

# PROVISION AND ACCESS OF HEALTH CARE SERVICES IN THE URBAN HEALTH CARE MARKET IN TANZANIA

*By Dr. Tausi Kida*

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## ABSTRACT

*This article summarizes the findings of a research project that provides evidence of existence of segmentation in provision and access of health care services in the urban health care market in Tanzania. It argues on the basis of field data that segmentation arises from of the influence of demand and supply in the health care market in an environment of widespread poverty. The implication is that segmentation of health care delivery into a two-tier system weakens the whole process of provision and access to health care, especially for the urban poor. It results on one hand to a relatively better quality upper tier of care for those who can afford it and, on the other, a lower tier of inexpensive health care services of generally inadequate and /or doubtful quality mainly to cater for the poor. Furthermore, the evidence in this article provides some support for a model of market segmentation involving two-way causation in which high incidence of poverty interacts with the health care system in a process of cumulative causation.*

*The deregulation and liberalization of the health sector adopted in Tanzania from early 1990's has brought about a dramatic shift in the system of health care delivery, from nearly exclusively 'free' public provisioning towards its extensive commercialization that includes the liberalization of private health care provision. The prevalence of commercialized health care, in this sense fee based, requiring out- of- pocket payment in all sectors, in the context of widespread poverty, raises concern about access by the poor to health care services. Therefore, contrary to policy intentions, this article argues that the urban poor frequently find themselves excluded not only from (decent) private health care, but also from access to decent public health care, given the current subsidy structure, its use within an extensively fee-based (commercialized) health system – in both public and private sectors – in the prevalence of widespread poverty.*

## 1.0 INTRODUCTION

This article summarizes the findings of a research project that provides evidence for existence of segmentation in provision and access of health care services in the urban health care market in Tanzania. It argues that the presence of segmented health care market in this urban setting is mainly the outcome of a systemic process of interaction of the demand and supply sides of the health care market in the context of widespread poverty. This article further argues that the bifurcation of health care delivery into a two-tier system limits better access to health care especially for the urban poor. This is because the segmentation process brings about an upper tier of better quality of care for those who can afford it and, a lower tier of inexpensive health care services of generally inadequate and/or doubtful quality mainly to cater for the poor.

This article therefore explains the application of health policy with respect to access to health care services in a context of widespread urban poverty. The theoretical value of this article lies partly in its application of the concept of market segmentation to health care market data. The article presents evidence of the process whereby the poor are crowded into a lower segment of the health care market, alongside exclusion from the upper segment as drawn on the theories of labour market segmentation (Piore 1973, Peck 1996, De Grip et al. 2006). This framework was designed to benefit from earlier studies that indicated elements of bifurcation in urban health care markets (Tibandebage et al. 2001; Mackintosh and Tibandebage 2002; Tibandebage and Mackintosh 2005) so as to explore the effect of the segmentation in the access and provision of health care services in Tanzania that has even accentuated in more recent years. This article argues that segmentation can be understood as an outcome of how poverty shapes the performance of the health care market. The concept of *segmentation* as has been analysed in the theories of labour market entails a process of compartmentalization and isolation of different groups of participants in the labour market. The interest in this concept is in particular on the product or the outcome of this state of compartmentalisation (Ryan 1981: 3-4). Market segmentation is therefore a process that leads to distinct market segments, which possess dissimilar characteristics and/or behave in a different manner.

In Tanzania the deregulation and liberalization of the health care sector since the early 1990s has been part of the overall socioeconomic reforms taking place in the country. These changes have brought about commercialization of the health sector through increased involvement of

private health providers and the introduction of fee-based structure in public health care facilities (Tibandebage et al 2001, COWI et al 2007). The prevalence of commercialised health care, in this sense fee based, requiring out of pocket payment in all sectors, in the context of wide spread poverty, raises concern about access by the poor to health care.

In this respect, an influential view in the literature and in policy practice propounded, among others by Gwatkin (2003), postulates that the commercialisation of health care services will move the better off towards private facilities in the public-private mix, thereby freeing the subsidised public health care facilities for the use of the poor. Contrary to policy intentions, the findings presented in this article indicate that the urban poor frequently find themselves excluded not only from decent private health care, but also from access to public health care, either as absolute denial of access due to inability to pay the fee or relative denial in the sense of poor quality public health services. In Tanzania, for most people, access to health care services - both private and public - involves out-of-pocket payments. Exemptions from user fees for the indigent formally exist in government facilities, but hardly apply in practice in Tanzania as in most African countries (Gilson 1997; Lorenz and Mpemba 2005; URT-MoH 2005). Under such conditions, commercialisation policies (in the context of widespread poverty) may counteract the stated intention to subsidise government health services for better access of care by the poor (Gilson 2005; URT 2002b).

## **2.0 METHODOLOGICAL APPROACH**

Field research for this paper was conducted in 2006 in Kawe ward – an urban ward - located in Dar es Salaam, Tanzania. This is quite a large ward, which features both low and high density areas, respectively indicative of richer and poorer populations, thus allowing for sampling across a wide wealth/income range. In addition, the ward has varied infrastructure for health care, including both public and private health care facilities at different levels. The research was conducted at three distinct levels: household level, health care facilities and municipal level.

The household survey was the *core* component of this research that brought understanding of the demand side of the market, specifically the components of health seeking behavior, utilisation of health care services and the interaction of health care use with poverty incidence. The survey covered 300 households and adopted a multilayered structure of the units of analysis. All individuals within each household were surveyed, covering all illness episodes in the household in the past three months and all visits related to each episode.

