Circumventing ‘free care’ and ‘shouting louder’: Eye health system sustainability in government & mission facilities of north-west Tanzania

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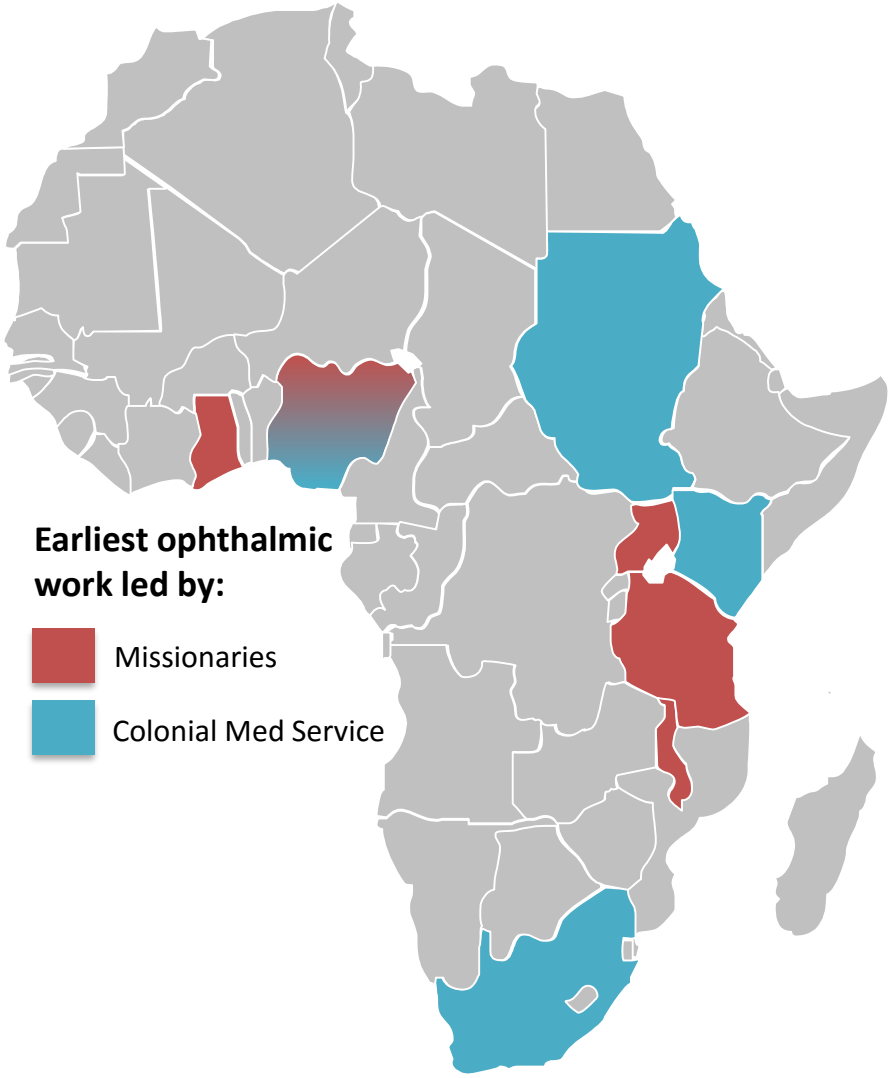
Missionaries & eye care in Africa

- Post-WWI to 1960s: Ophthalmic work done by church missions & colonial service
- SSA today: 1 in 7 eye workers in mission/NGO facilities
- EHSAs: NGOs provide bulk of eye equipment & consumables
- Vatican mtg: Parallel eye health systems unsustainable
- V2020: Paradigm shift needed to integrate systems



Study design

Q: How do Tanzanian eye teams work towards sustainability across mission & government sectors?

