EFFICIENCY AND EFFECTIVENESS OF STRATEGIES FOR PROMOTING ACCESS FOR THE POOR AND VULNERABLE GROUPS WITHIN USER FEE SYSTEM: MWANZA AND MISUNGWI DISTRICTS

BY

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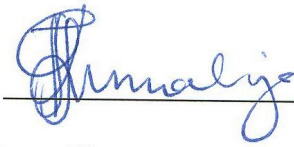
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To my children John and Jeremiah: For sacrificing their right to fatherly care for one year.

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ABSTRACT

The implementation of user fees while fostering equity in access of quality health services for the poor is still a problem in health facilities in Tanzania.

A cross sectional exploratory descriptive study was conducted in Mwanza at Sekou-Toure (Public) and Bukumbi (Voluntary) hospitals from 4th to 14th June 2002. The objective was to investigate the strategies for promoting access for the poor and vulnerable groups within their user fee systems.

A convenient sample of 335 exit interviews, administrators and health providers were involved in a study using qualitative and quantitative methods. Documentary reviews and observations were done. Check list was used to assess equipment and infrastructures. Out of 150 respondents from each hospital, only 35.5% of the public and 26% of the voluntary hospitals respondents were aware of the existence of the exemption mechanism in those hospitals. Exempt respondents in public hospital increased in number for the past five years and are associated with a total loss of 37,027,633 Tsh while exempt respondents in a voluntary hospital were static and associated total loss of 4,625,633 Tsh. The public hospital exemption system, which looks better than voluntary hospital exemption system, is managed by about 15 people and is a 24 hours activity. The voluntary hospital exemption system is managed by only one person, and is only active during official hours.

In conclussion, the findings from the study shows that the strategies implemented by the public and voluntary hospitals are not enough to effectively and efficiently identify the poor in their user fee system.

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LIST OF ABBREVIATIONS

AIDS – Acquired Immunodeficiency Syndrome

DANIDA – Denmark International Development Agency

DMO – District Medical Officer

DNO – District Nursing Officer

GDP – Gross Domestic Product

GNI-PPP - Gross National Income in Purchasing Power Parity

GTZ – Gesellsschft fur Technische Zusammenarbeil
(Germany International Cooperation)

HSR –Health Sector Reform

JICA – Japan International Cooperation Agency

MCH – Maternal and Child Health.

MOH – Ministry of Health

MOic – Medical Officer in charge.

NGO – Non-Governmental Organization

NOic – Nursing Officer in charge.

NORAD – Norwegian Agency for Development Assistance

SDC – Swiss Development Cooperation

UNFPA – United Nations Family and Population Agency

UNICEF – United Nations Children Education Fund

WHO – World Health Organization

CHAPTER ONE

1.1 INTRODUCTION AND BACKGROUND

Tanzania has an estimated total population of 36.2million people and a natural increase population rate of 5.6 per 1000. Life expectancy is estimated to be 52 years for male and 54 years for female. Tanzania has GNI-PPP per capital for 1999 U$500. By such indicators Tanzania is counted as the second poorest country in the world. (World Population Data Sheet-2001).

Until 1967, Tanzania followed the inherited colonial health system, which put more emphasis in urban health provision compared to rural health. After the Arusha Declaration of 1967, the stand was revised and more emphasis was placed on rural heath development. In 1977, the principal of universal free medical services for all Tanzanians was declared (MOH, 1996), and a ban on private for profit medical services was imminent. This meant that the government had to be the sole health provider in parallel with religious private not for profit health providers.

During the 80's, Tanzania was badly affected by economic depression. Factors that contributed to the poor economic performance in Tanzania were global economic crisis at that time, war with Uganda and the break of East African common market. Other factors were an increase in price of petrol and other imports and the steady decline of Tanzania shilling against dollar. The consequences of this were visible cuts in public expenditure on social services including health and education. In the

health sector, this manifested by the deterioration of quality and quantity of health services (Ilomo, 1989; Mujinja, 1990; Abel-Smith, 1992; Mujinja and Mabala, 1992).

As a consequence the government was not able to meet cost of buying drugs, was unable to meet the cost of repair and replacement of medical equipments and supplies, there was inadequate staffing with poor remunerations and morale, and poor management and supervision (Mujinja, 1990; MOH/Abel-Smith et al, 1992). Mbeba (1994) found a decline in number of contact per person per year in the utilization of public rural health centers and dispensaries. The declined found was from 6 in 1988 to 4 in 1992. The government responded to this declining of quality and quantity of health services by suggesting an introduction of a registration fee of Tsh 20 per visit per person. This suggestion was blocked by parliamentarians in 1988.

In a comprehensive health financing study to determine the level of funding in the health sector (Abel Smith, and Rawal / MOH 1992) found that majority of users were willing to pay for services provided if services are to be improved, and the improvement would mainly be on the availability of drugs. Another move by the government was to lift the imposed ban on the private for profit health provision in 1992 and public / private mix health provision was encouraged. This was followed by rapid expansion of private health sector facilities (Mujinja 1991). The role of the government in health care provision was to change from that of a provider to that of a facilitator. The government would remain as policy and guideline formulator,

health legislator, public health intervention and the provider of essential curative health care. (HSR 1994).

The government finally introduced cost sharing in 1993 to increase the public health sector finances, and to alleviate the further deterioration of quality of services offered in government health facilities. Guidelines were issued on how to implement this new policy and the poor, the vulnerable and those suffering from chronic ailments, were to be exempt from paying (MOH, 1993).

1.1.1 Organization of health services in Tanzania

Tanzania has a well-developed health system. The principles of primary health care were introduced in 1967 with the Arusha Declaration, which emphasized health services delivery in rural areas, where health services were scarce since colonial era and early post independence period.

The pyramid infrastructure of health facilities in Tanzania is as follows; 6 referral hospitals (including 2 which are special hospitals-Tuberculosis and Psychiatric), 20 regional hospitals (Mainland only), 131 district hospitals (Mainland only). Missionary hospitals serve as Designated District Hospitals in 17 districts. Also there are 20 private hospitals situated in Dar es Salaam (90%) and 18 parastatal hospitals, 293 government and mission health centers and 3014 dispensaries. It is estimated that nearly 90% of the population is within 10km of health facility (MOH, 2002).

1.1.2 Health financing in Tanzania

Tanzania health services financing mechanisms includes central and local government funds, funds from voluntary agents, religion organizations and donors. Other financial sources are community contribution, user fee, community health funds, and National health insurance (MOH, 2002).

(a) Central government funds

The central government finances the health sector in two ways: -

i) The Ministry of health provides funds to the referral hospitals and the various medical schools. It also provides funds to its parastatals such as the Tanzania Food and Nutrition Center and National Institute for Medical Research. The Ministry gives subventions to Kilimanjaro Christian Medical Center hospital, Bugando hospital and other designated hospitals belonging to religious organizations.

ii) The Prime Ministers office provides funds for the running of regional and district hospitals including salaries for their employees. At the same time the office of the prime minister gives subventions to the local councils for the salaries of running health centers and dispensaries.

(b) Local government funds

The local governments are responsible for the running of dispensaries and health centers in the rural areas. They have to provide funds for purchase of medicines and equipment, salaries and training and development of employees, construction and maintenance of the dispensaries and health centers. Local governments get their funds from government subventions and local taxes.

