A deadlock in health service delivery: Examining revenues lost from implementation of user fee exemption policy in Tanzania

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Abstract

Background: Tanzania, like other low and middle-income countries (LMICs), introduced user-fee exemptions in early 1990s for the purpose of increasing access to health care services for the poor and the most vulnerable groups. User-fee exemptions are granted to pregnant women, children under 5, persons above 60 years and patients with chronic diseases. While there is consensus on the effects of user fee exemptions on access to health care services, there are growing concerns that user fee exemptions are the source of poor quality of health services in public health facilities. However, studies on exemptions have predominantly focused on the demand side, looking into whether the poor and vulnerable groups receive the required health care services. Therefore, there is scant knowledge of the effects of user fee exemptions on the supply side. This study examined revenues lost due to implementation of user-fee exemptions in public health facilities in Tanzania.

Methodology: This study employed a case study design, and used documentary reviews and in-depth interviews in data collection. Thematic analysis approach was used to analyse qualitative data, whereas Microsoft Word Excel application was used to analyse the quantitative data extracted from documentary reviews.

Results: The findings indicate that public health facilities lost substantial revenues mainly from service functions such as medicines, medical consultation, laboratory, and delivery services. However, there were no mechanisms in place to offset the revenues lost by health facilities. Consequently, the loss significantly jeopardised provision of health care services.

Conclusion

The study concludes that public health facilities in Tanzania lose a substantial amount of revenues due to the implementation of user fee exemption policy, which significantly jeopardises provision of health care services. The government should increase subsidies to public health facilities and increase efforts to effectively implement health insurance schemes because they are viable and reliable sources of revenues for improving service delivery.

Introduction

After independence in 1961, Tanzania provided free health care services to its people.[1,2,3] This commitment was emphasised in the *Ujamaa* and Self-reliance Policy (SRP) enshrined in the Arusha Declaration of 1967. The government increased efforts to improve infrastructures through expansion of paramedical schools, village health centres and dispensaries in order to ensure that every citizen was within 5 kilometre-radius from health care facilities.[4]

In the early 1980s, Tanzania went through a severe economic crisis, which disrupted the management and financing of health system.[1] Consequently, this situation spurred the World Bank (WB) to exert pressure on Tanzania to liberalise social sectors to boost social services through cost-effective

interventions.[5] Tanzania was thus forced to introduce user fee as the cost-sharing principle. The WB envisioned that user fee would be an important source of facility revenues that would create financial sustainability in health care system.[6] As time went on, user fee charges could not address the funding gap.[7] Subsequently, several funding options were explored, including the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF).[8]

Despite these initiatives, access to health services by the poor was still a major challenge. In response, the government introduced user fee exemptions in 1994 in order to increase access to health services for the poor and marginalised groups .[9] User fee exemptions are categorised in terms of mandatory and non-mandatory exemptions. On the one hand, mandatory exemption is referred to as free health care services to groups of people based on demographic and disease characteristics.[7] This includes pregnant mothers, under 5 children and people with chronic diseases, such as HIV/AIDS, cancer, sickle cell anemia, tuberculosis and cholera. Non-mandatory exemptions, on the other hand, are temporarily granted to people who are not able to pay for health care services, but they are in need of health care services.[10] Such groups include elders above 60 years and poor people who may be determined by health providers or Social Welfare Officers. Patients who qualify for waivers are identified and recommended by health workers and community leaders to get free health services.[10]

There is a consensus that user fee exemptions have been put forward as an approach to increasing priority in health service utilisation, reducing impoverishment and achieving universal access to health services.[9,11] However, there is a concern that user fee exemptions are the source of poor quality of health services in public health facilities.[9,13] Specifically, by eliminating user fee charges, health facilities have lost revenues that are key to improving the quality of health care. Consequently, health facilities often run out of medicines and medical supplies as well as inadequate motivation for those who do extra works.[13,14] In addition, the loss has affected the ability of health facilities to expand health infrastructures to accommodate the influx of patients.[13] Although most public health facilities depend on government subsidies to offset lost revenues, the subsidies are not timely disbursed and, sometimes, funds are not provided at all.[15] It is also observed that user fee exemptions decrease staff work morale as a result of increased workload.[16]

Earlier studies on exemptions have only focused on the demand side; looking into whether the poor and vulnerable groups of the society receive the required health care services. To the best of our knowledge, there is no study in Tanzania which has examined the effects of user fee exemptions on the provision of health services in public health facilities. This study, therefore, aimed to fill this knowledge gap by examining the effects of user fee exemptions on the supply-side.