The sampling method adopted for the household survey was *mixed multistage cluster sampling* or, the purposeful selection of the administrative streets coupled with random selection of households using two-stage cluster sampling. An administrative street (popularly known as *Mtaa in Swahili*) is equivalent to a village in the rural structure. The first stage involved the purposeful sampling of the administrative streets in Kawe ward. At this stage three administrative streets were selected (Ukwamani, Mlalakua and Mzimuni) out of the total administrative streets in Kawe ward. *Ukwamani* was selected because it comprises a large poor community in a very densely populated squatter area. In this regard, most poor households were found within this street. The second street *Mzimuni*, lies along the coast and comprises a larger area of low density population, mostly occupied by high-income group. The third street *Mlalakua*, is in a medium density area, the population from this area were found to be a medium level welfare group. The second stage involved the random sampling of ten-cell units from the selected administrative streets. Each ten cell- unit comprises a minimum group of ten household under the leadership of a ten cell-leader known as *mjumbe*. The third stage involved the random selection of five households from each selected ten-cell unit. Table 1 summarizes information on the sampling process on each selected street in Kawe ward.

**Table 1. Number of sampled ten-cell units and households in the selected streets – Kawe ward Dar es Salaam**

Selected Street/Hamlet	Total Number of Ten Cell Units	Number of Sampled Ten Cell Units	Total Number of Households in the Sampled Ten Cell Units	Number of Households Selected in Each Sampled Ten Cell Unit
Ukwamani	97	20	504	5 (5*20=100)
Mlalakuwa	63	20	365	5 (5*20=100)
Mzimuni	170	20	451	5 (5*20=100)

*Source: Author Data (2009)*

In health facilities, two sets of interviews took place: health care provider interviews and exit patient interviews. Fourteen (14) health care providers were sampled: three (3) hospitals (one municipal public hospital, one private for profit and one private not for profit hospital); two (2) health centres (one public and one private) and nine (9) dispensaries (two public, two not for profit, four private for profit dispensaries and one private informal /not registered dispensary). The sample of health care providers included in this exercise was based on the preliminary information obtained from the household survey. In addition, 140 patients were interviewed on exit from the selected health care facilities. Lastly, at the municipal level, the information came from Kinondoni municipality through data, focus group discussions and one on one interviews with management of health care services at different levels.

### **3.0 EMPIRICAL FINDINGS**

The main empirical contribution of this article is the evidence of segmentation in the provision of and access to urban health care services. This section provides evidence that the urban health care market is bifurcated into two segments: the upper segment serving the better off and the lower segment serving mainly the poor. It is shown that these two segments of the health care market have distinct institutional characteristics, distinct behaviors on the supply and demand sides, as well as distinct competition pattern. The subsections below provide empirical result to substantiate this claim and show how segmentation occurs.

#### **3.1 Is there Segmentation in Health Seeking Behaviour (HSB)?**

Table 2 shows a close relationship between poverty, health seeking behaviour (HSB) and access to health care services. Differences in the wealth status of individuals impact on their health seeking behaviour and hence access to health care services. This suggests that what you possess matters in accessing decent health care services. The data show that the poorer/middle income households rely considerably on the services provided at the dispensary level, particularly on the services provided by private dispensaries (about 44% visited private dispensaries). However, the better-off households predominantly utilize the services provided by private hospitals (68% utilized private hospital care). Furthermore, when they seek for specialized care, the poor/middle depend more on the services offered by public hospitals compared to the better off.



**Table 2: Utilisation of health care services at household level, by asset levels**

Facility Visited	poor/middle	better-off	Total
Public Disp/HC	2256 <b>20</b>	149 <b>6</b>	2405 <b>18</b>
Private Disp/HC	4965 <b>44</b>	397 <b>16</b>	5362 <b>39</b>
Private Hosp	983 <b>9</b>	1673 <b>68</b>	2655 <b>20</b>
Public Hosp	2712 <b>24</b>	220 <b>9</b>	2932 <b>22</b>
Tradition/Spiritual	245 <b>2</b>	16 <b>1</b>	261 <b>2</b>
<b>Total</b>	<b>11160</b> <b>100</b>	<b>2456</b> <b>100</b>	<b>13615</b> <b>100</b>

Key: weighted counts  
column percentages

Pearson:  
Uncorrected chi2(4) = 175.0055  
Design-based F(2.97, 169.15) = 27.7217 P = 0.0000

### 3.2 Poverty and Exclusion from Access of Health Care Services

The data indicates a close association between poverty and exclusion from access to health care services. There is a substantial problem of failure to consult health care providers when individuals fall ill, or exclusion from access to health care services. The household survey shows that 30 per cent did not consult any health care provider when ill or injured. This problem affects mostly individuals from poorer households, particularly those located in squatter and medium density areas. The elderly group is also highly affected as out of all their reported illness episodes, in nearly half (48%) the person did not consult any health care provider (see Table 3).

**Table 3: Lack of consultation with health care provider by age group**

Age Group	Consultation with Health Provider		
	YES	NO	Total
Under five	3118	379	3497
	<b>89</b>	<b>11</b>	<b>100</b>
6-17 yrs	2823	1059	3883
	<b>73</b>	<b>27</b>	<b>100</b>
Adults	6808	3473	10281
	<b>66</b>	<b>34</b>	<b>100</b>
Elderly60+	866	815	1682
	<b>52</b>	<b>48</b>	<b>100</b>
Total	13615	5727	19342
	<b>70</b>	<b>30</b>	<b>100</b>

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Key: Weighted counts  
 Row percentages (Italic, Bold)  
 Number of observations = 733

Pearson:  
 Uncorrected chi2(3) = 36.9209  
 Design-based F(2.28, 129.70) = 6.0986 P = 0.0019

**Source: Author's Household Survey Data (2009)**

The two main reasons that were put forward by the respondents from the household survey to explain low rates of consultation when ill or injured are high cost of accessing care and self medication (see Table 4). Whereas for the poorer and middle level households, their top- most reason for not accessing health care provider was the cost element compared to the better of households i.e. 46% compared to 9% respectively.

