An equity analysis on the costs of access to and use of health services in Tanzania

Tanja Naledi Gordon, Human Science Research Council Pretoria

Josephine Borghi, London School of Hygiene and Tropical Medicine

Background

Several barriers hinder households from access and use of health services, especially in low- and middle-income countries. The cost of access to and use of services is one of the barriers: this can include the direct (money) costs of transport and services use, or indirect costs of labour productivity loss. Direct and indirect costs contribute significantly to welfare loss, and may lead to catastrophic spending especially among poor households. Although some studies have documented the direct costs, little is known on the burden of direct and indirect costs of accessing and using health services and how these are distributed among socioeconomic groups, especially in settings with poor health systems. We provide such evidence from Tanzania.

Methods

We used data from 1407 patient exit interviews in 150 facilities from eleven districts in Tanzania. The survey was in January 2012, which collected information on indirect costs: time costs of travelling, waiting and consultation time, and direct medical and non-medical costs. To assess the inequities, all costs were disaggregated by patient’s socioeconomics quintiles and place of residence. We used three measures of inequity: equity gap, equity ratio and concentration index.

Results

We found the average and median travel time were 30.1 minutes and 20 minutes, respectively. The burden of travel time as an indirect cost was significantly greater among the poorest. The average and median direct travel cost was 0.50 USD and 0.23 USD, respectively, and this cost burden was significantly higher among the least poor. Both direct and indirect costs of access were similar between rural and urban residents. The average waiting time and consultation time were 46.7 minutes and 12.9 minutes, respectively. The consultation time was similar across quintiles and location, while the poorest patients waited longer than their counterparts. 17.8% of patients paid for healthcare and paid on average around 0.96 USD. The least poor patients and urban residents paid more than their counterparts.

Conclusion

Tanzanian health system should ensure equitable healthcare access and use to all people for universal coverage. While exemptions seem to be effective at reducing the burden of direct medical costs among the least poor, strategies are needed to tackle indirect costs which are borne more by poorer groups. Such strategies could include: the establishment of maternity waiting homes, transport vouchers, incentivising providers to target the poor, increase outreach and social protection measures. Other responses are beyond the health sector and needs a cross-sector collaboration.