Health Care Financing in Tanzania
2005 FACT SHEET No. 1

COST SHARING

DESCRIPTION

Cost sharing in government health facilities was introduced in 1993. This revised the previous health financing policy that aimed to provide health services free to all from all government health facilities. The previous policy was deemed unrealistic as GOT financing was insufficient to truly provide all services for all of the population, and the policy resulted in poor quality and inequitable health services delivery. Attempting to cover everyone with free essential health services resulted in poor quality care and poor coverage. The poor suffered the most, as they had fewer alternatives, whereas the wealthier members of the population could opt out of the government system and pay private providers.

The objectives of cost sharing are to (i) generate additional revenues to bridge the gap in government allocation, (ii) improve availability and quality of health services, (iii) strengthen the referral system, (iv) rationalize utilization of health care services, (v) improve equity and access to health services by pooling financial risk and cross-subsidizing costs and (vi) strengthen community voice (users/payers) towards improving service quality and provider's accountability.

Exemptions: The scheme charges fee for service[1] for different health services in government health facilities. However, the government has mandated that the following are exempted from paying fees at any government facility:

- Exemption based to particular services; these are maternal and child health services including deliveries.
- Particular age groups; these are all children under the age of five.
- Particular diseases; these are diseases that drains substantial income from the patients, such as chronic diseases (e.g., tuberculosis and AIDS), and any disease if it is an epidemic.
- Populations that can not afford to pay because of income.

Health Services Fund & Drug Revolving Fund: At hospital level, unlike at health centers and dispensaries, fees are essential to operating costs. They constitute between 30%-60% of the non salary recurrent health expenditures of

[1] The rate of the fees is a very small proportion of the actual cost of the service. Up until 1996 the charges were very indicative in the sense that there was a fixed price per item prescribed irrelative to its actual price. Then the prices were set at 50% of the actual cost of the drugs.

the hospitals[2] .The Drug Revolving Fund is Fund that was established under Drug Capitalization Programme. It was meant to support the hospitals in replenishing funds for the procurement of drugs and medical supplies. The Programme was introduced when it was realized that the Medical Stores Department had introduced cash and carry policy in the procurement of drugs, since the government budget was not adequate to cover the total cost of drugs requirement and hospitals were needed to buy on cash basis a drug revolving was introduced to address the problem of cash shortage in the procurement of drugs. The Ministry therefore opened a separate account to take care of the financing of hospital drugs and this is the Drug Revolving Fund. The fund is charging 50% of the actual cost of the drugs. One would look at it as one form of strengthening the cost sharing policy.

The Health Services Fund is a fund used to collect revenue from other services other than drugs.

Phased Implementation: The introduction of cost sharing in government health facilities was implemented in four phases; the first phase which from July 1993-June 1994 included the referral hospitals and some services in the Regional hospitals, the second phase, starting July 1994 to Dec 1994 introduced fee for service in Regional hospitals, the third phase from January 1995 onwards was in District hospitals. The fourth phase, which was to begin immediately after completion of introduction to all district hospitals, was health centers and dispensaries. The last phase took longer than originally envisaged, and to date is not fully introduced – less than half of the districts are charging fees in government health facilities at health center and dispensary levels. The reason for this delay was the Government's decision to develop safety nets for rural populations (the Community Health Fund, which is intended to provide free membership cards to indigent households allowing them to be waived from paying fee for service, and which encourages other households to pay an annual membership fee instead of fee for service). There have also been greater difficulties encountered in financial management in rural areas.

EXPERIENCE TO DATE

Achievements: Since the introduction of user fees, drugs supplies have improved, hospitals have been rehabilitated and improvements in attitudes of health providers have been noted (as patients are seen more as clients and as patients voice expectations and demands). There is also a change in community attitude towards the concept of free services: people are more aware that services have a cost and a value, and that they have a right to know how their money is used. There have been improvements in rational utilization of health care services, and in the management of funds at different levels.

[2] Assessment of impact of exemptions and waivers on cost sharing revenue collection in public health services (Prof Msambichaka et al), 2003 and reports of hospitals presented in MOH health financing meeting held in Morogoro April 2005.

Constraints: Exemptions for those who can not afford to pay has not been working effectively. At the same time, revenue collection is not collected to its optimal levels. Capacity to manage funds and budget under the HSF and DRF is still limited though hospital teams were oriented on hospital revenue targeting. Not all management committees well represent communities in decision making.