**Table 4: Reasons for no consultation with health care providers per episode**

Reasons No Consultation First)	HH assets indicator			Total
	poorer	middle	better	
No Need	200	416	80	696
	<i>7</i>	<i>21</i>	<i>10</i>	<i>12</i>
Too Expensive	1354	748	71	2172
	<i>46</i>	<i>37</i>	<i>9</i>	<i>38</i>
Bought Drugs	1272	595	325	2192
	<i>43</i>	<i>30</i>	<i>42</i>	<i>38</i>
Other Reasons	116	257	294	666
	<i>4</i>	<i>13</i>	<i>38</i>	<i>12</i>
Total	2941	2016	770	5727
	<i>100</i>	<i>100</i>	<i>100</i>	<i>100</i>

Key: weighted counts  
column percentages (italic, bold)  
Number of observations 205

Pearson:  
Uncorrected chi2(6) = 139.6102  
Design-based F(3.81, 217.07) = 2.9339 P = 0.0236

**Source: Author- derived from Household Survey Data (2009)**

### 3.3 Problem in the Public Sector: The Poor are Off-loaded

Inadequacy of public health care provision restricts demand for public health care services and therefore leads to literally shedding off the poorer from the public health system. As a result, excess demand mainly falls on the lower level private health care providers or leads to total exclusion of the poor in accessing health care services. The main factors that affect the performance of health workers and hence contribute to the “shedding off or offloading” the poor from utilising public health care services include; severe shortage of human resources for health; poor infrastructure/working conditions (including weak referral system); and organisational and supervision aspects (COWI et al 2007, URT-MOH 2005, URT-MOHSW 2007a, 2007b Hongoro and Normand, 2006, Gilson et al 2005).

Table 5 shows that low quality public care pushes the poor into the private sector. In Table 5, poorer households located in Mzimuni (squatter) depend heavily on the services offered by the private dispensaries despite the fact that the public dispensary is located right at the centre of this street. One can explain this heavy reliance by the poor in Mzimuni squatter area on the private dispensaries by the fact that the only public dispensary in that area has a bad reputation for its services including bad behaviour of health workers.

*"I only take my daughter here to the MCH clinic. But when she gets sick, I take her to the Catholic dispensary, because there the health care workers are not polite and attentive to patients."* (Female, 22 years old, mother of child under five, public dispensary, squatter area).

*"The health workers here don't care about the well being of the patients, they are usually rude and do not do proper diagnosis for the patients."* (Female, 19 years old, public dispensary, squatter area).

**Table 5: Utilisation of health care services of the poorer group, by spatial location**

Facility Visited	Street			Mzimuni[2]	Total
	Mzimuni [1]	Ukwamani	Mlalakua		
Public Disp/HC	386 <b>13</b>	600 <b>29</b>	215 <b>38</b>	34 <b>6</b>	1236 <b>21</b>
Private Disp/HC	2009 <b>70</b>	586 <b>29</b>	147 <b>26</b>	139 <b>26</b>	2881 <b>48</b>
Private Hospital	19 <b>1</b>	39 <b>2</b>	8 <b>1</b>	153 <b>29</b>	219 <b>4</b>
Public Hospital	468 <b>16</b>	818 <b>40</b>	195 <b>34</b>	201 <b>38</b>	1680 <b>28</b>
Total	2882 <b>100</b>	2043 <b>100</b>	565 <b>100</b>	527 <b>100</b>	6016 <b>100</b>

Key: Weighted counts  
Column percentages (Bold, Italic)  
Number of observations = 204

Pearson:  
Uncorrected  $\chi^2(9) = 185.3034$   
Design-based  $F(4.83, 275.18) = 4.9006$        $P = 0.0003$

**Source: Author (2009)**

### 3.4 Pricing Behaviour, Payment Structure and Segmentation Mechanism

The pricing behaviour of facilities and the payment process can be shown to generate the segmentation in the urban health care market. Pricing is the core element of market interaction and that causes segmentation. The current commercialized urban health care market operates in a competitive environment that is also driven by weak health financing mechanisms. The

predominant payment system of 'out of pocket' practice is accompanied by very thin protective/insurance systems. Table 6 confirms this situation: out of all the visits recorded by health care providers, 82 per cent were financed out-of-pocket relying on resources within the household. Payment from the employer and other arrangements played a small role in financing care services for those who succeeded in accessing the service.

**Table 6: Source of payment for visits to health care providers, by asset level**

who_paid2	poorer H	middle-l	better-o	HH assets indicator Total
HH member	5281	4145	1741	11166
	85	84	71	82
Insurance	8	25	76	110
	0	1	3	1
Employer	369	543	554	1466
	6	11	23	11
Exemption	571	218	84	873
	9	4	3	6
Total	6229	4931	2456	13615
	100	100	100	100

Key: weighted counts  
column percentages

Pearson:  
Uncorrected  $\chi^2(6) = 45.2993$   
Design-based  $F(3.57, 203.73) = 2.6497$   $P = 0.0403$

**Source: Author (2009)**

### ***The Demand Side: Coping with Existing Payment Structure***

Qualitative evidence indicates that individuals from poorer households are struggling to cope with the existing payment structure and therefore have developed various coping strategies to access health care services. These include<sup>1</sup>:

#### ***(i) Request for salary advance***

The employed poor (formal/informal) are sometimes forced to request a salary advance in order to finance health care bills.

<sup>1</sup> The quotes are illustrative of many on each topic

*"My husband is the one who always pays the medical bills in case there is a need to go to the hospital. But it is too expensive for him compared to the salary he earns at the end of the month. Sometimes he asks for an advance from his next salary in order to clear the bill"*(Female, 30 years, squatter area).

