ACCESS TO "FREE" HEALTH SERVICES IN TANZANIA

A DESK STUDY

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C O N T E N T S

DESK STUDY OF ACCESS TO "FREE" HEALTH SERVICES

TERMS OF REFERENCE
SCOPE OF WORK

Health services are supposed to be free in Tanzania. To what extent do ordinary people have free access to health facilities, especially in the rural areas? What are the mechanisms by which people are obliged to pay for services? If they cannot/will not pay, will they obtain any services (Drugs, Advice, Treatment)? Does the expectation of free services make them less available than if the expectation was to pay for them? Are there any examples of self-help establishment of basic health services outside the mainstream Government/Voluntary Agency System?

A Desk Study is required, giving examples of how services are provided on the ground, if and how payment is effected, with indicative costs if possible.

1.0 INTRODUCTION

Health services in Tanzania are provided through four systems. The first and most extensive in the rural areas is the traditional system. Most people in the rural areas first visit the traditional "doctor" for treatment or advice when they have a health problem, before they turn to modern medicine. The word "doctor" is used in its widest traditional sense and ranges from elders, Traditional Birth Attendants (TBAs), Herbalists, Soucerers, Clavoyants etc.
Traditional health service providers charge directly or indirectly in cash or in kind for their services. The charge is received almost always after services have been rendered.

The second and next extensive health service provider is the Government which provides about 70% of modern health care services. In the rural areas this is often the second level of the health care system. This will be the system that this paper will examine in more detail.

The third health service providers are the several Non-Governmental Organizations (NGOs) who are estimated to provide more than 30% of modern health services. They charge a modest cost for curative services on a cost-sharing basis, and provide free preventive and promotive services. Their services are qualitatively better than those provided by the Government. Reference will be made to these services in the course of our discussion.

The fourth and last health service providers are the private modern health providers who are almost exclusively confined to the urban areas. Their services are provided through two major means - private health units (dispensaries or hospitals) and Pharmacies where a number of them have mashroomed to fill the vacuum created by severe drug shortages in Government health units. This is inspite of Government ban on private medical practice in 1980.

This paper discusses the Government Health Services, the extent to which ordinary people especially in the rural areas have free access to these services, the mechanisms by which people are obliged to pay, their expectations, and the self-help participation of people in the provision of their own health services outside the mainstream Government and NGO system.

The sources of information which have been used are the results of various evaluations, the personal experience of the author in working in the system for a period of more than a decade and information from health service users and providers in Singida region (Iramba and Singida Districts) and District Medical personnel from more than 20 districts, using open ended questionnaires.

2.0 GOVERNMENT POLICY ON THE PROVISION OF HEALTH SERVICES

With the exception of "grade one services" in a very few regional and consultant hospitals the Government delivers all types of health services free from direct user charge. This policy emanates from the Arusha declaration of 1967 which proclaimed Ujamaa and Self-Reliance as the national ideological policy, and re-emphasized in 1971 at the biennial meeting of the then ruling party TANU (Tanganyika African National Union). Much of the widespread health care services infrastructure that is evident now in the rural areas of the country is a result of the 1971 re-emphasis.

The policy directs the government to place greater emphasis on rural than urban development and that health care services must be provided freely to all Tanzanians and as close as possible to their places of residence, and that emphasis must be on preventive and promotive health care, rather than curative care as it had been in the past. The rationale was that the 90% of the countries population which lives in the rural areas must be the focus of planning and implementation, and to ensure that the basic needs of water, Education and Health services are available to all the population. In the provision of Health services, equity became the catch word.

It is impressive to put on record that the basic philosophy and strategy underlying this policy are consistent with the Primary Health Care (PHC) approach to achieve Health for All by the year 2000 (HFA/2000) which was unanimously recommended ten years later by member states of the World Health Organization (WHO) at the World Health Assembly in 1977 and adopted by the Alma-Ata declaration one year later.

The characteristic feature of PHC was the emphasis it laid on community involvement in deciding, planning, managing and implementing local health activities. Health is not the concern of the health sector alone, other sectors have a major role to play in improving the health status of the population.

Our intention now is to analyse the extent to which the present health delivery system is freely accessible to the ordinary citizen.

3.0 ACCESSIBILITY TO FREE HEALTH SERVICES

Health care accessibility depends on the system of its delivery, its availability and the level of use of the available services.