5 case studies:

- 2 mission sector eye teams
- 2 government eye teams
- LARESA network

Interviews

Observations

Social network analysis

Participatory exercise:
sustainability analysis process

Eye care in Tanzania

1930s: Cataract operations at mission

1961: 40% hospitals church-run

1970s: KCMC & 1st specialist hospitals

1971: Self-reliance necessitates spectacles

1978: WHO Alma Ata, hospital resources divested into primary care

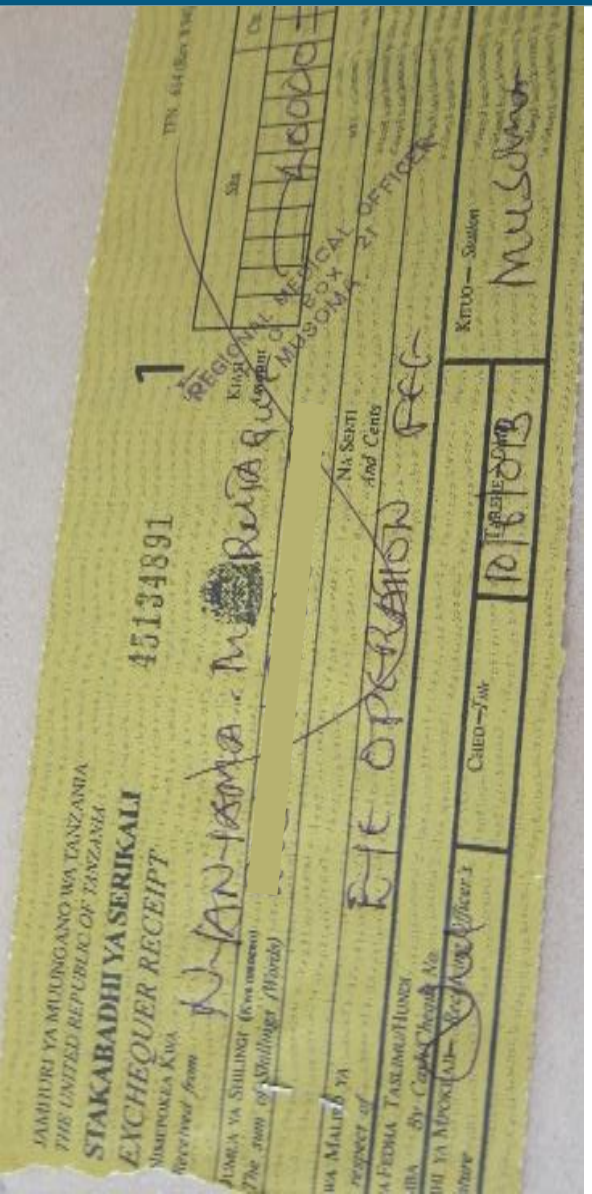
1975-85: 1st Tz AMOOs, o'gists, optoms

1980s: WB structural adjustment

1990s: Renewed hospital investment; User fees in gov't facilities

2012-13: Government 'blind spot'; Eye care 'all under the NGOs' precarious

Strategy 1:
Sustainability Funds



'<u>Sustainability funds</u>': bank accounts for donor & user fee income

- Maintained by 3 eye teams
- 'Virtual' sustainability fund begun in 4th (Independent tracking of income to demonstrate value of service)

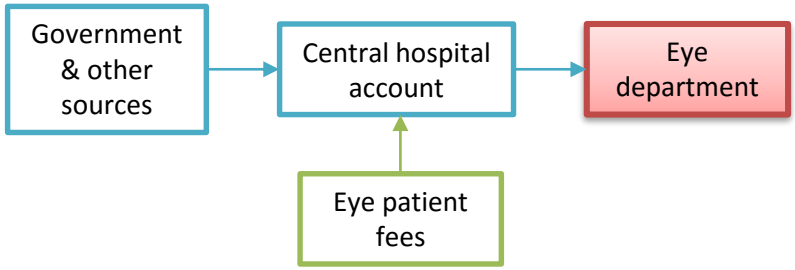
Protected teams from hospital bankruptcy & eye neglect