**(ii) Request for assistance from other close relatives and friends**

In some incidents, the poor are forced to request for financial assistance from their close relatives and neighbours in order to finance medical expenses.

*"When I was suffering from malaria, I did not have the money hence my brother had to come and take me to the hospital and he paid the bill. My chronic illness has not been treated either due to lack of money; I have failed to pay for further investigations required"*(Female, 60 years old, squatter area).

**(iii) Use of business capital to finance care**

In some cases the poor are forced to use their relatively small business capital in order to finance health care services.

*"My wife has spent part of the capital for her small business (retail shop) to finance my health problems—if we continue in this way the shop can close down."*(Male, 55 years old, squatter area).

**(iv) Forced to compromise expenditure on other basic needs**

In some cases, the poor have to spend a large part of their (small) salaries on medical bills and thus compromise expenditure on other basic needs.

*"I was able to pay the medical bills, but it was very expensive compared to the income I earn per month. Hence, I have almost spent my one month's salary on medical bills—but other important expenditures are still waiting for me to sort them out such as house rent, food, etc."*(Male, 43 years old, squatter area).

**(v) Use all/part of their small family savings**

The few poor individuals who have some savings are sometimes forced to spend a large part of it (if not all) to finance their health care bills.

*"For the case of our son's illness, the payments for drugs and consultation fees were too high, but luckily, my wife had some savings, which she used to pay the bill at*

*that time, but she spent all of it and was left with no savings.” (Male, 45 years old, squatter area).*

**(vi) Accumulate debt through deferment of payment**

In some cases, the poor develop mutual relationships with the health care providers, especially the private dispensaries, and can defer their medical bills promising to pay later. This practice is convenient especially for the poor but it ties them to debt and also reduces their flexibility of choosing the health care facilities that could be providing higher quality care.

*“The nearby private dispensary always allows us to defer payments. We have now deferred payments for many illness episodes. I think we have accumulated a debt of about 65,000 Tsh and we have not been able to pay it yet” (Male 62 years old, squatter area).*

**(vii) Abstain from/postpone treatment**

In some cases, the poor are forced to postpone and/or abstain from receiving the required health care treatment until they secure the funds.

*“The cost was very expensive. Now I’m still sick but I cannot afford to go back to the health care facility because I don’t have money.” (Male, 35 years old, squatter area).*

**(viii) Prioritising household members in receiving health care services**

In some cases, the poor are forced to prioritise ill household members on seeking health care services given their limited resources. This is because in some situations they cannot afford to take all the ill members at once to consult a health care provider. For example, in some situations they would prefer to take children for better quality care while the adults wait for cheaper alternatives.

*“For children we have no choice but to take them to the health care facility, but for us adults when we get sick we just buy drugs from the pharmacy to cut down the medical costs” (Female, 36 years old, squatter area).*

**(ix) Wait and see until the case is an emergency**

Some of the respondents revealed that when someone in their household falls ill they do not rush to consult the health care provider, but wait until the case is severe. This behaviour can be dangerous especially when small children are involved as they are taken to the hospital when the condition is very severe or too late to treat.

*"We only go to the hospital when we really see it is a severe case, otherwise the cost of care and the time involved to access the services is too much"* (Female, 38 years old, squatter area).

**(x) Forced to undertake partial treatment**

This study also indicates that sometimes the poor have to undertake partial treatment, as they cannot afford to pay the full cost of treatment.

*"The cost of medicine is just too high - when the doctor prescribes drugs, we either purchase half of the dose or buy them in small quantities, sometimes not according to the dosage prescribed."* (Female, 52 years old, squatter area).

***The Supply Side: Coping with Low Ability to Finance Care***

The health care providers also face a challenge if they try to provide adequate and good quality health care services. Many suppliers struggle financially due to low ability of users to finance care and the very low coverage of the existing insurance system. The evidence shows that in the lower segment of the health care market serving the poor majority, the facilities are under severe financial pressure and yet they face difficulty if they try to charge market prices on the service they offer. Health care service providers, especially the private dispensaries, have to survive in a highly competitive market while providing services to low income level clientele, who mostly finance care through out- of- pocket payments. In order to cope with this challenge, the service providers have developed diversified coping strategies to help them survive in the current market. These include:

**(i) Deferment of payment**

This mode of payment was found to be practised mainly by private dispensaries located in squatter areas. In this arrangement, the users and providers of health care services develop a mutual understanding in meeting the cost of the services. The users are mainly poor with limited (if any) savings and in most cases live near the health care facility. The health care providers thus can to defer (i.e. postpone) payment by the poor. The providers who take part in this kind of arrangement are mainly those who experience financial pressure caused by high competition, especially from neighbouring dispensaries and drug stores.

*"This is a very normal practice and it is happening almost every day; and it is also important for our survival to keep our customers. We know most of the people we serve, so when they do not have enough money we allow them to bring the money*



*later.*" (staff-in-charge, private dispensary for profit, squatter area).

In this arrangement, the users and providers depend on each other to survive in the market. The supplier is forced to enter into this arrangement with the main intention of retaining its client share in the market. On the other side, the users of health care services are willing to forgo the flexibility of choosing the provider of their choice. They are willing to enter into this arrangement in return for the ability to access health care services in time of need. All the private dispensaries interviewed (in the squatter area) practiced the deferment of payment.

*"This is a very common practice around the area; we even have a register book for that purpose. The patient has to explain his/her problem at reception and then the in-charge makes the decision whether the payment will be sorted out in future."* (The staff –in-charge, private dispensary for profit, squatter area).

The interviews also show that the upper level of private health care provision (i.e. private hospitals/health centres) does not practice this payment system. This is because the private hospitals/health centres mainly serve the better-off, who in most cases are comfortable in financing their health care expenses. Furthermore, it is difficult to set up a payment deferral system at this level since the customers they serve are many and come from different geographical locations. Therefore, it is hard to establish these informal relationships and to follow up on payment once the customer has received medical services.