3.1 The health care delivery system

In Tanzania, health care delivery by the Government is done through an extensive network of facilities at the central, regional, district, divisional ward and village levels. These facilities are designed for both primary contact between the user and the provider and for referral of patients to the appropriate next level of care should the initial contact not be equipped to deal with the health problem. The referral system roughly follows the administrative structure. Starting at the lowest level it is meant to comprise of:a) the village level, where the Village Health Worker (VHW) trained in basic first aid sanitation and nutrition education make referral to:

b) the dispensary, which is staffed by at least one Rural Medical Aid (RMA) and capable of providing basic curative and preventive care, who would in turn made referral to:

c) the Rural Health Centre (RHC) staffed by a Medical Assistant (MA), who is better trained than the RMA but offering basically similar services and assisted by about eight trained health workers with some bed capacity of about 15,

d) the District hospital which is usually staffed by at least one graduate Medical Officer (MO) with assistance from several categories of trained health personnel, offering both primary health care and more sophisticated outpatient and inpatient curative and preventive care,

e) Regional hospitals offering similar services to those of the district hospital, but with more sophistication in diagnosis treatment and qualified personnel, and lastly

f) Zonal Consultant hospitals offering same services as the Regional hospital but with much more sophistication in diagnosis, treatment and specialized personnel.

The District, Regional and Zonal (Consultant) hospitals also service as <u>first level health care contact</u> with the immediate neighbourhood a <u>training and supervision</u> centre for lower level health workers, and also as a <u>referral centre</u> from the next lower level for the provision of curative services. The Organizational and Management structure follows the hierachial referral system.

3.2 <u>Health care availability</u>

The availability of health care services can be described in terms of the number of health facilities per population, the deployment of staff and the presence or absence of basic equipment, and supplies and facilities. As shown in Annexes I and II the ratios of population per health facility by region, and the availability of human resource per population although do not meet set targets show that Tanzania has established a relatively wide and equitable coverage of health care. The emphasis of health delivery to the rural population without an equal attention to the urban areas has led to a major problem of primary level facilities in the urban areas. For example the PHC review in 1984 found out that some dispensaries in Dar es Salaam were attempting to cater for

300,000 population instead of the target of 6,500. The result is that the consultant hospitals in the urban areas, like Muhimbili Medical Centre (MMC) in Dar es Salaam act as dispensaries and thus overstretch their personnel and facility capacity to do adequate consultation for more serious referred patients.

On the whole, the rate at which health facilities have been provided even in the rural areas has always been outstripped by the relatively high population growth rate. With the coverage targets shown in Annex 1 (a hospital in each region and district, a RHC per 50,000 population and a dispensary per every 6,500 population) a doubling of the health budgets by 2,000 would be required given projected population growth. This is unlikely to happen given the grim economic situation, unless an economic miracle happens.

3.3 Health care utilization

Accessibility to health care services is commonly expressed as physical accessibility in terms of geographical distances between the majority of people in the catchment area and health facility. It is also measured by calculating the average per capita utilisation of health services and assessing the trends. We find it important, however, to also extend the definition of accessibility and in addition describe possible economic and cultural obstacles to the utilisation of the health services. The quality of care can be described in its professional and managerial as well as in its human sense.

3.3.1 Physical accessibility

Evaluations and reviews of the health sector which have addressed the question of the physical accessibility to the health services have shown that about 93% of the total rural population lives

within 10 km of some health facility and 72% within 5 km within an hours walking distance. Although these figures are more than 10 years old (1978) there is no reason to believe that they have dropped. In fact the PHC review of 1984 showed that in the six regions which were surveyed, 73% of the population lived within an hour's walking distance to a health facility as were 95% of all urban households. This reflects Tanzanian's unusual degree of success in implementing a primary-level and rurally oriented health care strategy by African Standards.

3.3.2 Economic factors

Since all health care delivered at government institutions is free of charge and physical accessibility to the health facilities is within reach of the majority of the population, and the referral system is also supposed to operate at government expense, the economic accessibility to all levels of health care in Tanzania should be unlimited and cover all strata of the population.