(c) Voluntary agencies and Religious Organization

Voluntary agencies, religious organizations and faith groups run health services and several health facilities such as hospitals, health centers, dispensaries and health institutions. The organizations finance these services through their own funds, and service charges. The government provides subsidies to these organizations.

(d) Funds from donors

Many countries and organizations assist Tanzania in the provision of health services. Such assistance is provided in different forms. Major donors provide funds to the Ministry of Health for the running of national, regional or district health projects. Other donors assist by bringing their experts and offering medical equipment and medicines. Such assistance is usually directly extended to the government or routed through International organizations like WHO, UNICEF, DANIDA, NORAD, JICA, UNFPA, GTZ, Ireland Aid and SDC.

(e) Community contribution

Community contributes to services provided through cost sharing for health care services. Their contributions will be in the form of cash or in kind.

i) User fees

Communities are encouraged to contribute through user-fee in health facilities to complement the government financing. However, exemptions will be provided to the poor, the indigent and vulnerable groups for the following reasons: Increase access of health services to those who cannot afford to pay, public health services such as maternal and child health, and epidemic prone diseases.

ii) Community health fund.

Community Health Fund is recognized as an effective tool for mobilizing voluntary community involvement and participation in supporting their own health care. It provides an opportunity for seasonal income earners in the informal sector to pay for their health services before they fall sick. Advocacy and promotion of the scheme will be stepped up to mobilize communities to join the programme.

iii) National health insurance

This is a mechanism to ensure medical protection of employees in the formal sector. Both private and public health insurance schemes will be continue to be encouraged. (MOH, 2002)

1.1.3 Targeting mechanism in user fees system

Various mechanisms have been developed to protect the access of the poor and vulnerable groups to health care or other services when user charges are introduced. These mechanisms have been characterized as direct and characteristic targeting. (New brander and Sacca, 1996). However there are potential problems that would emerge if the proposed mechanisms would not work efficiently. Problems commonly associated with these targeting mechanisms are under coverage and leakage. {Grosh (1994) as quoted by New brander and Sacca, (1996)}. Leakage occurs when the non-poor receives the benefits intended for the poor. Here the non-poor receive the designation of poor, though they are not, which allow them to receive the services at no or reduced charge though the person has the ability to pay for the services.

Under coverage occur when the poor do not receive the intended benefits because they are erroneously categorized as non-poor or they must still pay the fee despite their waiver.

1.2 STATEMENT OF THE PROBLEM

In order to accommodate the poor along with the introduction of user fees, the government of Tanzania introduced the exemption mechanism to protect the poor and vulnerable groups against the cost of care (MOH, 1993). The move is recommended in maintaining equity in health care provision but there are problems in its operation and these are leakage and under coverage (New brander and Sacca 1996).

The problem is really pronounced in public and voluntary hospitals as reported in a study done by Hussein (1995) in Dar-es Salaam city hospitals and found a big "Type 1 error". About 30% of public users interviewed indicated inability to pay while the proportion exempted was small about 3%.

Bureaucracy in exemption as found by Hussein, (1995) and Oester, (1998) affects the consumers of health care, while health workers on the other hand, find themselves in undecided situation when policy guidelines on who to exempt are vague. A study by Russell and Lucy (1997) done on countries with the policy to exempt the poor, found that local decision makers used the definition of poor flexibly and hence did not assist health staff to decide who to exempt and this increased the subjectivity and inconsistence in implementation.

In another study Msamanga et al (1996) reported that health workers normally get problems in identifying, people who cannot really pay from those who are just not willing to pay.

Community leadership involvement in recommending the poor patients to get exemption is practiced in Tanzania. Msamanga et al (1996) found that the community understanding of the poor people was high. Likewise, Gwatkin (1999) quoted in IHSD (2002) identifies that, individual targeting where poor families are given exemption cards for free access to health care has shown success of up to 80% in Thailand. The set back of health card mechanism is that it does not cater well for the dynamic aspect of the families moving in and out of poverty lines. It has also been reported that effectiveness and efficiency of the exemption mechanism will depend on how it will operate along with the strategies employed to accommodate the poor. (Msamanga et al 1996).

1.3 RESEARCH QUESTION.

What are the strategies employed in exempting patients from paying and how do they affect effectiveness and efficiency in providing health services.

1.4 RATIONALE OF THE STUDY

The government of Tanzania, in an attempt to make funds sufficiently available for the maintenance and operation of health institutions and to avert the declining quality of the services, in 1993, introduced user charges in government hospitals throughout the country. This was to serve as an alternative source of financing the health services. In conjunction with user fee, the government introduced the waiver and exemption systems to protect the poor and vulnerable groups.

Efficiency of these safety mechanisms is important in order to avoid the potential dangers of leakage and under coverage, among serious effects. No study has been done so far to study specifically on how efficient are these safety mechanisms in identifying the poor and how effectively are operated by the responsible institutions. So it is on this basis that this study is designed to determine strategies for promoting access for the poor and vulnerable group within user fee system. Findings from this study, which the author did in Mwanza region, will help the region and national policy makers to find possible solutions accordingly.

1.5 OBJECTIVES

Broad

To determine efficiency and effectiveness of strategies for promoting access for the poor and vulnerable groups within a voluntary and a public hospital user fee system.

Specific

1. To explore pricing, their changes and other strategies used to accommodate the poor.
2. To assess the process used to grant exemption and its effectiveness
3. To assess the efficiency of the waiver and exemption mechanism.
4. To determine consumers perception on charges and the waiver / exemption mechanism.
5. To explore problems associated with the waiver / exemption systems.
6. To explore health providers' opinion on the exemption.

CHAPTER TWO

2.1 LITERATURE REVIEW

The introduction of fee for service in the government health facilities has been one of the most visible policy changes associated with changes from government dominated health services to market oriented health services financing provision. Public health services were traditionally provided free in most developing countries. And, since government resources have decreased in real terms, while demand has increased in many countries, more private resources have been required to increase the quality and quantity of health services. The introduction of cost sharing is one of those additional sources of revenue that are needed to operate the public sector health system. (Newbrander and Sacca 1996).

In order to secure further loans from the International Monetary Fund (IMF) and the World Bank (WB) governments in the developing countries were forced to devalue their currencies and cut back their public expenditure (Abel- Smith 1985; Waddington and Enyimayew, 1989). Throughout this period of economic crisis, national health expenditure in Sub Sahara Africa has decreased, not only in terms of absolute allocation but also in relation to total budgets (Korte et al, 1992). This has resulted in loss in quality of care, lack of drugs, low resource allocation and low morale on part of health personnel in health facilities. Some areas, the essential health services ceased to function (Berman, 1996).

2.1.1 Health expenditure and financing in developing countries

Health expenditure accounts for 5% of GDP and 5%-10% of government expenditure in developing countries. In spite of this, there is still pressure to increase health expenditure in this period of declining public sector resource availability in many developing countries (Akin et al, 1987). The financing of health care has therefore become an increasingly critical issue in most developing countries particularly in Sub Sahara Africa (Korte et al, 1992). As many governments in the developing world face growing constraints on the availability of resources to finance health care, efforts to seek alternative forms of financing have intensified (Thomason et al, 1994).