*"We do not have any system in place that allows us to defer payments, patients are required to pay cash or be covered by the health insurance."* (staff in-charge, private for profit health centre, non-squatter area).

*"We do not have this policy...all payments must be done in cash at the time a patient is receiving the services."* (staff in-charge , private dispensary for profit, non-squatter area).

On rare occasions public facilities have also to accept this mode of payment, especially for inpatients. This happens when a patient claims not to have the money after he/she has already received the service. Unfortunately, in most cases, they do not come back to pay the money and it is hard for public facilities to trace them and follow up on their bills.

**(ii) Fee reduction**

*"The deferment of payment is mainly happening for the admitted patient. Some of them after discharge claim not to have money. The relatives promise to bring the money later, but usually you do not see them again. For the Out Patient Department (OPD) this is not allowed (if it is not an emergency); someone will be given the services equivalent to the money that she/he has. Then she/he will be referred to the welfare office. If accepted, he/she will be exempted for the remainder of the bill; and be given a pink card (to indicate it is a temporary exemption)" (Health Secretary, municipal hospital).*

In some cases, the health care providers have to reduce fees for their patients. Half (seven) of the health care providers interviewed admitted to occasionally allowing fee reductions for their clients. Of these seven health care facilities, five (7) were private dispensaries (all located in squatter and medium density areas), one a private hospital and one a private health centre. However, the fee reduction practiced at the lower level facilities is different from that offered in the higher-level facilities. In most cases, the higher-level facilities negotiate with patients for fee reduction on transactions that involve a large sum of money.

*"Yes, we usually experience some payment problems especially with the in-patients; sometimes we are forced to reduce part of their total charges. However, for the OPD this is not allowed." (In Charge, private for profit hospital).*

The private dispensaries located in the squatter areas revealed that under normal circumstances they would not be in favour of this practice. Now, they feel forced into this practice, mainly to avoid losing their customers to drug stores. They also allow fee reductions mainly for specific/selected services. For example, consultation and registration.

*"Yes, we mainly reduce the registration and consultation fees to avoid losing our customers to the nearby drug stores." (In Charge, private for profit dispensary, squatter area).*

*"The only fee that we tend to reduce/remove is that of registration and consultation; for the remaining fees if someone is unable to pay at a particular moment, he/she can be considered for credit." (staff-in-charge, private for profit dispensary, squatter area).*

### ***(iii) Overpricing and abuse of the insurance system***

Overpricing techniques exist in the private health sector across all levels. This practice mainly occurs (without awareness of the patient), with the intention of increasing revenue for the health care facility or their staff. In one interview with a respondent from the private dispensary located in the squatter area, it was clear that in some cases they increase fees intentionally for some of their clients. They indicated that they overcharge through their own judgment of a patient's ability to pay, based upon a patient's dress and the nature of their economic activity. In this scenario, patients receive different charges for the same type of service provided.

*"We need to survive in this market; overall our charges are about the same compared to other dispensaries around the area. However, in some cases the charges can vary from one patient to the other depending on their ability to pay...to prevent the facility from going into bankruptcy.... We are sometimes forced to judge the patient's ability to pay by looking at the way they dress, the work they do and so on. Therefore the slightly better off can be charged more."* (staff-in-charge, private for profit dispensary, squatter area).

The abuse of the health insurance system is also one of the illegitimate measures used to increase revenue for the health providers. In this case, instances occur of overprescribing and /or provision of unwanted services (e.g. special examination procedures, laboratory tests, etc) specifically for those few patients covered by insurance. Currently, the private health insurance system is still young and operates mainly within private hospitals and a few specialised clinics. In some of the interviews conducted with private hospitals, they mentioned that abuse of the insurance system is common and very tempting to misuse. As lame excuse, they indicated that it takes a long time to claim their money, especially from the private health insurance companies after service delivery to the insured patient. In some cases, officials from these private insurance companies request bribes in order to facilitate the payments.

*"There is a need to develop further the insurance system to cover the poor and therefore avoid out of pocket payment system. At the moment there are few people (mainly the better-off) who are covered by these private insurance companies (and NHIF). But having this private insurance coverage increases temptation for the private health care providers to conduct unethical practices like over prescribing, unnecessary laboratory tests and so on."* (Staff-in-charge, private for profit hospital, non-squatter area).

*"The private insurance system is still very young and fragmented. It is very hard for the health care providers to operate in this system. Once we have provided the required services to the insured patients, it is very hard to get reimbursed -in some cases the officials from these companies demand bribes from us in order to facilitate payment for the services we have provided."* (Staff-in-charge, private for profit hospital, non-squatter area).

Furthermore, price differences were observed in the services provided by diverse health care facilities according to level, sector and location of the facilities. Table 7 presents a simple average summary of selected prices for drugs, diagnosis tests and basic procedures for each of the 14 facilities covered in the health care provider interviews. This was calculated by taking the average of the prices on the following items in each facility: blood for MPS test, routine stool test, routine urine test, blood HB test, anti malarial SP drugs (adult dose), Mebendazol (adult dose), Amoxicillin (adult dose) and charge for incision and drainage.