The lack of transport in rural health facilities, however, implies that the referral system does not normally function. Obviously this is particularly serious for emergency cases, and those with life threatening disease especially if they belong to the group of population with no economic resources, to enable them hire private transport to the hospital, if at all available. Even other economic obstacles to an equitable delivery of health services to the population do exist unofficially as will be seen later. These two factors have a serious negative impact on the vulnerable and under-privileged groups of the population.

3.3.3 Cultural factors

Though not sufficiently recognized/cultural obstacles to the utilization of health services may be very important in Tanzania. A number of patients with treatable disease may abscond from hospital on cultural grounds usually on the advice of relatives who have made arrangements for treatment by a traditional healer. This is particularly so when the patient is suffering from a condition which takes some time to be cured like tuberculosis or malnutrition. Other patients are not brought to the health facility when they suffer from a condition which causes convulsions e.g. high fever (malaria) or meningitis in the mistaken belief that when they get an injection they would die.

3.3.4 Attendance to health services

Increased average per capita utilisation rates of health services are commonly interpreted as indicators of an improved health delivery system. This interpretation is not necessarily correct. An increasing average per capita utilization rate may result from a major increase of utilization by some population groups which may not necessarily be the most in need.
A shift in health care seeking habits as it may occur in the presence of severe drug shortages may also result in changes in the utilization rates. In 1972, the average per capita utilization of outpatient care in Tanzania was 4.3 and it was unchanged by 1978, when the Health Inventory was done (3, 8). It is estimated that the average number of outpatient visits per person per year has remained about constant over the years, at about 2.5 visits per annum(1). In both 1972 and 1978, nearly two-thirds of the outpatient visits were to the lowest level of facility and the overral percentage for primary level facilities was 72% and 84% respectively for 1972 and 1978[1]. There is evidence to indicate that the importance of primary level visits has remained fairly constant over the years, and

may have slightly increased with the introduction of the Essential Drug Programme (EDP) to the RHCs and dispensaries which has assured these levels with better drug supplies than in the hospitals.

3.3.5 Coverage by specific health services

An examination of the coverage rates for various services indicate that the rural health facilities are actually being utilized by those who need it most i.e. children under five years of age and women in their child bearing age. It also gives evidence that the government emphasis on preventive care has been effectively translated into action in many areas.

The evaluation of maternal and child care in Tanzania done in 1981(9) estimated that 85% of all pregnant women received ante-natal care, and more than 55% of all deliveries took place at a health institution. The PHC review of 1984[2] in which the author participated as a resource person indicated that these figures had increased to about 95% for antenatal coverage and 60% for institutional health deliveries respectively. For Dar es Salaam 80% of the deliveries had been attended by a trained health worker. In the six regions surveyed (Iringa, Morogoro, Arusha, Lindi, Rukwa and Shinyanga) about 75% of the women took malaria chemoprophylaxis (chloroquine) during pregnancy with the index child, and the figure for Dar es Salaam was 93.5%.

The coverage for child health care was equally impressive. An average of 90% of rural children had been seen twice or more by a qualified trained worker, 93% in Dar es Salaam, 75% had a growth chart at home in rural areas (85% in Dar es Salaam) and almost all children who had seen a health worker had been

weighed at least twice. The Expanded Programme of Immunisation (EPI) coverage survey in 1986 found 53% of children aged 11-23 months to be fully immunized a figure exactly similar to the 1984 PHC review for the better served regions (Iringa, Morogoro and Arusha). Recent (1990) figures from the Ministry of Health show that the EPI 1990 target of 80% has been exceeded. Actuall realization is estimated to be about 83%. Even for measles, the figure is about 80% which gives a very high child protection index. The immunization coverage for Measles is sometimes called the "Child Protection Index", since measles is the last vaccination to be given, and usually a child who has been vaccinated against measles should have been fully vaccinated against all the other immunizable diseases (Tuberculosis, Polio, Diptheria, Pertussis and Tetanus).

These coverage statistics are impressively high by any standards. The question, however, is whether this high accessibility and coverage of health services at the primary level can be maintained.

3.4 Quality of health care

The human quality of health care is difficult to assess. A certain indication, however, can be given through a description of the time used for examination of patients. According to the 1978 health evaluation report, on average health workers spend less than five minutes per patient for consultation. Presently the figure is believed to be three minutes. It hardly needs to be pointed out that a consultation time of this length does not allow the health worker to make a satisfactory assessment of the individual and establish a rapport, a necessary human factor in the provision of health services.