Methods

Study design

This study adopted a case study design, an empirical inquiry that investigates a phenomenon within its real life context, and from the perspective of the participants involved in the phenomenon.[17] A case study seeks to understand how individuals construct the meaning of an event or activity that occurs within their surroundings.[17] This approach was considered appropriate as it allowed the researchers to critically examine key service functions through which most revenues are lost.

Sampling procedures

A multi-stage sampling was used in this study. Three out of eight health zones recognised by the Ministry of Health (MoH) were involved in this study.[18] The selected zones were the Southern Highlands Zone, the Eastern Zone, and the South-Western Zone. In each zone, random sampling was used to select one region. In this regard, the Southern Highlands Zone was represented by Njombe, the Eastern Zone was represented by Morogoro, and the South West Zone was represented by Mbeya Region. Random sampling was used to select one district council from each region. Eventually, Njombe, Mbarali, and and Kilosa District Councils were selected. Similarly, a systematic sampling was used to select one District hospital in each District council under investigation. Random sampling was then used to select two health centres in each District Council, making a total of three health facilities. Table 1 summarises Demographic information and health indictors of the study districts.

Table 1
Summary of Demographic Information and Performance Indicators of District Councils.

Demographic and Health indicators	Njombe DC	Mbarali DC	Kilosa DC
Population size (N)	85,747	300,517	438,175
Annual population growthrate	2.4%	2.8%	4%
Antenatal care + 4 (ANC) visits coverage	84.4%	70.5%	66.5%
Proportional of pregnant women received $TT2^{+}$	64%	67%	62%
Institutional delivery coverage	44.6%	89%	66.5%
Maternal Mortality Ratio per 100,000 live birth	NL	42.2%	52.2%

Source: National Bureau of Statistics (2012), Demographic Health Survey (DHS2, 2020).

Data collection techniques

The study used two data collection techniques, namely in-depth interviews and documentary reviews. At the district level, interviews were conducted with Health managers. At the facility level, interviews were conducted with service providers. Interview guides were developed by the first author (TN) and supervised by the second author (SOM). The interviews were conducted by TN and lasted between 45 to 60 minutes. Saturation point was determined when no new information was coming out in the successive interviews. Table 2 summarises the categories of the respondents involved in in-depth interviews.

Table 2
Categories of Respondents for In-depth Interviews

Categories of respondents	No. of in-depth interviews			
	Kilosa DC	Mbarali DC	Njombe DC	Total
District health managers	4	5	3	**12**
Health service providers	9	6	12	27
Total Key informants	**13**	**11**	**15**	**39**

In addition, documentary review included financial documents such as statement of income (profit and loss account), Council Comprehensive Health Plans (CCHPs), and payment receipts.

Data analysis

A thematic analysis approach was used to analyse qualitative data[20] following a number of steps. First, interviews were transcribed verbatim by a trained transcriber, and were checked for accuracy by the principal investigator (TN). Second, both authors read the transcripts in order to understand the depth and breadth of the data set. Third, TN developed a list of initial codes based on the objectives of the study. Then, SOM reviewed and approved the initial codes. Using NVivo 12 software, interviews transcripts were then coded to the initial codes. Other codes which emerged during the coding process were added concurrently. Fourth, responses were compared across respondents and study districts. Key phrases and expressions of the respondents were retained and used to support the findings.

Quantitative data were analysed using Microsoft Excel programme. Then, Auto Sum was used to calculate total revenues collected and lost accrued from each service functions. Eventually, lost revenues were compared against generated funds and presented in tables.

Ethics approval

This study received approval from the University of Dar es Salaam, and from District council authorities. Verbal informed consent was obtained from all respondents before conducting interviews. Verbal consent was mostly preferred to written consent because in our study settings, signing of consent forms would be perceived by respondents as a threat. Moreover, data corpus was accessible only to the team members. During the presentation of findings, individual identification was totally avoided.

Data availability

The dataset collected for the study is not publicly available because respondents did not give consent for public sharing of the information. However, summaries of the information and data collection tools are available from the corresponding author upon formal request.

Results

Substantial lost Revenue

The information collected from facility income statements and Comprehensive Council Health Plan shows that district hospitals lost substantial amount of revenues mainly from delivery, pharmaceutical, laboratory and medical consultation services. Table 3, of Annex 1 summarises the revenues lost from medical consultation services in District Hospitals A, B and C.

Findings also indicate that free delivery services in public health facilities greatly contributed to the decline of revenues. Table 4 of Annex 2 shows revenues lost due to free delivery services against revenues collected from user fee charges.