**Table 7: Average prices for services and payment mechanism by level, sector and location of the facility**

Level	Sector	Location Category	Simple Average (price in TZS)	Deferment of Payment	Fee Reduction
Dispensary	Public	Medium Density	<b>450</b>	No	No
Dispensary	Private/Unregistered	Squatter	<b>563</b>	Yes	Yes
Hospital	Public	Medium Density	<b>563</b>	No	No
Dispensary	Private/Catholic	Squatter	<b>625</b>	No	No
Dispensary	Public	Squatter	<b>650</b>	No	No
Dispensary	Private	Squatter	<b>831</b>	Yes	Yes
Dispensary	Private	Squatter	<b>875</b>	Yes	Yes
Dispensary	Private	Squatter	<b>944</b>	Yes	Yes
Health Centre	Public	Medium Density	<b>950</b>	No	No
Dispensary	Private	Medium Density	<b>1 263</b>	Yes	Yes
Health Centre	Private	Low Density	<b>1 325</b>	No	Yes*
Dispensary	Private	Low Density	<b>1 500</b>	No	No
Hospital	Private	Low Density	<b>1 731</b>	No	Yes*
Hospital	Private	Medium Density	<b>1 988</b>	No	No

Notes:

Number of Health Care Facilities: 14,

Source: Author's Health Care Provider Interviews

\* = Not common practice (see section 5.5 – fee reduction)

**Source: Author (2009)**

Overall, the data shows that the public health care facilities are less expensive than the private sector. The private sector hospitals had the highest charges compared to other health care facilities. However, the unregistered/informal private dispensary located in the squatter area

had lower prices than other private facilities. A squatter facility manages to charge lower prices because it is operating illegally and therefore keeps very low operational costs. Furthermore, a Catholic dispensary located in the squatter area also appears to have lower prices when compared to other private dispensaries in the squatter area. However, this dispensary did not offer deferred payments or fee reduction/removal on registration and consultation charges. This hinders the poor in accessing its comparatively good quality services.

On the other hand, a private dispensary located in the low-density area had higher prices than dispensaries in the squatter area. This dispensary serves individuals from better-off households who have a higher ability to pay than the poor who utilize the private dispensaries in the squatter area. This facility also did not practice deferment of payment or fee reduction on registration and consultation, which also indicates that its clientele can finance their health care needs.

### **3.5 Informalisation Mechanism and Unregulated Health care Market**

The current health care market is characterized by the presence of an informalisation mechanism within both provision of and access to private health care services especially to the lower segment that serves the poorer. The informalisation process is a market mechanism, which results from a response to poverty interacting with an unregulated health care market. This process includes aspects of illegality (failure to register), aspects that contravene specified rules and regulation, and those aspects that do not contravene specific rules but are nevertheless problematic.

The data presented in this article indicate that there is currently insufficient implementation and enforcement of basic regulatory requirements. The qualitative evidence shows that there is inadequate information about and knowledge of regulation mechanisms provided to users and providers of health care services.

*"The system of licensing and supervision needs to be improved. We don't understand how they organise their inspection and what exactly needs to be done in this exercise."*  
(Assistant Medical Officer, private not for profit dispensary, squatter area).

*"There is a habit of the supervisors from the municipal office to criticise more than to provide useful guidance, education and advice. In the recent change of sterilisation*

*technique, without involving the ideas of the private sector, they just showed up and started to criticise; instead of providing education on how to go about the newly introduced change in sterilisation method” (Medical Officer in Charge, private for profit dispensary, medium density area).*

Furthermore, there is also no adequate capacity at the municipal level to enforce the regulations. This links to inadequacy in financial and human resources at the municipal level for effectively carrying out the supervisory and regulatory activities effectively (Mujinja et al 2003, Soderlund et al 2000).

*“It is easier to supervise the public health care facilities, as their information is available and better organised. The supervision of private facilities is cumbersome and very problematic; this is because the information regarding their location and operation is not updated regularly. Some private facilities are closing down and others are moving to new premises without informing the MMOH office. The correct number of operational private facilities in the municipality is currently not available” (Respondent, Municipal Office, Kinondoni).*

*“There are about 22 health officers at the MMOH conducting the inspection and supervision activities. Unfortunately, these officers have many other assigned activities. This makes the inspection and supervision enforcement system from the municipal level to the health care facilities weak. In principle, every Monday there is a routine schedule to supervise the specified facilities, however in most cases the schedule is not adhered to. This is either due to transportation problems or the responsible officers have been assigned other tasks” (Respondent, MMOH Office, Kinondoni municipality).*

In the fieldwork all health care providers stated that the current regulatory system is weak and therefore it is easier for them to take advantage of the system by operating in disregard of the regulations set by municipal authorities. In an extreme case, the existence of the informalisation mechanism cited above provides loopholes for some facilities to operate completely illegally (without registration); and this provides strong incentives for these facilities to maximize profits as it allows the facility to operate at the lowest cost possible while jeopardising the standard and safety of the services offered.

For example, one illegal operational private dispensary was discovered during the survey. This facility started its operation in 1997 as a part time arrangement and the service were

conducted only in the evening hours inside the (previously) congested premises of the owner. In 2003 the facility started to operate full time and larger premises were acquired to accommodate the expansion of the business. In these new premises, the staff-in-charge managed to hire three rooms in one of the congested houses in the squatter area which are used interchangeably; during the day the rooms are used mostly as a health care facility and in the evening as the ordinary living premises for the staff-in-charge. Despite the increased demand for the services provided to the poor community around the area, the facility is run single handedly by the staff-in-charge without assistance from other health personnel. The staff-in-charge was well aware that she is running an illegal health care facility, but since she has been in the market for some years and people around the neighbourhood have gained some confidence in her services, she did not appear worried about her actions.