The quality of care can also be assessed through the performance

of health workers in patient management and the availability of essential drugs and supplies.

Studies which have addressed the question of patient management, have shown that despite the limited training and almost lack of continuing education of primary level health staff, patient management is satisfactory. In the rural areas, this has been helped by the success of the Essential Drug Programme (EDP) introduced in 1984 which regularly distributes essential drugs in the rural dispensaries and RHCs. These successes however, have been limited by lack of equipment and other supplies and above all by the highly problematic transport situation.

4.0 PEOPLES PARTICIPATION IN HEALTH CARE

Integrating PHC activities into the collective life of local communities and making the grass-roots Village Health Workers (VHWs) accountable to the village local government are essential means for the achievement of the PHC objectives. Community participation in the provision of their own health care in terms of adapting favourable life styles conducive to healthy value systems and active participation in kind and where possible in cash is important to ensure the protection and promotion of health for all.

During the 1960's a remarkable spirit of self-help was evident and a substantial number of primary level health facilities like dispensaries, primary schools, small water projects, roads, etc. were constructed through active community participation, outside the main stream of Government and NGO systems. This spitit seems to have "died" in the course of time, despite the impressive subsequent development of extensive political and administrative structures linking the village to the various levels of the Party and Government which are uniquely placed for mobilization, implementation and monitoring of health services at the community level. The failure to marshall increased support in kind or in cash for their own health activities from the communities has meant the entrenchment of a top-down decision making in health matters, and has left the villagers to look on the state as a potential source of health care handouts and absolving themselves from taking responsibility for their own health. This situation is slowly changing with the establishment of local governments which must now use part of the development levy to run the dispensaries and RHCs. Mention should also be made of the renumeration in kind or in cash given to VHW by some of the village councils who have appreciated their

services. Some VHW are known to have received up to 1,000/= per month from the councils. Effective spontenous community participation in crisis situations especially during disease epidemics is evident in all areas. Sometimes communities may raise cash to help bear the cost of referral for some of their members or expand services appreciated by the community.

Whilst an increased community contribution to implementing PHC services may increase the leaverage of the community in the health related decision-making process, poor villagers in very poor areas can hardly be expected to shoulder any cash costs. This is a vital aspect of the issue of health care delivery which needs to be borne in mind. No doubt, however, that a major effort is needed to facilitate the involvement of ordinary citizens in the provision of their health services individually and collectively.

5.0 FREE HEALTH CARE SERVICES IN NEED OF TREATMENT

5.1 Physical deterioration of facilities

Most of the rural health infrastructure (dispensaries and RHC) we see today was erected between 1972 and 1982. Due to low budgetary allocations and the near absence of maintenance culture and shortage of maintenance technicians in Tanzania most of these structures have not been maintained and some buildings have reached a more or less advanced stage of decay. Maintenance of physical equipment and transport facilities is one of the weakest points in the government health care system. The costs for repair in the absence of maintenance are very high amounting to more than TShs.424 million at 1988 prices for rural dispensaries alone, as estimated by a MOH/DANIDA mission in 1985. The situation now is likely to be worse.

5.2 Deterioration of the availability of drugs and supplies in the urban areas

The development of a national list of essential drugs, consisting of 192 items, and the implementation of the EDP in the form of essential drug kits through DANIDA/UNICEF support since 1983 has been very successful. Since the EDP program does not cover the urban areas, there has been a crisis of drug availability in the urban primary level health care units. A recent (May 1990) survey done by SHIHATA (a Government owned News Agency) in Dar es Salaam showed that most patients prescribed medicine in these units have to go and purchase them from the Private Pharmacies in town. The situation is similar in most urban areas, and this limits free health care accessibility by the vulnerable groups. In some health units, basic facilities like soap, kerosene, kerosene lamps, water etc. are in very short supply.

5.3 The deterioration of the health budget

The trends of government spending on health relative to other sectors has been declining despite great efforts to bring aggragate spending on health back to the real levels that pertained at the time of the implementation of the PHC initiative in 1973/74. Table 1 illustrates this point.