Furthermore, pharmaceutical services lost substantial revenues along with other free services granted by district hospitals. Table 5 of Annex 3 presents the revenues lost due to user fee exemptions against the revenues collected from user fee charges.

Besides pharmaceutical, free laboratory services also depleted revenue in district hospitals. Table 6 of Annex 4 summarises revenues lost against the revenues collected from laboratory services in District hospitals.

Apart from District hospitals, Health centres also experienced a significant loss of revenues from free medical consultation, pharmaceuticals, delivery and laboratory services. Table 7 of Annex 5 presents the revenues lost against the revenues collected in Health Centre A, B, C, D, E and F. Moreover, delivery services led to substantial revenue losses. Table 8 of Annex 6 summarises revenues lost against fund collected from user fee. Furthermore, Table 9 of Annex 7 and Table 10 of Annex 8 presents loss of revenues in pharmaceutical and laboratory services respectively in Health Centres.

Similar findings were commonly reported by respondents during interviews. Respondents underlined reasons and consequences of lost revenues in health facilities. Respondents reported that funds were lost because majority of service users did not pay for the services. They underlined that exempted groups such as children under 5, pregnant women and people above 60s were most users of health services. Respondents also reported that there were no mechanisms in place to subsidize facilities for the lost revenues. This is exemplified by one respondent:

*“Our facility loses substantial funds by implementing user fee exemptions. This is because groups such as children under 5 years, pregnant women and elders above 60 years use more free services; and there are no any deliberate mechanisms from either central or local government to reimburse our facility for the lost revenues” (*ID with Health Manager, District Hospital A*).*

Respondents frequently reported that loss of revenues was one of the reasons for poor service provision in public health facilities. Health managers reported that they were not able to allocate funds to the projects which they sought would improve service delivery. Respondents also underlined that some facility infrastructures were dilapidated, and needed serious renovation but health facilities had no

sufficient funds. Respondents emphasised that renovation and construction of new infrastructures depended on internal sources of revenue, including user fee charges. some respondents narrated thus:

"Sincerely, user fee exemptions are a deadlock in service delivery although it benefits some poor and most vulnerable groups. User fee exemptions drain big revenues from the health facilities. If lost revenues were collected, they would help the facility management to improve infrastructures. We are not able to renovate our buildings because our facility does not generate sufficient funds. As you know children, pregnant women and elders do not pay although they are the most users of the health services" (ID with Health Manager, Kilosa District Council).

Other respondents added:

"You know, our facility fails even to expand wards in order to admit more patients. In fact, our facility wards are too small to allow additional beds; and this is why you see some patients sleep on the floor or even share beds. If you ask our Hospital Administrators what is the solution to this problem, they reply that the facility faces a significant shortage of funds. Many patients are exempted and thus they do not pay for health services" (ID with Service provider, District Hospital B).

"We have many plans which we sought to implement to improve facility infrastructures. We planned to build offices, a waiting shed, and to extend wards but we failed because the funds we collect are not enough. We do not receive funds from the district council even for minor repair of our buildings. All costs associated with maintenance and running offices are the responsibility of the facility. For now, the facility is unable to do it because majority of service users do not pay for the services" (ID with Health Manager, Mbarali District Council).

In the same line of argument, health managers reported that lost revenues made health facilities to accumulate many unpaid arrears to staff and service suppliers. It was the view of the health managers that some health facilities were not able even to pay extra duty allowances to staff. Some respondents narrated that:

"Our staff claim their extra duty allowances for several months. We know their claims are genuine, and we would like to pay them on time. However, we cannot do this because we don't have funds. The little funds we collect from user fee and other sources are not enough to settle staff allowances. This situation demoralises some staff although they don't complain openly" (ID with Health Manager, District Hospital B).

"Frankly speaking, sometimes we undermine the rights of our staff for not giving their rights on time. In fact, our staff have been claiming their extra duty allowances for a long time. Some claims have taken more than six months since workers submitted to us, but we have not paid them. In fact, we don't know when we shall pay them because right now, we have no money. Whenever we try to collect funds from services, we fail to reach targets simply because the majority of our service users do not pay, thus causing huge revenue loss" (ID with Health Manager, District Hospital A).

Some service providers confirmed that they had not been paid their extra duty and on call allowances for a long time. This is exemplified by some respondents, thus:

"We have been called several times to attend to patients outside normal working hours. Sometimes, we are called when we go to bed. Instead of sleeping, we come to the facility and attend to patients. We expected to be paid these allowances immediately. But if you ask the Matron, she says the facility has no money. In fact, it is discouraging" (ID with Service provider, Health D).