Typically, alternative methods of financing health services include such areas as providing insurance or other coverage, charging users of health facilities, greater cooperation with the private sector and the effective use of non governmental resources (Yoder, 1989). The main options, according to Abel-Smith and Rawal (1992) are compulsory health insurance, community financing and user charges. Russell et al (1995) also reported the same, that governments are supplementing tax revenue by increasing direct household contributions to the health sector through a variety of policy reforms: user fees at government facilities, the adoption or encouragement of community based financing schemes and the encouragement of non-profit making but fee-charging non-governmental organizations.

2.1.2 Introduction of user fee and promotion of quality and equity

Utilization is less likely to decline following the introduction of fee if users perceive health services to be more effective and of greater value for money (Litvack and Bodart, 1993). Utilization statistics show an increase in attendance at health facilities in four countries (Benin, Niger, Liberia and Zaire) after cost recovery was introduced, mixed results in three countries (Guinea, Nigeria and Senegal) and across the board decrease in utilization in one country, Ghana (Shaw and Griffin, 1995). According to Russell and Gilson (1997), two supportive measures are recognized as important pre condition for service improvement:

a.) Decentralized financial control.

Retention and use of revenue at the point of collection and policy guidelines for health services facility management, which promote and support the conversion of revenue into services improvements that benefit the poor.

b.) Carefully designed fee schedules with exemption.

For those with limited access to cash at the time of illness, fee will increase financial barriers to health services access and utilization unless policies to exempt fee payment for poor and vulnerable groups are implemented efficiently and effectively. Donors and policy makers recognize the need for exemption to make care affordable for poor and vulnerable groups (World Bank 1993; Russell and Gilson, 1997). According to Wills (1993), two types of exemptions are important for the promotion of public health and access for those unable to pay. These are:

- A fee schedule that subsidize services essential for public health services (e.g. maternal and child health services, immunizations).

- A policy that exempts those unable to pay.

Decentralized responsibility for exemption decisions is argued to be a means of improving the accuracy of targeted benefits.

It is good to have a well functioning exemption mechanism in order to achieve the objective of exemption for the poor. In a study done in public, voluntary and private hospitals in Kilimanjaro and Mara regions in Tanzania, it was found that exemption systems in voluntary hospitals seems to work better than in public hospitals because the system is decentralized and it takes into consideration the local situation, rather than using the national set standards of public hospital criterion. (Msamanga et al, 1996).

2.1.3 Effects of prices on health seeking behavior

People perceive illnesses differently. That perception will be an important determining factor to seeking health care. An individual or household has to undergo several decision making process before conclusion. Mwabu, (1986) has discussed this decision making process in three stages; First, awareness of the presence of illness in the family will make them to decide whether or not to seek health care. Secondly, the type of health care provider has to be decided upon and here various provider alternatives including self-care and decision on which one to go to has also to be made. Lastly, the household / patient has to decide whether or not there is a need to seek further treatment if cure is not effected after a period of time.

Apart from making decisions of where to seek care, there are factors that can determine demand for health care. Researchers have shown that these factors include age, gender, income, education and employment status, type and severity of illness, cultural factors, price of care, distance and cost in time in reaching a medical facility, time spent in waiting to get medical care at the facility and quality of care offered. The availability of drugs, equipments, number and competent staffs are supply side factors (Heller; 1982, Akin et al 1986, Musgrove 1986, Mwabu, 1986; Stanton and Clemens 1989; Ellis and Stephenson 1992).

Several studies suggested that the most vulnerable social strata i.e. poor (Yoder et al, 1989; Bloom, et al, 1993) rural or isolated population (Creese 1991) children and elderly (Waddington and Enyimayew, 1989) are the most affected groups by the introduction of direct cost recovery. The price elasticity of demand may differ significantly from one social category to another (Gertler and van de Gaag, 1990).

Review studies on utilization reveal that income and more generally ability to mobilize resources are highly associated with the utilization pattern of the communities (Haddard, 1992). Non-users frequently report that they have not sought health services because the utilization costs are high (Stanton and Clemens, 1989).

Gertler and van der Gaag (1990) found a significant relationship between price elasticity of demand and income in their study of demand for health care in Peru and Cote d' Ivoire. For the lowest income quintile, utilization reductions in response to price increase was significant at all price levels and become elastic for the higher price ranges considered. Similar conclusions were made by Bitran (1989) in Santo

Domingo, Dominican Republic. However, he found price to be only slightly more important in lower than higher income groups in determining the decision to seek care once illness was reported. Contrary, the Bamako Initiative (BI) scheme in Cameroon where user charges was introduced in tandem with improved quality of care, showed that utilization of health services increased instead of decreasing even among the poor (Litvack and Bodart, 1993).

2.1.4 Equity and Exemption in health facilities in Tanzania.

On equity issues and protection of the poor, the World Bank argued that user charges would promote equity as the revenue collected from those who are able to pay would be used to cover expenses used by those unable to pay, cited in (Akin et al, 1987). In a study which involved NGO hospitals in Tanzania, the exemption mechanism were present in 95% of NGO hospitals and they used different criteria for example age, (children under fives), severity of illness, inability to pay, disability and chronic diseases (Mujinja and Mabala, 1992).

In a study done to evaluate the cost-sharing programme implementation in public hospitals in Tanzania, the exemption mechanism in place was found to be weak to cater for the disadvantaged. (Munyetti et al, MOH 1999).

The problem of a possibility of humiliation to the poor during seeking and receiving exemption has been documented in one study done in Dar-es-Salaam City hospitals. Hussein (1995), found that, exemption mechanism in Dar-es-Salaam City hospitals was lengthy and time consuming and that there was a possibility of humiliation to

those exempted since none of them went back to seek another exemption in another visit. This possibly resulted in a decline in utilization of health care as was found in another study done in government owned hospitals in Dar-es-Salaam City, where there was a 50% decline of utilization of health care following the introduction of user fee (Hussein and Mujinja, 1997).

A study done in public, private not for profit and private for profit hospitals in Kilimanjaro and Mara regions, (Msamanga et al, 1996) found the exemption system in voluntary hospitals to work better than in public hospitals because the system is decentralized and it takes into consideration the local situation rather than using the nationally set standards used in public hospitals.

New brander and Sacca (1996) in a study on cost sharing and access to health care for the poor in Tanzania found the theoretical construct of the waiver mechanism to be sound but its implementation flawed. The authors mentioned three primary factors to be responsible for the poor effectiveness of waivers i.e. lack of training of hospital staff, lack of records regarding the number and value of waivers, and lack of information to promote waivers among communities and the public.

There is a need to look on the gap existing in the efficiency of exemption procedure, its administration and management operational so as to promote access for the poor and vulnerable groups within user fees.

CHAPTER THREE

3.0 METHODOLOGY OF THE STUDY

3.1 Selection of study area

Mwanza City (Sekou-Toure hospital) and Misungwi (Bukumbi hospital) were selected for the study mainly due to their conveniences to the researcher in terms of familiarity, easiness of communication, low cost and limited time.

3.2 Description of the study area

Mwanza region is located northwest on the southern shore of Lake Victoria. It has a total surface area of 35,187 square kilometers of which 15,092 square kilometers are covered by the waters of lake Victoria. The population of Mwanza was estimated to be 2,307,606 after the 1988 census, with an average population growth of 2.6 %. Mwanza city is the second largest after Dar-es- Salaam. Major tribes in the region are Wasukuma, Wanyantuzu, Wajita, Wakerewe and Wazinza. Other tribes include Wakara and Wahaya. Mwanza region is subdivided into seven administrative districts, which are Geita, Sengerema, Ukerewe, Magu, Kwimba, Misungwi and Mwanza City.