Table 1: Relative Government spending in Recurrent Budget 1970/71 - 1988/89

Year	70/71	73/74	75/76	80/81	85/86	86/87	87/88	88/89
Health % of total	5.2	8.9	6.9	5.9	6.6	5.6	6.2	?
Per capita expenditure (75/76 TSh)	?	?	24.8	29.4	18.4	22.7	24.5	26.4

Source: (Refs 1, 3, 4, 11)

The record year 1973/74 corresponds to a period of heavy capital investment in rural clinics and health centres following the 1971 Party's decision to restructure the health system in favour of the rural areas. Since then the percentage of recurrent government spending on health has declined substantially to a level of roughly 6% which is about the 5% average for sub-saharan African countries. If individual expenditures on modern and traditional health care were included the average figure could be much higher.

The same declining trend is observed when one looks at real spending per capita on health (table 1). Per capita real expenditure rose by 18.5% from 1975/76 to 1980/81 when it

reached its highest peak. Since then they have been declining reaching their lowest ebb in 1985/86 when they declined by 37.4% rising slowly through 1988/89 when the decline was 10% as compared to 1980/81.

These declining trends indicate that health spending has been one of the major victims of the national economic crisis, a common pattern repeated the world over. Despite the priority given to the social services (health included) in the second Economic Recovery Programme (ERP_2) through the Priority Social Action Programme (PSAP) the high levels of inflation and rapid population growth are unlikely to favour a significant increase in real per capita levels of health expenditure in the near future. Unless alternative health financing is forthcoming, a further decline is to be expected.

The deterioration of the health budget is diametrically opposed to the successes of health care accessibility which we have described earlier. The only plausable explanation is the role played by donors and NGOs in the developmental health budget. Multilateral donors, bilateral donors and private church and lay NGO's based mainly in Europe and North America provide substantial recurrent and development assistance in the form of finance, manpower and material supplies to the Tanzanian health sector. The health sector is only second to Agriculture as the biggest recepient of foreign aid, sometimes taking nearly 15% of bilateral technical assistance. Foreign assistance accounts for between two thirds and three quarters of development health spending. As an example the EPI programme alone in 1986 costed about 25% of the health budget. This is in sharp contrast to a mere one percent of Government development spending on health. The Government

is obviously aware of this disparity and hopes that the donor community would continue giving support until better economic times come and/or alternative sources of health financing are found. Otherwise the success of the provision of health services in Tanzania which is perhaps unequalled on the African continent will be impossible to sustain. A recent cost analysis of the immunisation programme indicate that the greatest scope for cost reduction in the short to medium term lies with the concentration of immunization activities and the more efficient use of vaccines.

5.4 The Human factor

A recent inventory of health facilities and human resource potential conducted by the Regional Commonwealth Secretariat based in Arusha in the Eastern and Southern African countries ranked Tanzania number one as having the highest indigenous health human resource capability. The same inventory ranked Tanzania at the bottom in terms of health facilities and renumeration of its humanpower.

The low wages and lack of working facilities coupled with an ever increasing inflation and a demotivating implementation of their schemes of service has further accelerated the deterioration of the health services. Medical ethics for a significant number of health workers have been set aside and corruption in the health system has taken root especially in the urban areas. A number of health workers have resorted to charging patients variable amounts of money for giving what is supposed to be a "free" medical service. Theft of drugs and supplies in the rural areas is rampant and the more ethicall conscious health workers have resorted to more acceptable additional sources of income like livestock keeping or farming.

The deteriorating working conditions for health workers and the subsequent corrupt practices have further undermined the quality of health care. It is pertinent to mention here that this situation is not unique to the health sector alone since the national economic crisis has taken its toll across all sectors. However, it is more noticeable and repugnant when practiced by health workers since the customers of the health sector would be charged corruptly at a time when they need greatest help and sympathy.

Although nationally this culminated to the resignation and appointment of a New Minister for Health, pent up frustrations of the medical personnel had to get a vent. This is what the recent (April 1990) strike by junior doctors and medical students at Muhimbili Medical Centre (MMC) in Dar es Salaam demonstrated.

The continued deterioration of the quality of Government health care has resulted in a crisis of confidence to the government health services. The governments pronouncement of several incentives for health personnel expected to cover other sectors as well to be unveiled in July 1990 will be a lubricant to the human factor. But as rightly pointed out by the Government, unless the economic performance improves through increased production and hard work there is a limit to what the government would be able to offer.