Demonstrated entrepreneurship to attract donations

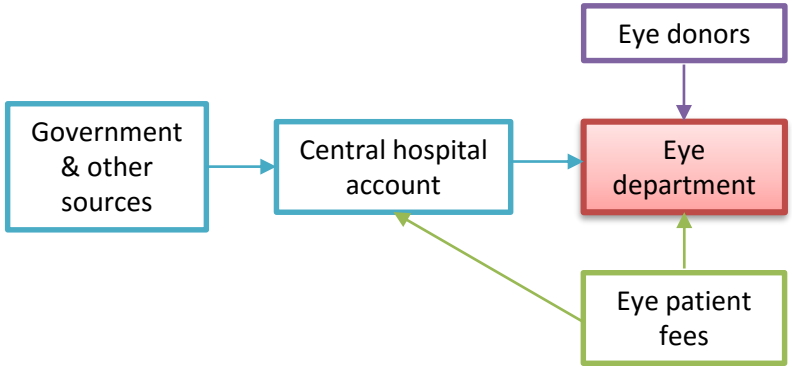
User fees most flexible, 'easy to get', 60% ideal

Eye revenue streams

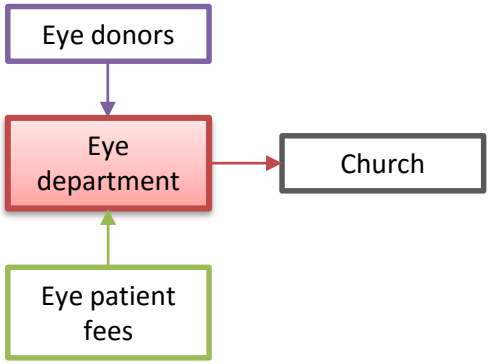
Government A:



Government B & Mission A:



Mission B:



Eye care user fees

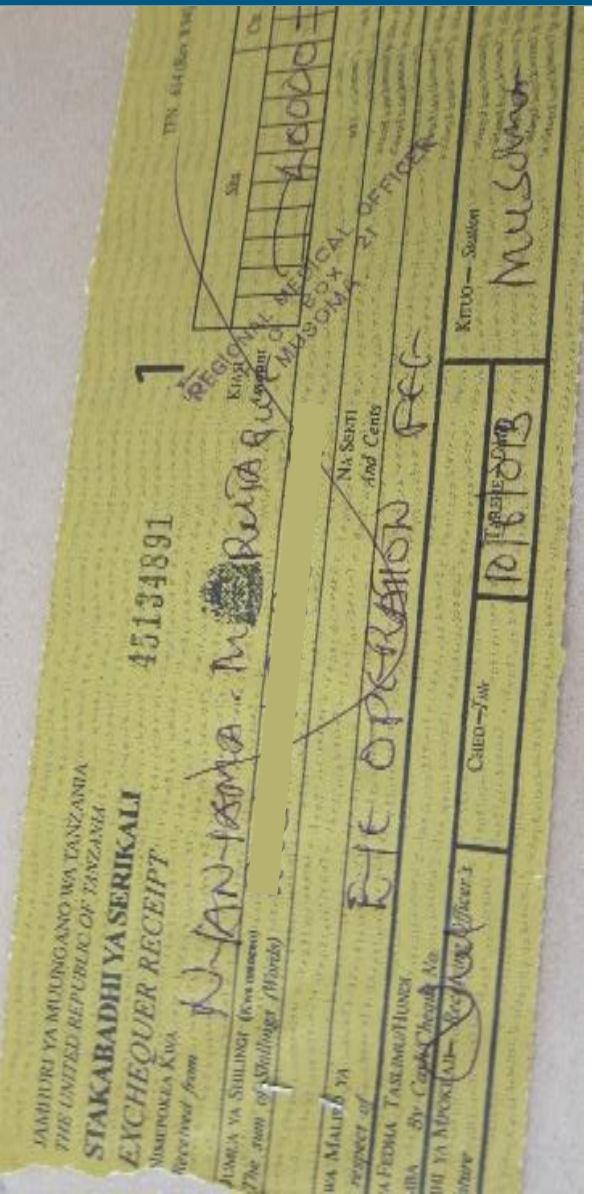
	Government A	Government B	Mission A	Mission B
Sources of income (TZS)				
Government	Unknown	17,180,000	7,900,000	0
Eye health donors	0	15,200,000	20,000,000	30,900,000
Patient fees	0	18,480,000	21,700,000	118,800,000
Total	Unknown	50,860,000	49,600,000	149,700,000
Patient fees charged for surgery	**50,000**	**40,000**	**130,000**	**150,000**