Misungwi district is situated south of Mwanza city and covers an area of 2,370 square kilometers. It has 4 divisions and 20 wards, and has a total population of 270,932 people; among them 57,166 are children under fives 59,605 are childbearing age women. The district has 2 hospitals one government and one voluntary, 3 health centers and 31 dispensaries.

Mwanza city is situated immediately south of lake Victoria and covers 425 square kilometers. It has 2 divisions, 20 wards and 17 villages. Mwanza city has a population of 548,466 people, among them 108,048 are children under fives and 138,213 are child bearing age women. The city has 4 hospitals, 1 government hospital and 3 private. Among the private owned facilities, one is the consultant hospital. There are 6 health centers among them one is the government health center and 56 dispensaries of which 20 are government, 5 are voluntary, 21 are private and 10 are voluntary owned.

Bukumbi hospital is located 32 kilometer south of Mwanza city and about 2 kilometer from lake Victoria. The hospital is situated in the northwest of Misungwi district near the shores of lake Victoria. It has the bed capacity of 196 and 125 workers. Table 3.1 below shows the staff working in the hospital for the past five years.

Table 3.1 Cadre working at Bukumbi Voluntary Hospitals for the period 1998-2002

CADRES	1998	1999	2000	2001	2002
Medical Officers	4	1	1	1	2
Assistant Medical Officers	0	0	1	1	1
Nursing Officers	2	2	2	3	3
Trained Nurses	18	20	20	22	28
Nurse Assistants	0	0	0	0	24
Laboratory Technologists	0	0	0	0	0
Laboratory Technicians	0	0	0	0	0
Laboratory Assistants	2	2	2	2	2
Pharmacists	0	0	0	0	0
Pharmaceutical Technicians	1	1	1	1	1
Pharmaceutical Assistants	3	3	3	3	3
Dentists	0	0	0	0	0
Hospital Secretary	1	1	1	1	1
Welfare Officer	0	0	0	0	0
Accountants	2	2	2	2	2
Clinical Officers	4	3	3	3	3
Clinical Assistants	1	1	0	0	0
TOTAL	**38**	**36**	**36**	**39**	**70**

Source- Medical Officer in charge, Bukumbi hospital (2002).

Sekou-Toure hospital is situated about 3 kilometers from the heart of Mwanza city in the area called Isamilo bordering Lake Secondary School and Mwanza City Hall to its eastern and western borders respectively. The hospital has bed capacity of 170. Table 3.2 shows the number of cadres working at the hospital for the past five years.

Table 3.2: Cadre working at Sekou-Toure public hospital for the period 1998-2002.

CADRE	1998	1999	2000	2001	2002
Medical Officers	4	4	4	4	4
Assistant Medical Officers	9	9	9	9	9
Nursing Officers	42	42	42	42	42
Trained Nurses	40	40	40	40	40
Nursing Assistants	92	92	92	92	90
Laboratory Technologist	0	0	0	0	0
Laboratory Technicians	2	2	2	2	2
Laboratory Assistants	4	4	4	4	5
Pharmacists	1	1	1	1	1
Pharmaceutical Technicians	2	2	2	1	1
Pharmaceutical Assistants	2	2	2	2	2
Dentists	1	1	1	1	1
Hospital Secretary	2	2	2	2	2
Welfare Officers	0	0	0	0	0
Accountants	1	1	1	1	1
Clinical Officers	8	8	8	8	8
Clinical Assistants	0	0	0	0	0
TOTAL	**210**	**210**	**210**	**210**	**209**

Source-Medical Officer in charge, Sekou-Toure hospital (2002)

There are differences in staffing level and staff retention between the two hospitals in the last five years. A voluntary hospital has the few different staff, as there were four Medical Officers in 1998, but this year only two medical officers are present. There is one Assistant Medical Officer since 2000 to date. Formally there was no Assistant Medical Officer. Some cadre i.e. Clinical Assistants are not present this year. There was one Clinical Assistant in year 1998. Some cadres are not present in the hospital like Nurse Assistant, Laboratory technologist and technicians, Pharmacists and Welfare Officer. In a public hospital generally there many different cadres and staff retention has been maintained for the past five years. Some cadres are not present i.e. laboratory technologists and welfare officers.

Table 3.3 below shows the total number of patients attended out patient departments in the two hospitals in the past five years. Generally, attendances in the voluntary hospital are lower than that of the public hospital for the period 1998- 2002. The difference in some years approaching five times i.e. 1998, which was the highest, and is three times in the year 2002, which is the lowest. Total difference in attendances in the period of 1998- 2002 in both hospitals is almost five times in favor of the public hospital.

Table 3.3 Total Out Patients department attendances in Sekou-Toure and Bukumbi hospitals for the period 1998-2002

	PUBLIC	VOLUNTARY
Year	**Attendances**	**Attendances**
1998	37959	7781
1999	35045	8667
2000	38582	8345
2001	32839	9049
2002	14356	4128
Total	**158781**	**37970**

3.3 Sampling

Bukumbi hospital and Sekou-Toure hospital were conveniently selected in order to study their strategies for promoting access of the poor and other vulnerable groups within user fee system since the two hospitals have almost similar bed capacity, infrastructure and equipments. The study was not aimed to compare the two hospitals strategies for promoting access for the poor and other vulnerable groups in their user fee system. A convenient sample size of 300-exit interview was selected 150 from each hospital. Every patient on the out patient queue who was an adult, aged eighteen years old and above was selected in the study. Administrators (Hospital administrators, Hospital secretaries, Medical Officer in charge, Matron, Nursing Officer in charge, Accountants and Cashiers), and the health providers were selected in the study. A total of 10 administrators and health providers from a public hospital

and 5 administrators and 10 health providers from the voluntary hospital were conveniently selected to be in the study.

3.4 Ethical issues

Permission to conduct research was obtained from relevant authorities. These include the Regional administrative Officer, Regional Medical Officer and District Medical Officer of Misungwi. Consent from the health care consumers (Outpatient) was solicited for being interviewed.

3.5 Data collection methods and procedures

Four research assistants were recruited to help the principal investigator in data collection, all of them were form four leavers, and were trained by the principal investigator two days on how to administer and fill the questionnaire forms. Pre testing was done at Misungwi district hospital to find out people's response to various questions listed. Relevant changes and modification were then made after pre testing.

(A) Health facility data

The level of utilization of a health facility for the past five years was determined by analyzing hospital outpatient records. A quality checklist was administered by the principal investigator, to the administrators in each facility. It inquired on the number and type of quality health staff, availability of essential equipment and their state. The equipments that were looked at were X-ray machine, microscopes, sterilizers,

sphygmomanometers and ENT sets. Availability of essential drugs and vaccines was recorded.

(B) Outpatient survey

The Kiswahili version of the questionnaire that had thirty-four both open and closed ended questions was administered to out patients. The questions focused on several issues such as demographic characteristics of the consumers, information and knowledge on exemption and their perception, direct costs incurred by patients for treatment of an illness and the source of funds for paying fees, alternative providers' where people seek care, reasons of seeking care in different providers, whether the patients were explained on their management plan, knowledge of the patients on who are supposed to be exempted and who are the poor.