6.0 PRESCRIPTIONS FOR THE TREATMENT OF THE HEALTH SERVICES

6.1 The Government's prescription

Mention has already been made of the priority budgetary allocation to health in ERP2 through PSAP. In this programme, the Government expects to introduce a user cost-sharing scheme on a pilot basis to gain experience before the scheme is made national.

In fact in the budget speech of 1988/89, the Minister for Health announced the introduction of a user cost-sharing charge of TShs.20/= per person per disease curative treatment. This has not yet been implemented probably because no clear provisions have been developed and a charging system needs to be carefully thought out. The teething problems which met the introduction of the 100 Kshs for hospital treatment in Kenya as cost-sharing measure in December 1989 should be a lesson to Tanzania. Patients are bound to expect timely and good quality health care which may be frustrated by inefficiency, mismanagement, corruption and greed. The question here really is not to question the importance of finding alternative sources to finance the health system, but to caution on the need to carefully prepare before any cost-sharing scheme is implemented.

6.2 The People's prescription

In order to find out the peoples feeling and perception of the health services, the author carried out a study which was done in two districts in Singida region. The districts participating were Iramba, where most people are served by a cost-sharing mission hospital and Singida Rural district where the majority of the population get both free and mission cost sharing health services. The results of this study are summarized in table 2.

The age range for those interviewed in Singida rural was 20-60 years with a median of 35.5 years, while for Iramba the range was 18-45 years with a median of 32 years. Nearly all those interviewed were subsistence farmers. An open ended questionnaire was used.

Table 2: Evaluation of "Free" Health Care in Singida and Iramba Districts (24-27th April 1990)

	SINGIDA RURAL			IRAMBA			TOTAL		
	Male (n=14)	Female (n= 8)	Total (n=22)	Male (n=10)	Female (n=10)	Total (n=20)	Male (n=24)	Female (n=18)	Total (n=42)
1. Health care Accessibility available all the time	64.3	37.6	54.5	90.0	90.0	90.0	75.0	66.7	71.4
2. Paying for most services	21.4	50.0	31.8	100.0	100.0	100.0	54.2	77.8	64.3
3. Tipping health worker	7.1	0.0	4.5	10.0	10.0	10.0	8.3	5.6	7.1
4. Ready to pay for Gvt. health services	14.3	0.0	9.0	40.0	80.0	60.0	25.0	44.4	33.3
5. Of those ready to pay would like to pay after treatment	100.0	-	100.0	100.0	100.0	100.0	100.0	100.0	100.0

One thing to notice is that already a substantial number of people, 64.3% in both districts are paying for their modern health services. Payment ranged from 50 - 2,000 Tshs depending on disease being treated. This is in a situation where there is availability of both mission and free government services. Our observation is that this situation is true all over the country because of the trust and confidence people have in the mission health services. Also, the NGO health services are provided with a better personal attention and empathy, and with strongly motivated health personnel than in government health units.

About a third of those interviewed mainly women are ready to share health care costs with the Government. In Iramba, the figure is 60%, while in Singida rural where their experience of paying for health services is low, the figure is only 9%. All those ready to pay would like to do so after treatment probably a reflection of the method used by traditional healers. The health services people would be ready to pay for include inpatient treatment and operations. Some women mentioned even the MCH services.

The two major reasons that were given for wanting to pay for Government health services were

a) to improve the quality of care (Buy medicines get good treatment) and
b) cost-sharing with the government.

The amount of money that they were ready to pay ranged from 50 Tshs to 1,000 Tshs with a median of Tshs 100. Only a few specified a schedule, some saying the payment should be done monthly. Others wanted it to be for one course of treatment and this would depend whether it is inpatient or

outpatient treatment. Still others were ready to pay 5% of the cost of treatment. All these costs are far above the Tshs 20 initially proposed by the Government in 1988/89.

Most people preferred to pay directly to the hospital cashier as is done in NGO health units. The rest wanted payment to be in a form of contribution, without specifying the mechanism to be used.

All those ready to pay wanted the money to be used for buying medicines. Only 5 (12%) mentioned in addition to medicines other hospital supplies like food, kerosene and transport.

Some few people were ready to pay for health care provided by NGO's but maintained that government health care should continue to be free of charge - because it is the governments responsibility.

