorities working together, systems are generally not in place to ensure that services respond to the priority needs of beneficiaries. Adequate management systems have not been instituted to ensure appropriate collection of fees and allocation of these locally-generated resources. Government has recently begun to publish information on priority sector allocations for each district; this is an important development in enabling people to monitor public funds earmarked for critical services. Because this information is not disaggregated below the district level, however, it is not possible to monitor expenditures at the village or facility level.

Exemptions and waivers:

Exemptions, and in particular waivers, are not systematically implemented and are not effective as a means of protecting vulnerable social groups and the poorest of the poor. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, small charges (e.g. cards, materials), and bribes. The exemption scheme is poorly implemented partly because accountability mechanisms are not in place, and because health service providers are not following procedures that are often unclear to them to begin with. But an equally important factor is the low uptake and lack of insistence on free services by the poor, primarily because they are not aware of their rights. A lack of clear criteria and policy guidelines for identifying people who are eligible for waivers has resulted in ad hoc decisions, without clear records or follow-up.

How poor people cope:

Many poor households have fallen deeper into poverty as they end up using their limited and critical assets to pay for treatment. They use meagre savings (if they have any) and sell their crops, animals, land and their labour. Those who can, borrow money or take a loan, or bond their assets. They are often forced to reduce their food intake and to take their children out of school in order to pay for treatment. These strategies to pay for care drive poor people deeper into poverty and increase their vulnerability significantly.

Health care seeking behaviour and choice of providers:

Typically, poor people's incomes are sufficient for subsistence only. They are frequently forced to resort to self-treatment, seek ineffective alternatives, or report much too late for care, often with fatal consequences. Many resort to traditional healers. If people can afford treatment at all, government facilities are normally the only option, especially in rural areas, as they may be close by and possibly less expensive. The overall feeling, however, is that if money can be found it is best to spend it at mission facilities which are generally known for staff commitment and availability of drugs and tests, but perhaps most importantly, for their willingness to defer payment and start treatment if necessary.

The way forward

The health sector is seriously under-funded despite the fact that it is a priority sector in the *Poverty Reduction Strategy*, and despite the fact that a healthy population is a basic ingredient of economic growth. Lack of funds, however, is not the only cause of the weak health system. Underskilled and de-motivated personnel, deficiencies in quality of care, weak and confusing management systems, lack of information provided to health consumers, and lack of access by the very poor to treatment characterize much of the current situation.

These factors, and more, have resulted in a health care system that requires not only massive investments of funds but also a renewed commitment and vision among all actors – government, policymakers, donors, non-governmental organizations, faith based organizations, health workers themselves and others – to generate fundamental change. This call for change is a particular imperative for Tanzanians living in poverty, for whom treatment is becoming increasingly unavailable, and for whom expensive private care is simply not an option.

The dilemma, then, is how to make quality care available to all – including the poor – in an environment of limited and insufficient financial resources and severely constrained human and material resources.

A number of questions have been raised in this report that merit immediate consideration:

• What mechanisms can be instituted to minimize the exclusion of poor and vulnerable persons from health

services while recognizing the very real financial requirements of the sector?

• What are the main priorities for improved quality of care for the poor? Affordable services? Available essential drugs? Well-equipped facilities? A motivated team of skilled health workers?

• How can existing cost structures be revised in order to increase poor people's access to quality health care? How can an effective mechanism of waivers and exemptions be instituted and enforced?

• How can problems of access to health facilities be addressed, including distance and affordable transport? How can the referral system be improved so it functions effectively even in rural areas?

• How can ordinary people get access to adequate and understandable information about allocations and expenditures at the local level? How can people be included in monitoring of health services and ensuring services are responsive to demand, and accountable to clients? How can people's recommendations be channelled and acted upon?

End of executive summary.

6,CONCLUSION

Action is urgently needed to create fundamental change in the health status of Tanzanians living in poverty. The issues documented in this literature review are a call to all actors – government, policymakers, donors, non- governmental organizations, faith based organizations, health workers and others – to make quality health care available to people, whether rich or poor.

In order for the goals of the PRS and health sector to be realized, however, particular commitments must be made to those who are impoverished, marginalized and otherwise vulnerable (R&AWG 2002, Hutton 2003). Action must reach beyond policies and guidelines to meaningful changes in service delivery and health outcomes. A major challenge for central and local governments is to deliver more and better services with the additional, though not necessarily sufficient, resources mobilised under the PRS.

At the same time, the health sector is under-funded25 and health expenditures have not always been in favour of the poor (R&AWG 2002, Gwatkin, 2003). Despite the PRS commitments, the absolute budgetary increase year-to-year for health has declined from a high of 41.12 percent in FY02 (after introduction of the PRS) down to a 5.68 percent increase in FY04 (MoH 2004b). The FY05 budget ceilings indicate that the health sector will actually have fewer resources in real terms than in FY04. Government health services have traditionally benefited the better off more than the disadvantaged, especially for secondary and tertiary care, which accounts for most government health care expenditures (Castro-Leal et al. 2000, quoted in Gwatkin 2003).