Information on demographic characteristics such as age, sex, marital status, education and household size was also collected. Information on exemption, source of information on exemption, exempted patients, reasons of not being exempted and perception on exemption was collected. The direct costs incurred for treatment of an illness episode in public hospital versus voluntary hospital were established. Information was obtained on all costs met i.e. means of transport, registration costs, laboratory investigations, x-ray investigations and costs of medications. Who pays and the source of payment for the treatment of the illness episode was established to identify proportion of consumers who paid out of pocket, those who borrowed money and proportion exempt from paying user fees.

Information on whether management plan was explained on drugs used, their side effects, the course of treatment and next appointment was also collected.

(C) In depth interview

In depth interviews were conducted with the administrators (Hospital administrators, hospital secretaries, Medical Officer in charge, Matron, Nursing Officer in charge, Accountants and Cashiers) and the health providers (Assistant Medical Officer, Nursing Officers, Clinical Officers, Trained Nurses, Dentist, Anesthetist, Laboratory and Pharmaceutical Assistants). With the administrators the interview aimed at getting the supply side perspectives on issues on existence of exemption, its operation, information dissemination on exemption, staff working in exemption and whether they have been trained, problems and loss caused by the exemption mechanism and any changes made since its inception. The health providers were asked if they were aware of the existence of exemption, their involvement in the management of the system, and opinion on the operation of exemption and their suggestions on how to improve the exemption system.

3.6 Data entry and data validation and analysis

Data was entered in a computer using EPI INFO 6 software. Questionnaires from the two hospitals were given serial numbers. All questions were coded prior to data entry. Validation of data entry was done by checking for consistency and for any unreasonable entries. A frequency printout for the different questions was done and if there was any missing information or unreasonable entries, a search for the questionnaire form(s) using serial number(s) was done and the information verified

by checking the actual questionnaire form itself. Data were analyzed using EPI INFO 6 program.

3.7 Study limitations.

1. Time limit. Time allocated for data collection was not enough for someone to collect a sufficient sample size because of poor attendance of out patients especially in a voluntary hospital.
2. Communication was a problem since some people in the voluntary hospital were not able to communicate in Kiswahili.

3.8 DEFINITION OF TERMS

Poor

The poor are the people who are deprived of basic needs. Poverty can be defined in relation to deprivation either as a lack of means (purchasing power) to avoid deprivation, or as an end in its own right (deprivation itself). **Deprivation** is defined as a state of observable and demonstrable disadvantage relative to the local community or wider society or nation to which an individual, family or group belongs.

Vulnerable groups.

This group included are children under five, the elderly, and women for MCH, patients with certain illnesses such as tuberculosis, leprosy, polio, AIDS, cancer, diabetes regardless of whether they are poor or not.

Exemption

Is a mechanism that individuals are provided with free care because they cannot afford to pay and meet certain prescribed criteria in the responsible health facility.

Waiver

A term used to describe reduction or elimination of fees for the poor based on an assessment of their inability to pay as per prescribed guidelines in the responsible health facility.

Leakage or Type I error of targeting

When the non-poor receives benefits intended for the poor. Here the non-poor receive the designation of poor, though they are not, which allow them to receive the services at no or reduced charge though the person has the ability to pay for the services.

Under coverage or Type II error of targeting

This occurs when the poor do not receive the intended benefits because they are erroneously categorized as non- poor or they must still pay the fee despite their waiver.

Access

The ability (probability) to receive health services and is influenced by a mix of demand and supply factors.

Efficiency

The ability of any mechanism to rightly isolate as many indigents as possible at a given low possible cost.

Effective

The ability of the mechanism to achieve the pre set objectives.

Isolating

Identifying and picking the indigents from the group of individuals.

Equity

Equal access to available care for equal need irrespective of income, education level, age, sex, geographical location, health status or some combination thereof (Whitehead, 1990; Mooney, 1987; Musgroove, 1986;as quoted by Msamanga et al, 1996)

Indigents

People who are deprived of natural richness; poor people, the needy.

CHAPTER FOUR

4.0 RESULTS

4.1 Demographic profile

The demographic profile of the public and voluntary outpatient interviewed is shown in table 4.1. A total of 300 respondents were interviewed 150 from each hospital. About 64% and 52% of the respondents were female in public and voluntary hospitals respectively. About 40% of the respondents were those of age group between 21and 30 years in public hospital while in the voluntary hospital, 27.3% of the respondents were those of two age groups, 21 to 30, and 31 to 40 years. The lowest proportion of respondents in the public hospital were those in the age groups below 20 and those over 50 years old, be 9% and 8.7% respectively while in voluntary hospital, the lowest proportion of respondents were those below 20 years and age group between 41and 50 years who were 11.3% and 21% respectively.

Over 60% of the respondents turned at the public hospital were married, 28.7%were single, 2.7%were divorced while those cohabiting and widow together were 3.3%. In the voluntary hospital 64% of respondents were married, 28% were single, 6%were widow, 1.3% were divorced, and 0.7% were those cohabiting. Respondents in a public hospital, who reported to have had primary education, were 54.7% and 27.3% had secondary education while 9.3% had post secondary education. In voluntary hospital 48.0% of respondents had primary education, while 20.0% had post secondary education and 18.0 % had no formal education. About 10.7% of respondents had secondary education and 3.3% had adult education. Over 40% of

the respondents interviewed in public hospital were those from families with a household size of between 4 and 6 people, while 37.3% of respondents in voluntary hospital were those from households that had more than 6 members.

TABLE 4.1 DEMOGRAPHIC PROFILES OF RESPONDENTS.

		PUBLIC		VOLUNTARY	
		N0	%	N0	%
1	**Total no: interviewed**	150	100	150	100
2.	**Gender:**				
	Female	54	36	72	48
	Male	96	64	78	52
3	**Age group**				
	< 20	14	9	17	11.3
	21 - 30	60	40	41	27.3
	31 - 40	40	27	41	27.3
	41 - 50	23	15	19	12.7
	> - 50	13	8.7	32	21.3
4	**Marital status**				
	Single	43	28.7	42	28
	Married	93	62	96	64
	Divorced	4	2.7	2	1.3
	Widow	5	3.3	9	6
	Cohabiting	5	3.3	1	0.7
5	**Education status**				
	No formal education	12	8.0	27	18.0
	Primary education	82	54.7	72	48.0
	Secondary education	41	21.3	16	10.7
	Post secondary education	14	9.3	30	20.0
	Adult education	1	0.7	5	3.3
	Household size				
6	**Household size**				
	One	11	7.3	13	8.7
	1.3	49	32.3	37	24.7
	4 – 6	66	44	44	29.3
	> 6	24	16	56	37.3

4.2 Accessibility of outpatient respondents to the hospital

Respondents were asked on the distance they travel to the hospital. Table 4.2 shows that 73.3% of the respondents in a public hospital and 49.3% of the respondents in the voluntary hospital were located less than 5 kilometers from the hospital. Those located more than 15 km were 2% in the public hospital and 25.4% in a voluntary hospital.

Table 4.2 Distance (km) respondents travels to a health facility by ownership

	PUBLIC (Urban)		**VOLUNTARY (Rural)**	
	N	**150**	**N**	**150**
Distance	n	%	n	%
< 5km	110	73.3	74	49.3
6—10 Km	25	16.7	30	20
11—15 Km	12	8	8	5.3
> 15Km	3	2	38	25.4
TOTAL	**150**	**100**	**150**	**10**

4.3 Means of travel to hospital

Respondents were asked on the means of travel the hospital.