Patient fees: greatest contributor to eye team income

Differences in overall income associated more with income teams could accrue through patient fees (rather than donations)

More financial autonomy in missions hospitals

Strategy 2:
Avoid exemptions



1993: Preg women & <5y exempt from user fees

2007: Elderly have contributed to nat'l devel, therefore ≥60y justifies exemptions

Policy widely seen as unimplementable: "ours [eye disease] is a condition which is not involved in free care"

All teams maximised user fees by avoiding exemptions for elderly patients (majority of users)

Justifications:

- Mission hosps: less at risk of public shaming
- Gov hosps: minimum standard policies (e.g., equipment) not implemented by central govt

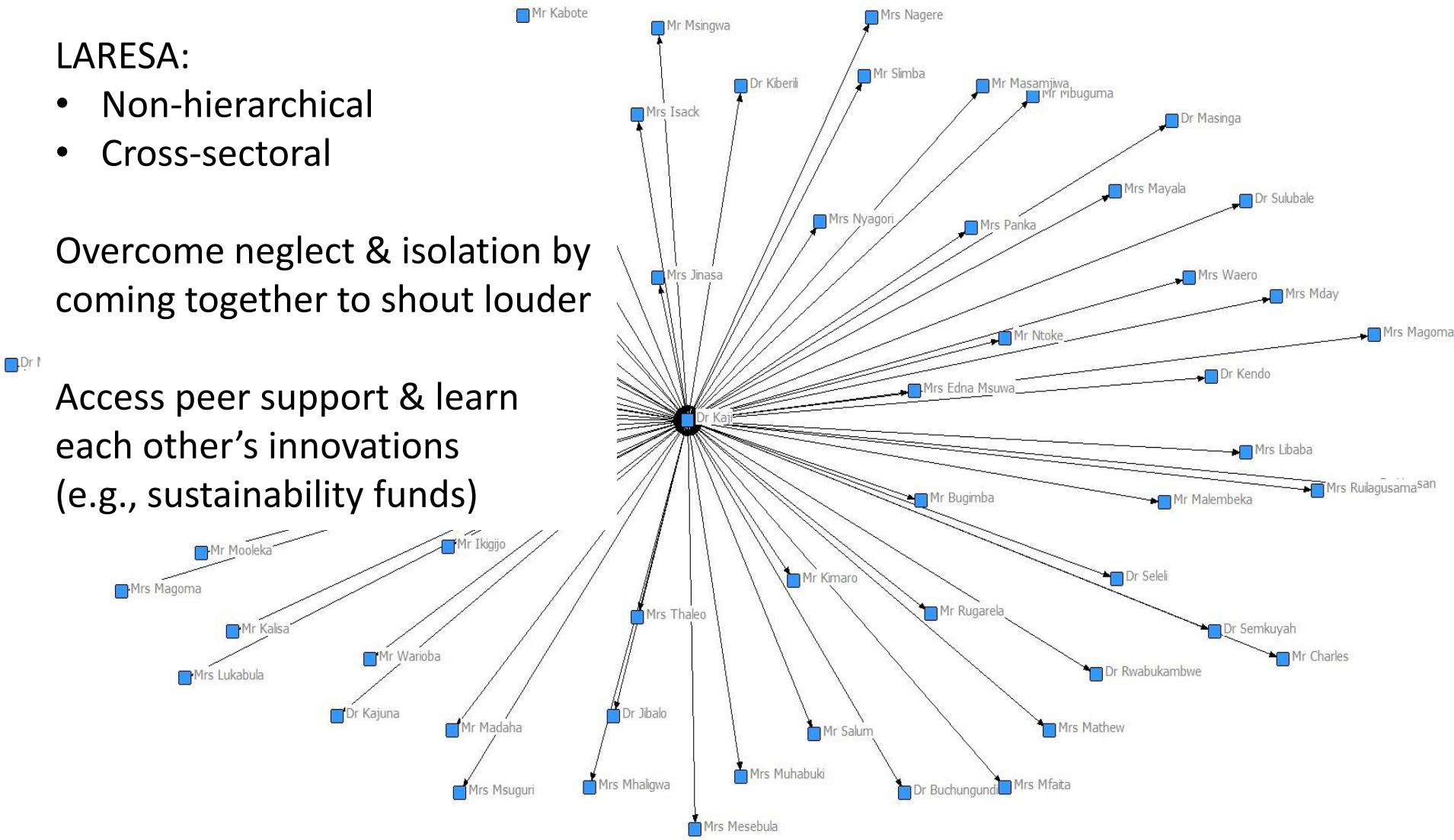
A network to 'shout louder'