The conclusion which we can draw from this small and unrepresentative sample study is that there is a substantial number of farmers who are ready to pay for government curative health care, provided that the quality of care is improved. Our experience from other areas indicate that this is the general view and expectation of the many ordinary citizens.

6.3 Prescription by the medical personnel

Opportunity was taken to interview 22 medical officers attending a workshop in Dar es Salaam on 23 April 1990. Nearly 80% of the medical officers came from various districts outside Dar es Salaam and work as District Medical Officers (DMOs). Some were from the Central Ministry of Health, and others were

representing NGO's offering immunization services. The interview was done by the author himself through an open ended questionnaire. Table 3 gives a summary of the results.

More than 90% of them felt that patients should pay for health services. The majority (60%) preferred only a certain category of patients to be charged, mainly based on the level of income (66.7%).

The amount to be charged varied from 50-200 Tshs, but the majority (40%) wanted a proportion of the cost or 50 Tshs to be paid. The majority of Iramba people suggested twice as much, 100 Tshs as already discussed in section 6.2

When the question on what should the charging system be was asked, the immediate response was, how do the NGO's do it? This is reflected in the finding that 85.0% wanted the health facility to directly charge. As for those farmers in Singida, the doctors wanted the money charged to be used for the purchase of drugs and supplies (50%) and general running of the health facility (40%).

Table 3: Medical Personnel Views on Paying for Health Care (n=22)

View	No. (n=22)	%
1. Patients should pay	20	90.9
Of those who said pts should pay		
2. Categories of patients to pay:		
(a) All categories	8	40.0
(b) Only certaincategories	12	60.0
Of those who said only certain categories:		
(c) According to income	8	66.7
(d) Except health personnel	1	12.5
(e) Except preventive services	1	12.5
(f) Except underfives	1	12.5
(g) Except disabled	1	12.5
3. Amount to be charged (Tshs)		
(a) 50	5	25.0
(b) 100	4	20.0
(c) 200	1	5.0
(d) Proportion of cost	8	40.0
(e) Other	2	10.0
4. Charging system		
(a) Direct by health facility	17	85.0
(b) Other (levy, insurance)	3	15.0
5. Use of charged money		
(a) Drugs and supplies	10	50.0
(b) Pay medical staff	2	10.0
(c) Transport	2	10.0
(d) Other	7	40.0

7.0 CONCLUSIONS AND RECOMMENDATIONS

In Tanzania, ordinary people have an impressively high access to health care particularly preventive care. Rising costs with a deteriorating real income and a high population growth are putting immense strain on the country's health care services, calling to question the country's ability to sustain a "free" health care system. The question of how can health services be financed in Tanzania is pertinent now than it has never been before.

Using direct user charges is a regressive alternative because many patients will not be able to always pay. This may also have an effect on the most vulnerable groups by discouraging the utilization of preventive services whose relevance may not be immediately seen. Also, due to the recurrent disease episodes, which are higher in the low than in the high socio-economic groups, user charges will further decrease household income to meet other basic needs. Direct user charges for purposes of cost-recovery cannot, therefore, be recommended for the group of public services which meet the basic needs like, public health and preventive measures (MCH services, immunization etc.) and even for curative services. However, it seems acceptable from our previous discussion for the introduction of user charges for purposes of cost-sharing. As pointed out by the doctors, this should be done on a selective basis, probably using income as the criteria. This is probably the system followed by the traditional healers, as it is very rare to find patients who are completely incapable of paying for health services rendered by the traditional healers. For a cost-sharing policy to work, medical services should be decentralized in order to make them more efficient an responsive to the people's needs. The provisions of such a policy needs to be made clear, and widely discussed before implementation.

Community financing could be an alternative or in addition to cost-sharing user charges. Apart from the Local Government, the Cooperative Unions could work out a mechanism by which health care in their area could be financed so that the most vulnerable groups are protected from the effects of direct user charges.

Another method which could work well in urban areas is to do economic targeting of user fees, so that those capable of paying would be obliged to go to a graded hospital on a more or less cost-recovery basis.

Although the issue of user charge is politically sensitive, the question now is not <u>whether</u> it should be introduced, but <u>how</u> it should be introduced with minimal effect to the vulnerable groups.

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