Table 4.3 below shows that 50.7%, 30.7% and 18.0% of the respondents from the public hospital reported that their means of travel to the hospital were public transport, personal transport and walking, respectively. In the voluntary hospital, 34.7% of the respondents reported to have had used public transport while 32.7% used personal transport and walked.

Table 4.3 Mode of transport used by respondents

	PUBLIC (Urban)		**VOLUNTARY (Rural)**	
	N	**150**	**N**	**150**
Transport	**n**	**%**	**n**	**%**
By foot	28	18.7	49	32.7
Personal transport	46	30.7	49	32.7
By public transport	76	50.7	52	34.6
TOTAL	150	100	150	100

4.4 Type of illness

On type of illness, the respondents were asked if they had acute or chronic illness. Table 4.4 shows the type of illnesses the respondents had. In a public hospital 74.7% of respondents had acute illnesses while 25.3% had a chronic illness. In the voluntary hospital 75.3% of respondents had acute illnesses while 24.7% of respondents had chronic illnesses.

Table 4.4 Types of illnesses reported by respondents

Type of illness	PUBLIC (Urban)		VOLUNTARY (Rural)	
	N 150		N 150	
	n	%	n	%
Acute	112	74.7	113	75.3
Chronic	38	25.3	37	24.7
TOTAL	150	100	150	100

4.5 Pricing, their changes and other strategies used to accommodate the poor

The hospital administrators in both the public and voluntary hospitals were asked on prices charged in their hospital and other strategies to accommodate the poor. Table 4.5 shows different prices of health care in the public and voluntary hospitals, which include prices for registration, consultation, investigation, X-Ray, drugs, delivery charges and admission for different grades.

The Matron in the public hospital mentioned that the prices were introduced in 1994 and the following strategies were employed by the public hospital. a- the waiving of

consultation fee. This was done in 1996 after finding the necessity to waive it as one way to accommodate the poor.

(a) The removal of delivery charges. This was done with the same purpose of accommodate the poor and was done in 2000.

(b) Reduction of admission fee grade III. Patients are now paying Tsh. 1000 for the whole period the patient is admitted instead of Tsh. 1000 weekly. This reduction of admission fee was done in 1996.

At the voluntary hospital which has been trying to charge at low prices for long time ago, strategies employed to accommodate the poor, as presented by the hospital administrator were

(a) The registration fee was reduced from Tsh 1000 to Tsh 500.

(b) Consultation fee was waived which was Tsh 500.

(c) Admission fees grade I and II was reduced from Tsh 3000 and Tsh 2500 to Tsh 2500 and Tsh 1500 respectively.

All these were done in the year 1994 in a voluntary hospital in order to accommodate the poor. Overall, prices of different procedures like investigation (B/S, Stool examination, urinalysis, Full blood picture and ESR), X-Ray, delivery and admission charges in a voluntary hospital are higher than in the public hospital. The only different is the registration fee, which is higher in public than voluntary hospital. Drugs were initially being charged at Tsh 40 for a full course of treatment in a public hospital. The current price of 50% of the market price for a full course of treatment was started due to capitalization of hospital pharmacies in 1999. In the voluntary

hospital, the price of drugs has been kept at 50% of the actual market price early 70's.

Table 4.5 Fees in Tsh. charged for different services by ownership of facility

SERVICE		PUBLIC (Urban)	VOLUNTARY (Rural)
Registration		1000	500 (1000)
Consultation		Removed (300)	Removed (1000)
Investigation		100—2000	100—2500
X-Ray		1500—3000	2000—3000
Drugs		50% of the cost. (40-per item)	50% of the cost.
Delivery charge		Removed (500)	1000
Admission	Grade 1	1500	2500 (3000)
	Grade 2	1500	1500 (2500)
	Grade 3	1000 Throughout the stay. (1000 weekly removed)	1000

N.B In brackets are the former charges.

(i) Awareness of the existence of exemption.

Respondents were asked if they were aware of the existence of exemption in the hospital that they had visited. Table 4.6. Shows that a higher proportion (35.5%) of the respondents reported to be aware of the existence of the exemption in the public hospital compare to those in voluntary hospital (26%).

Table 4.6 Respondents awareness of the existence of exemption by ownership of facility

	PUBLIC (Urban)		VOLUNTARY (Rural)	
	N	150	N	150
AWARE	n	%	n	%
YES	53	35.5	39	26
NO	97	64.7	111	74
TOTAL	150	100	150	100

Respondents, who reported that they were aware of the existence of the exemption system, were asked about the source of the information on its existence. Table 4.7 shows that 58.4% of respondents in the public hospital mentioned health workers as the main source of information followed by 51.1% who mentioned radio. In a voluntary hospital the leading source of information reported was the radio77.0% and 25.6% mentioned health workers.

Table 4.7 Respondents source of information on exemption

	PUBLIC (Urban)		VOLUNTARY (Rural)	
	N	53	N	39
Source of information	n	%	n	%
Radio	27	51.1	30	77.0
Political rally	5	9.4	3	7.7
Newspaper	9	17.0	9	23.1
Posters in hospital	10	18.9	9	23.1
Health workers	31	58.4	10	25.6
Village/ward leaders	18	34.0	1	2.6

Observation was also made during the survey by the principal researcher and his assistants and it was found that in both hospitals there were no posters around the hospital surroundings that would keep people aware of the existence of exemption mechanism. During the in-depth interview the Medical Officer in charge of the public hospital reported that,

> "*...the posters were removed due to ongoing renovations, but plans are there to put them back after the renovation and to replace them with those that are not easily destructed...*"

In a voluntary hospital there were no posters neither any plans to put them in place.

4.6 Processes used to grant exemption: effectiveness of the system

The in-depth interview conducted in both hospitals, which involved 10 administrators from the public and 5 administrators from the voluntary hospitals on the process of granting exemption, revealed that both hospitals do not have forms to be filled by patients who would want to apply for the exemption. They follow set guidelines. The exempt patients had to carry with them a letter from Ten Cell Leaders, which is to be presented to the Out Patient Registry Department. In the public hospital, the Matron narrated the process as follows: After the registration of the patient in the Out Patient Registry office, then;

(a) The patient is directed to the hospital matron.

(b) At the matron's office, history on the individual is taken and details such as age, marital and employment status are sought.

(c) The individual is asked if he or she has a relative or friend who can help in the paying of user fee.

(d) A brief medical history on the current problem is taken. These include duration of illness, the presenting complaints and whether the individual has sought treatment for the current problem at a particular facility or at any other place.

(e) When the matron is convinced that the individual cannot pay, then registration for exemption is done and a patient is given a number and the card is stamped.

(f) Then the patient returns to the Out Patient Registry and follow the normal procedures. He or she will proceed to different sections, where he / she receives treatment free of charge.

In the voluntary hospital, the hospital administrator also reported about the process they use to scrutinize patients who need exemption. She reported that after the patient has been directed to her office, she took a detailed social and family history including employment and marital status, whether he or she has a relative or friend who can help in the paying of user fee. A brief medical history of the current problem is taken.

"...when I am convinced that the individual cannot pay, I seek opinion of the medical officer in charge and it is only under the recommendation from the Medical Officer in Charge the individual could get free treatment..."

"...Sometimes the individual may be forced to deposit a collateral security in order to be granted exemption and pay after he / she has recovered..."