More recently though, the share of GoT spending on primary and preventive services has increased and funding is shifting more towards "other charges" (e.g., medicines and other supplies) indicating a move to bring services closer to the people. This is a very positive development.

Although health spending as a proportion of the total GoT budget has increased from 7.5 percent in FY00 to 8.7 percent in FY03, these figures are still low and have not reached the goal for per capita expenditure needed to achieve basic health outcomes for the population (NGO Policy Forum 2003a). There also exist high and unexplained inequalities in per capita resource allocation between regions and between districts. The new resource allocation formula instituted to distribute health funds according to more equitable criteria is an important achievement for pro-poor development. More actions to this effect are seriously needed to bring, in the words of President Mkapa: "specialized and differentiated help" to the poor.

Seven themes emerge from this review for reflection and action:

Access

• Poor quality of care, health care charges (official and "unofficial"), long distances coupled with poor roads and inadequate and unaffordable transport facilities, and poor governance and accountability mechanisms – all limit poor people's access to health care.

• Lack of essential drugs and supplies, of “skilled providers,” discrimination against clients who are not able to pay, and poor referral systems result in poor quality of care.

Health care charges

• Health care charges have placed an impossible financial burden on the poorest households who are often excluded from using health facilities when they most need them.

• Cost sharing revenue generated has not necessarily impacted positively on quality of health care, nor on access to health care by the poorest. • User fees are not the only charges the poor have to pay; other costs include travel time, transport costs, other “unofficial” costs including bribes, and for drugs and supplies.

• The CHF may have improved the quality and range of available services, but the scheme is not necessarily benefiting the very poor in a more equitable way.

Part icipation and decision-making

• Adequate management and information systems have not been put in place to ensure appropriate collection and utilization of fees.

• Communities are generally not involved in planning and financial management of health services to ensure that health services focus on meeting their priority needs.

• Ordinary people at the community level do not have access to information about budgets, incomes, expenditures, use of medical supplies, etc. and are therefore not in a position to effectively monitor their use.

Governance and accountability

• Community participation is limited in part due to a general lack of knowledge about recent reforms, but also because poor people do not know their rights or feel they can exercise them.

• Reliable mechanisms for raising concerns and for channelling these to the district level for action are not in place.

• Studies point to dissatisfaction regarding a range of health system issues: cost, quality assurance, access, availability and equitable distribution of basic services, abuses of power, financial mismanagement, corruption and lack of responsiveness.

Exemptions and waivers

• Exemptions, and waivers in particular, are not effective as a means of protecting vulnerable social groups and the poorest of the poor.

• Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, some small charges (e.g. cards, materials), and bribes. Many of these costs are beyond the reach of the very poor.

• A lack of clear criteria and policy guidelines for establishing people who are eligible for waivers results in individual ad hoc decisions, with no clear records or follow-up by management. Poor people themselves are not routinely informed of the procedures for getting exemptions and/or waivers.

• Lack of funding to health facilities to compensate for loss in revenue due to exemptions and waivers has a negative impact on the facilities performance and discourages facilities from granting of exemptions/waivers.

How poor people cope

• Many poor households pay for health care by resorting to a number of short-term survival strategies, especially in times of emergencies. As a result they fall deeper into poverty and have limited resources

remaining for other essential needs.

Health care seeking behaviour and choice of providers

• Poor people's incomes are typically sufficient for subsistence only; many people living in poverty opt not to seek treatment at all, or resort to traditional healers. If they can afford it, they opt for government health facilities, because they are cheaper compared to private and religious facilities and they tend to be nearby.

The dilemma, then, is how to make quality care available to all – including the poor – in an environment of limited and insufficient financial resources and severely constrained human and material resources. A number of questions have been raised in this report that merit immediate consideration:

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With the second PRS currently being developed, this is a perfect time to meaningfully address the issues raised in this review and to strengthen health care provision for the poor.

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WOMEN'S DIGNITY PROJECT

The Women's Dignity Project (WDP) was established to prevent and manage obstetric fistula,* enhance the

dignity and rights of those living with the condition, and promote gender and health equity. We base our work on the understanding that health conditions affecting poor people result from social, economic and political factors that underlie poverty.

WDP seeks to:

- Better understand girls' and women's vulnerability to fistula

- Strengthen communities and organizations to take action on fistula and the inequities impacting the poor

- Stimulate public debate and action to address these inequities

- Influence programs and policies to promote the dignity and rights of the poor WDP also assists girls and women to get fistula treatment and begin their lives anew.

If you would like to find out more about our work, or to support a girl or woman with fistula, please contact us:

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