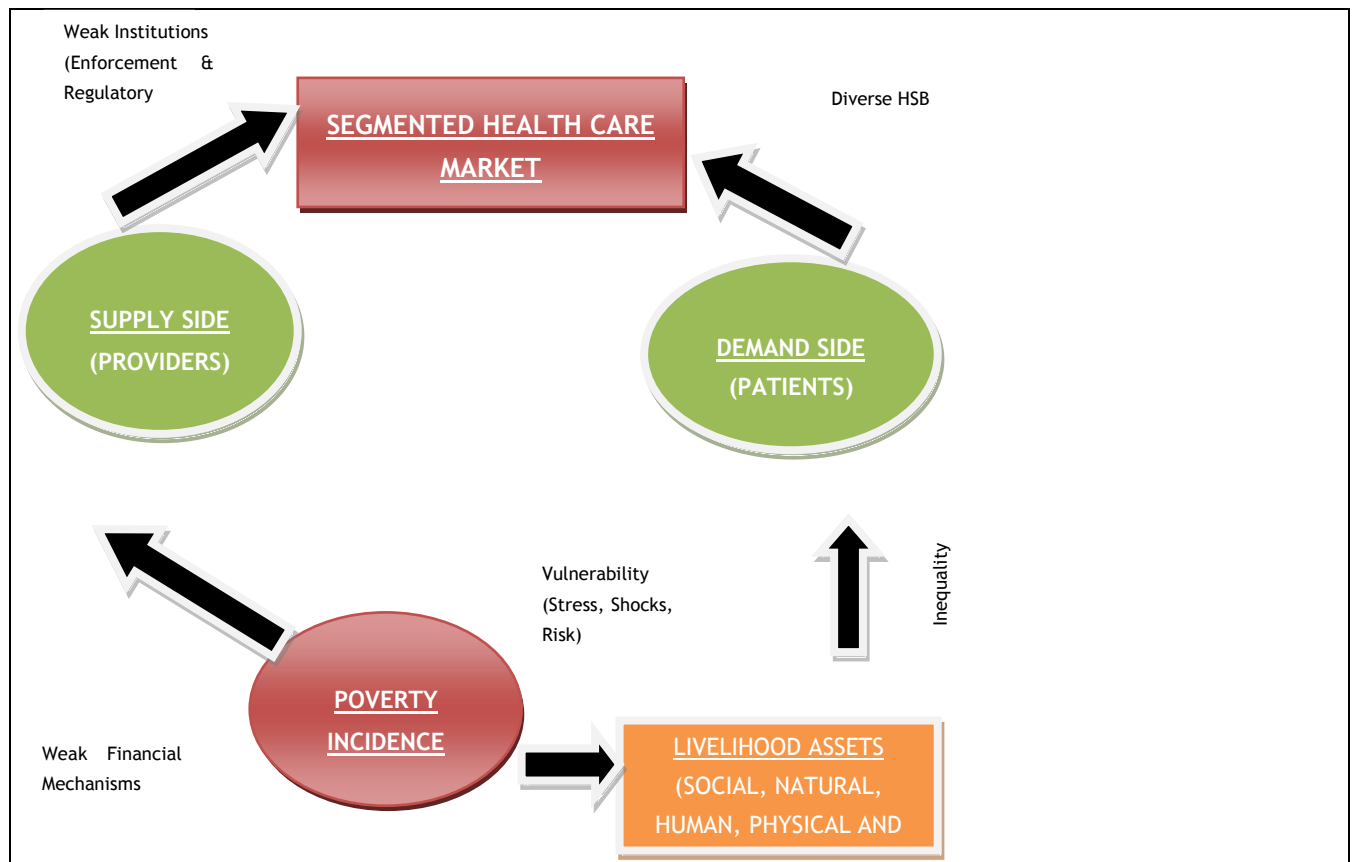
*'Yes, I know what I am doing is not right and this facility is running completely illegal, but people need my services and you will see for yourself that I am cheaper compared to other facilities nearby' (Owner, Illegal Operational Dispensary, Squatter area).*

#### **4.0 DISCUSSION: TWO WAY SEGMENTATION MODEL**

As mentioned earlier, this article argues that segmentation can be understood as an outcome of how poverty shapes the performance of the health care market. Based on the labour market theories, market *segmentation* entails a process of compartmentalisation that leads to distinct market segments, which possess dissimilar characteristics and/or behave in a different manner. The evidence entailed in this article is to provide some support for a model of market segmentation involving two-way causation in which high incidence of poverty interacts with the health care system in a process of cumulative causation. The outlined model is supported by the evidence presented in the findings sections and helps to explain it. The relations of causation in the segmentation process can be described as follows: First, poverty instigates segmentation in the health care market (see Figure 1). That is poverty shapes (in a segmented manner) the health seeking behaviour (demand side) and provision (supply side) of health care services. In the highly commercialised health care market, the unequal distribution of livelihood assets/income shapes the ability to access health care services among different welfare groups in society. This condition brings about segmentation on the pattern of health care seeking behaviour and ultimately on the utilisation of health care services as depicted in section 3.1 and 3.2

Poverty also adversely affects the ability of health care facilities to finance the required health care services. This is because the provision of health care services depends heavily on the capacity of users to finance the provided health care services. These results are presented in section 3.4 above. In this regard, the weak health insurance system and heavy reliance on out of pocket payments leads to an unequal capacity of users to finance health care services largely from out of pocket spending and hence segmentation in provision of adequate and quality health care services.