Records on the patients who were exempted were examined and table 4.8 shows the total patients who were exempt for the outpatient attendance in both hospitals. The public hospital attendance has not been increasing but the number of exempt patients was steadily increasing for the past five years prior the survey. Contrary, in the voluntary hospital the number of exempt patient and the Out Patient attendances who are small in number compared to the public hospital attendances has been almost stable for the past five years (See table 4.8).

Table 4.8 Total outpatient attendances and those exempted in Sekou-Toure and Bukumbi Hospitals for the period 1998-2002

	PUBLIC (Urban)			VOLUNTARY (Rural)		
Year	Attendance	Exemption	%	Attendance	Exemption	%
1998	37959	4608	12.1	7781	196	2.5
1999	35045	5895	16.8	8667	239	2.8
2000	38582	7331	19.0	8345	221	2.6
2001	32839	8342	25.4	9049	215	2.4
2002May	14356	4866	33.9	4128	96	2.3
TOTAL	158781	31042	19.6	37970	967	2.5

i) Out patient respondents perception on whether the exemption reaches the targeted people.

The respondents were asked about their perception on whether the exemption reached the targeted people. Table 4.9 shows respondents responses on whether the exemption reached the targeted people. About 30.7% of public hospital respondents reported that the exemption mechanism reached the targeted people, while 69.3% reported that the exemption mechanism did not reach the targeted individuals. In the voluntary hospital only 6.7% of the respondents reported that the exemption mechanism reached the targeted individuals.

Table 4.9 Whether the exemption reaches the targeted ones

	PUBLIC (Urban)		VOLUNTARY (Rural)	
Reach the targeted	N	150	N	150
	n	%	n	%
YES	46	30.7	10	6.7
NO	104	69.3	140	93.3
	150	100	150	100

ii) Reasons given by outpatient respondents on why the exemption did not reach the targeted individuals.

Outpatient respondents, who reported that the exemption mechanism did not reach the targeted individuals, were asked to give reasons for their responses as shown in table 4.10. About 71% of the respondents in the public hospital reported that people were not aware of the existence of the exemption while 28.8% said the exemption system was poor. In the voluntary hospital, 75.7% of the respondents reported that people were not aware and 24.3% reported that the exemption procedure was poor.

Table 4.10 Reasons on why exemption not reaching the targeted ones

	PUBLIC (Urban)		VOLUNTARY (Rural)	
Reason	N	104	N	140
	n	%	n	%
People not aware	74	71.2	106	75.7
Poor exemption procedure	30	28.8	34	24.3
	104	100	140	100

iii) Problems encountered by administrators during exemption process

Administrators reported different problems encountered in the process of granting exemptions during in-depth interviews. Problems mentioned by all ten administrators interviewed were leakages, under coverage and failure of compensation from Police cases. The public hospital accountant had this to say

> *"...the biggest problem in exemption system is that there is a good number of leakages and under coverages..."*While the hospital cashier had this to say,
>
> *"... another problem is emergency police cases are treated free and the hospital is not compensated for the costs incurred in treating such cases despite claims that are submitted to the respective government department (ministry)..."*

During the in depth interview in a voluntary hospital, all the five administrators interviewed mention leakage and under coverage as the problems encountered. The voluntary hospital administrator said,

> *"...the biggest problem in the exemption mechanism is the leakage which are many..."*

So, the finding that there are large numbers of leakages and under coverage as reported from both public and voluntary hospitals, shows that the exemption mechanism in these two hospitals is not effective in identifying the poor.

4.7 Efficiency of waiver / exemption mechanism

Efficiency-Ability of any mechanism to rightly isolate as many indigents as possible at a low possible cost

(a) Loss experienced due to granting exemptions

About the issue of loss of revenue, which has been experienced due to exemption in both hospitals, table 4.11 shows amount of revenue lost for the period 1998-2002. The table also shows the reduction of the loss incurred in a public hospital by half in the year 2000 onward and its steady decline from that year. Commenting on that the public hospital accountant said,

> *"...this is the time when capitalization of hospital pharmacies starts which charges 50% of the market price for each item of the drug in the hospital pharmacies instead of the previous amount of Tsh 40 for each item of drug. Also during this period the national workshop on exemption was conducted in Morogoro involving all administrators, accountants and cashiers of all public hospitals in the country. These help us to improve collection of revenues and management of exemption...."*

In a voluntary hospital, the loss experienced has been static for the period 1998-2002.

Table 4.11 Loss in Tsh caused by exemption against total collection in a Public and Voluntary OPD attendances

	PUBLIC (Urban)			VOLUNTARY (Rural)		
YEAR	T/Collection	Loss	%	T/collection	Loss	%
1998	22078200	6912885	31.3	10687000	994111	9.3
1999	20408052	6591129	32.3	11060972	1100670	10.0
2000	54930004	9097410	16.5	11074741	1072274	9.7
2001	62637148	10011661	15.9	12571766	1000190	8.0
2002 May	31902350	4800926	15.0	5997529	482971	8.0
Total	**115,711,354**	**37414011**	**32.3**	**51392008**	**4650216**	**9.0**

Source-Medical Officer in charge Sekou-Toure and Bukumbi hospitals.

(i) Staff working on exemption

When asked on the number of staffs working on the exemption system in the public hospital, the hospital Matron said that,

> *"...About 15 staffs are working in the exemption system. During the working hours, matron assisted with two other nursing officers are responsible for exempting patients. After working hours and on weekends, the supervisors in charge of the shifts are responsible for exempting the patients...*

" Concerning the presence of exemption committee and a Welfare Officer in the public hospital, the hospital Matron added this,

"... The hospital management team is responsible for day to day monitoring of the exemption system. The hospital does not have an Exemption Committee and a Welfare Officer who would exempt patients if he / she was present. I am acting as the welfare officer..."

In the voluntary hospital, the Matron reported that

"...the exemption mechanism operates during working hours only, and the hospital administrator is the only person responsible for granting exemption to patients. The hospital does not have an Exemption Committee and a Welfare Officer. Duties of a Welfare Officer are performed by the Administrator..."

(ii) Training and motivation for the people who work on exemption

On training and motivation for the people who work on exemption, the Medical Officer in charge of the public hospital reported that,

"...there was no formal training neither motivation which had been given to workers who deal with exemption. However, he reported that when seminars on exemption are conducted, then those who are working on exemption are given priority..."

In a voluntary hospital, no training to the administrator who works on exemption.

4.8 Consumers perception on charges and waiver / exemption mechanism

i) Cost incurred in Tsh for treatment of an illness episode

The average expenditure in Tsh incurred by the outpatient respondents to obtain care in both hospitals is shown in table 4.12. The average expenditure on registration, laboratory investigation and drugs in the public hospital were Tsh 1000, 897.40 and 1541.40, respectively.

In the voluntary hospital the average expenditure on registration, laboratory investigation and drugs cost were Tsh 524.70, 1012.20 and 2621.90. The overall mean total cost (out of pocket) for a public hospital was 3481.70 and 4120.00 for a voluntary hospital. This means that the voluntary hospital users pay more on average than public hospital users in laboratory investigation and drug cost. The registration fee in the public hospital is higher than the voluntary hospital. There are 8 missing outpatient respondents in the total registered respondents. The explanation is that these are the patients who were exempted in all procedures i.e. registration, laboratory investigation and drug cost. There is a system in a public hospital where the exempted patients pay registration only and get exemption in the rest of procedures or get full exemption.