LARESA:

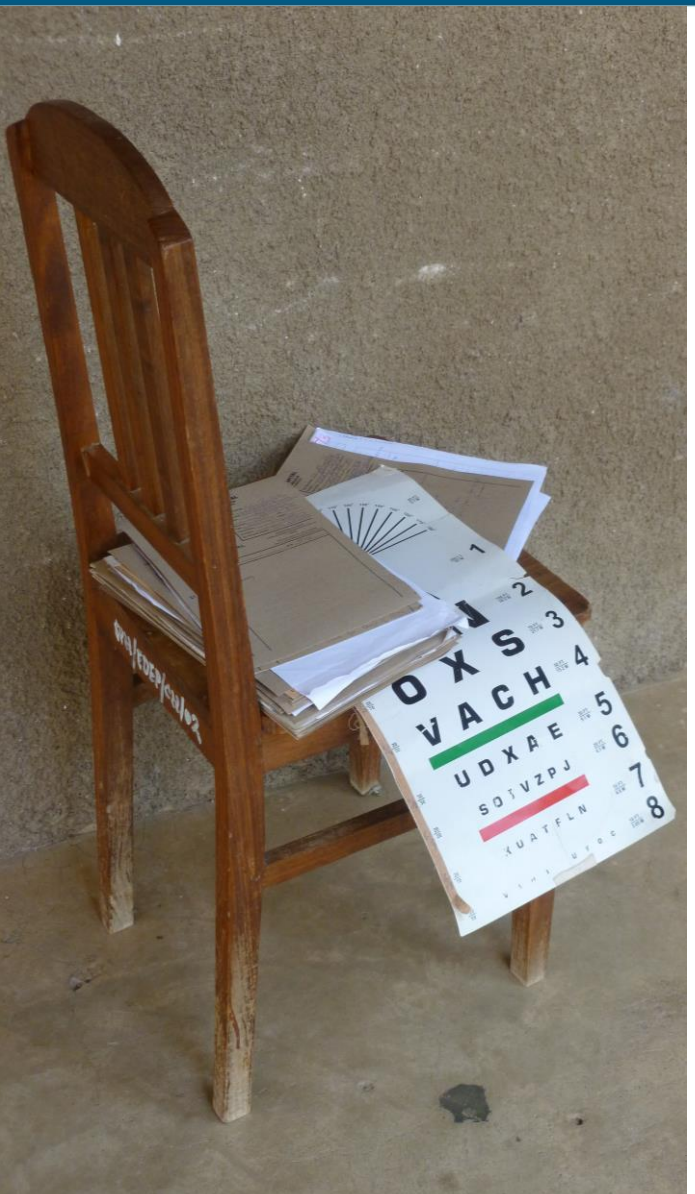
- Non-hierarchical
- Cross-sectoral

Overcome neglect & isolation by coming together to shout louder

Access peer support & learn each other's innovations (e.g., sustainability funds)



Conclusions



Mission teams had greater autonomy to increase income from user fees by not implementing government policies for 'free care', widely seen as non-sustainable.

But: teams in both sectors found similar strategies, even when their management structures were unique.

Informal rules shared through social networks therefore govern eye care in this pluralistic system, where eye care is neglected

→'Neglect' generates unexpected dynamics which affect eye health system sustainability