Another respondent added:

"We are demoralized because we work hard but paid less. We don't get even extra duty and other allowances on time. Sometimes, we think to quit but we ask what if we leave this job? Will we get a better job than this? In fact, the situation is even difficult in private hospitals. We hear from our friends complaining that the situation is worse than what we face. My friend, let me tell you this, we have no other options" (ID with Service provider, Health Centre C).

Discussion

This paper has examined the effects of user fee exemptions on the provision of health care services in public health facilities in Tanzania. The findings indicated that public health facilities lost substantial revenues mainly from such services as medicines, medical consultation, laboratory, and delivery services. Health facilities provided free health care services to exempted groups such as children under 5, pregnant women, elders and people with chronic diseases as stipulated in the exemption policy and guidelines. However, there were no mechanisms in place to reimburse facilities for the lost revenues. Therefore, the revenue lost following implementation of user fee exemption policy significantly jeopardised provision of health care services. Revenues are important elements in service delivery for they are used to purchase medicines and medical equipment, to improve facility infrastructure and to motivate staff for the excellent services they provide to clients.[14]

There is ample evidence that user fee exemptions in LMICs contributes to a substantial loss of facility revenues.[9] For example, in Burundi, the introduction of user fee exemptions policy by decree of the president led to decrease of facility revenues and thus hindered facility management from accomplishing plans which they sought to implement.[14] The study also reported that majority of public health facilities in Burundi often ran short of office consumables such as hygiene and cleaning equipment, rim papers, and fuels.[14] A study conducted in Kenya indicated that introduction of user fee exemptions declined facility revenues to the extent that hospital management could not improve maternal wards.[13] Space in maternal, in particular were too small to allow to additional beds for pregnant mothers. Similarly, in Zambia, user fee exemptions contributed to the loss of facility revenues.[21] The revenues lost due to execution of user fee exemption forced management to reduce the number of facility meetings and allowances of meeting participants.[21] This, in turn, created chaos from meeting participant as it was against facility circulars.

Reimbursement has proven to be an effective approach to buffering the impacts of lost revenues. For instance, in Zambia, Kenya and Burundi, although reimbursement had shortfalls, it was of great help in the facilitation of daily facility operations.[13,14, 21] Therefore, there is a need for the government to reimburse health facilities for the loss of revenues caused by user fee exemptions. This is an important aspect because the demand for services is increasing rapidly, thereby exceeding the capacity of health facilities[1]. In Ghana, two regions were reimbursed differently, and this led to great successes. Specifically, regions which conducted normal deliveries were paid at a relatively generous rate, but complicated caesarean services were paid below the national rate.[3] In Zambia, although reimbursement was not timely organised, it based on actual free services granted to patients; and this strengthened service provision.[21] It is worth noting that if reimbursement is carefully managed, facilities will be able to improve infrastructures and facilities, to pay staff allowances and to procure adequate medicines and supplies for the clients they serve. In Nepal, subsidies not only rejuvenated service provision but also reduced catastrophic payment of households specifically in deliveries services.[21]

However, studies have also indicated that even if reimbursement is organised, it is still insufficient, delayed and unpredictable.[21] These shortfalls negatively affect the performance of health facilities, leading to poor quality of services. The findings underline the need for the government to increase efforts to effectively implement health insurance schemes because they are a viable and reliable source of generating sufficient revenues for financing health systems.

Strengths and limitations

This study has strengths and limitations; first, data were collected using diverse sources; documentary reviews and in-depth interviews. This made it possible to triangulate the findings across different sources. However, the study was conducted in only three rural districts and thus, the findings may not adequately reflect experiences of user fee exemptions in other districts of Tanzania.

Conclusion and recommendations

This study concludes that public health facilities in Tanzania lose substantial revenues due to the implementation of the user fee exemption policy. The revenues lost significantly jeopardised provision of health care services. In order for public health facilities to provide quality services in the context of user fee exemptions, the government should increase subsidies to public health facilities. In addition, the government should increase efforts to effectively implement health insurance schemes because they are a viable and reliable source of generating sufficient revenues for financing the health system.

Declarations

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Competing interests

The authors declare that they have no competing interests.

Authors' contributions

TN conceptualised the study and collected and analysed the data. SOM supervised the study. TN drafted the manuscript. SOM provided critical revision of the manuscript for important intellectual content. Both authors approved the final manuscript.

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