**Figure 1: Poverty Instigates Segmentation in the Health Care Market**



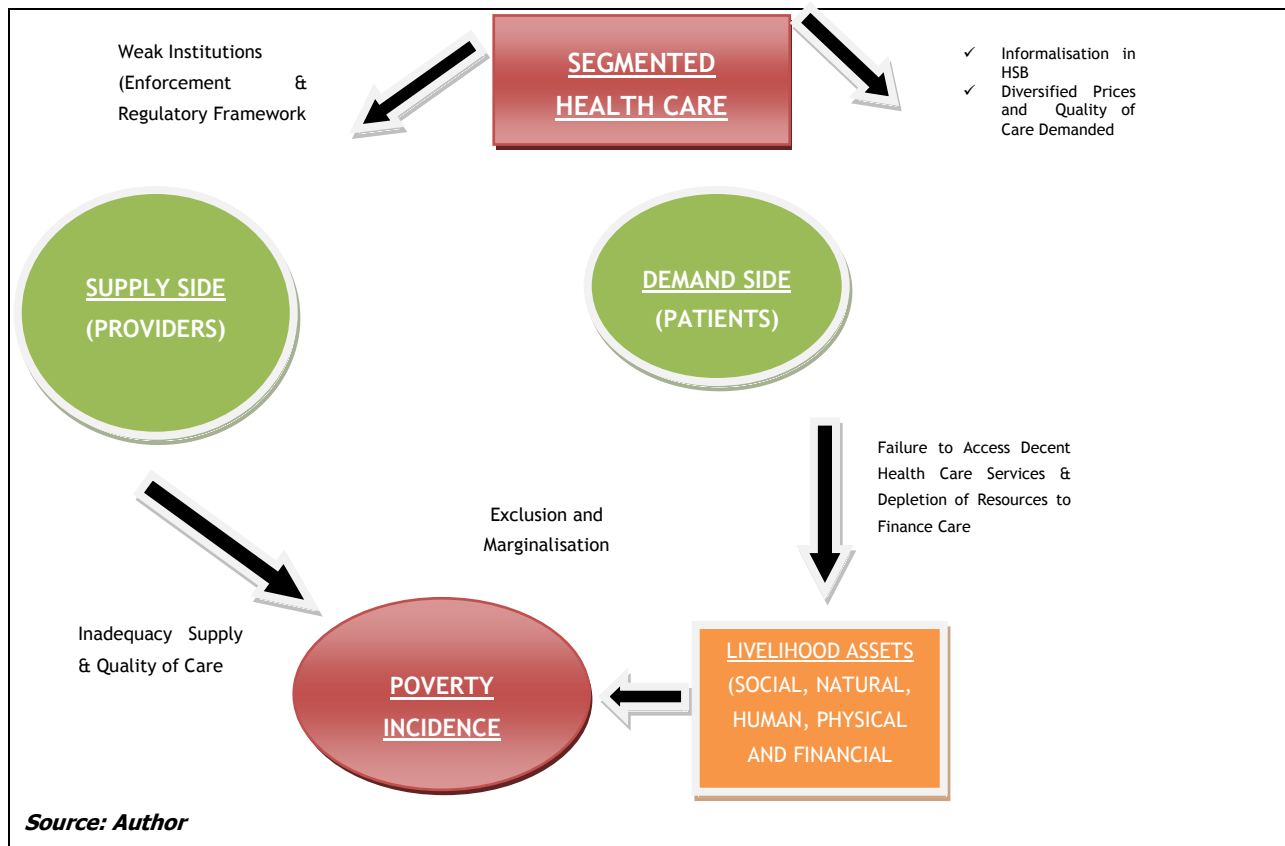
Source: Author

Secondly, once there is segmentation in the health care market, a feedback mechanism developed that leads to further intensification of the poverty incidence (See Figure 2). On the demand side, the existence of the commercialised health care system and unequal ability of users to finance health care services results in exclusion and/or access to poor quality health care services, which in turn contributes to a high incidence of poverty. As seen in Section 3.2 and 3.4 the poor often fail to access decent health care services due to inability to pay, a weak



protection mechanism in the public health care system and weak pooling/insurance mechanism. In this way, users of health care services, especially the poor, are forced to develop various coping strategies to access health care services. On the supply side, the segmented health care market results in an informalisation mechanism in provision of health care especially in the lower segment in order to respond to differential pressures in the segments of the market. This process impacts the quality of care provided to the poor, and therefore an intensification of poverty incidence. This point of informalisation mechanism is explained in the section 3.5.

**Figure2: Segmentation in the health care market intensifies poverty incidence**



## 5.0 CONCLUSION

This article summarizes the findings of the research project that provides evidence for the existence of segmentation mechanism in provision and access of health care services in the urban health care market in Tanzania. It argues that the presence of segmented health care market in this urban setting is mainly the outcome of a systemic process of interaction of the demand and supply sides of the health care in the context of widespread poverty in the

country. This article further argues that the bifurcation of health care delivery into a two-tier system limits better access to health care, especially for the urban poor. This is because the segmentation process engenders an upper tier of better quality of care for those who can afford it and, a lower tier of inexpensive health care services of generally inadequate and/or doubtful quality mainly to cater for the poor.

This article therefore puts forward policy propositions on how to enhance access to health care services in a context of widespread urban poverty. The theoretical contribution of this article lies partly in its use of the concept of market segmentation to apply to interpret health care market data. The article provides some support for a model of market segmentation involving two-way causation in which high incidence of poverty interacts with the health care system in a process of cumulative causation.

The findings show the following patterns:

- existence of a segmented health seeking behavior and utilization, as influenced by widespread poverty;
- the existence of a close association between poverty and exclusion in health care services;
- existence of a segmented pricing and payment structure which is a key catalyst in the whole segmentation mechanism; and
- the emergence of various coping strategies on the demand and supply sides to deal with the bifurcated health care market.

Furthermore, it has been explained that the public health provision is not functioning well and hence the off-loading of the poor to the lower level private dispensaries, which further intensifies the segmentation phenomenon. Finally, there is an emergence of the informatisation mechanism as a result of poverty interacting with a weak regulatory structure.

It is therefore concluded that the health reforms in Tanzania have in practice resulted in a powerful mechanism of social exclusion of the urban poor from accessing decent health care services, instead of being inclusionary to the poor as intended by policy. Therefore contrary to policy intentions, the urban poor frequently find themselves *excluded* not only from (decent) private health care, but also from access to public health care, given the inadequate public provision, an extensively fee-based (commercialized) health care system - in both public and private sectors - and the prevalence of widespread poverty. The paper used the words "shedding off" of the poor, not for romanticizing the phenomenon, but because the system abandons them literally.

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