Table 4.12 Costs incurred for treatment of an illness episode by type of hospital

COST		PUBLIC (Urban)	VOLUNTARY (Rural)
Registration	n	142	150
	mean	1000	524.70
	Median	1000	500.00
	SD	0	255.132
	Range	0	200—2500.
Laboratory investigation			
	n	117	120
	mean	877.40	1012.20
	Median	500.00	900.00
	SD	581.90	519.70
	Range	500—3500	240—2500
Drug cost	n	134	149
	mean	1541.40	2621.90
	Median	1300.00	2000.00
	SD	1021.60	3887.70
	Range	100—5000	110—40000
Total cost (out of pocket)			
	n	105	113
	mean	3481.70	4158.55
	Median	3300.00	3500.00
	SD	1321.80	4320.00
	Range	1200—8000	1240—43400

ii) Source of user fee

Outpatient respondents were asked the source of money spent on treatment.

Table 4.13 shows that 70% of the respondents in the public hospital paid their treatment cost from out of pocket while 10% of the respondents their treatment cost was met by their employers. About 5% borrowed money in order to pay for their user fee and 14% were exempted. In a voluntary facility 75.3% of respondents paid their treatment cost from their pocket, 17.3% of respondents paid from borrowed money.

About 4.7% of respondents their cost were met by their employers and 2 .7% were exempt.

Table 4.13 Source of money for payment of user fees among outpatient respondents

	PUBLIC (Urban)		VOLUNTARY (Rural)	
Source of user	N	150	N	150
fee	n	%	n	%
Out of pocket	105	70	113	75.3
Employer	15	10	7	4.7
Borrowed money	9	5	26	17.3
Exempted	21	14	4	2.7

iii) Opinions of respondents on the amount of money spent

Respondents were asked to give their opinion on the money they spent on health care in both public and voluntary hospitals. Table 4.14 shows their opinions on the amount of money spent. In a public hospital 46% of respondents found it to be reasonable, 22% found it to be little, 18% found it is too much and 14% they did not know. In a voluntary hospital, 55.3% found it was reasonable, 34.7% found it was too much 7.3% found it is little and 2.7% said they did not know.

Table 4.14 Respondents opinion for money spent in treatment

	PUBLIC (Urban)		VOLUNTARY (Rural)	
Opinion	N	150	N	150
	n	%	n	%
Little	33	22	11	7.3
Reasonable	69	46	83	55.3
Too much	27	18	52	34.7
Don't know	21	14	4	2.7

The respondents, who found the user fee too much, were asked to mention the amount of money they are able to pay. Table 4.15 below shows that in the public hospital, 38.7% of respondents could afford to pay between 2001 and 3000 for health care, 35.5% could afford to pay less than Tsh 1000 for care, 16.1% could afford to pay more than 3000 and 9.7% could afford to pay between 1001 and 2000 for health care.

In the voluntary hospital 45.5%of respondents could afford to pay less than 1000, 40% could afford to pay between 1001 and 2000, 9.0% could afford to pay more than 3000 while 5.5% could afford to pay between 2001 and 3000.

Table 4.15 Amount of money respondents are willing to pay by health facility

Amount of money	PUBLIC (Urban) N 31		VOLUNTARY (Rural) N 55	
	n	%	n	%
< 1000	11	35.5	25	45.5
1001—2000	3	9.7	22	40.0
2001—3000	12	38.7	3	5.5
> 3000	5	16.1	5	9.0

4.9 Problems associated with waiver / exemption system

i) Problems that led respondents not to be granted exemption

Respondents who were not granted exemption were asked the reasons why the exemption was not granted. About 58.9% of the respondents in the public hospital reported that they did not know if the exemption system existed in the hospital, 7.7% said that the exemption procedure was long, 3.1% of the respondents reported to have had denied exemption and 0.8% of the respondents said that health workers would look down upon them and 29.5% of the respondents did not ask for exemption. In a voluntary health facility 53.4% of the respondents did not know the existence of the exemption system in the hospital, 2.1% said the exemption procedure was long 1.4% were denied exemption and 0.7% of the respondents said that health workers would look down upon them.42.5% of the respondents did not ask for exemption. The results show that more than 80% of the respondents from both hospitals were from two categories;

Those who did not know that there is exemption and

Those who did not ask for exemption.

Respondents who requested exemption and were denied in the two hospitals were only 4.5%.

Table 4.16 Problems that led respondents not being exempted

	PUBLIC (Rural)		VOLUNTARY (Urban)	
	N	129	N	146
Problem given	n	%	n	%
Procedure is long	9	7	3	2.1
H/workers will look down on you.	1	0.8	1	0.7
I did not know that there is exemption	76	59.4	78	53.4
I did not ask for exemption	38	29.7	62	42.5
I was not given exemption	4	3.1	2	1.4

4.10 Health providers opinion on the exemption system

In depth interview was conducted with 10 health providers to seek their opinion on exemption in each health facility. The table 4.17 below shows different responses to questions / issues discussed.

Table 4.17 Opinions of the health providers on exemption system

ISSUE	PUBLIC FACILITY (N = 10)	VOLUNTARY FACILITY (N = 10)
1. Knowledge of the existence of exemption in the hospital.	All of the health providers interviewed knew of the existence of the exemption system in the hospital.	6 of the health providers knew the existence of exemption in their hospital. 4 reported that they did not know that an exemption mechanism existed.
2.Health providers involvement in the management of the exemption system.	9 of the respondents are not involved in the management of exemption mechanism 1 of the respondents who was the head of a section was involved in the management of the exemption.	All respondents are not involved in the management of exemption mechanism in the hospital.
3.Health providers involvement in the exemption committee.	The facility had no exemption committee; instead hospital management team caters for exemption. Only 1 of the respondents is involved.	All respondents are not involved in the exemption committee.
4.Suggesting exemption to patients.	All of the respondents on several occasions have suggested exemption to the patients.	All of the respondents have never suggested exemption to the consumers.
5.Opinion of the health providers on the current operation of exemption if it was good enough in isolating the poor.	All respondents praised the exemption system as good although they cited leakage, under coverage and bribery as the main problems.	All respondents blamed the exemption system as inefficient in isolating the poor.
6.Opinion of the health providers to improve the exemption system.	7 of the respondents suggested that honest people should be appointed to deal with the exemption. 2 suggested on educational campaign to the people and health providers on exemption. 1 of the interviewees suggested on the formation of exemption committee and the health providers and consumers should well know criteria for exemption.	6 of the respondents suggested that a fully functioning exemption system should be established. 2 said that there is a need for a government subsidy to support the exemption system in voluntary hospitals. 2 suggested a need for a transparent in exemption system. 1 mentioned the need for a formation of an exemption committee and 1 said that Ten Cell Leaders should be involved.

i) Knowledge of the existence of exemption in the hospital

All providers of the public hospital knew about the existence of exemption and one senior Medical Officer commented on this by saying

"...we praise the government for putting the exemption in place because many poor people are benefiting on this exemption system..."

In the voluntary hospital, 6 health providers knew the existence of the exemption in their hospital but 4 respondents did not know. The hospital anesthetist said this

"...I have worked here for two years but I have never seen any one exempted here...."

ii) Health provider's involvement in the management of the exemption

Nine of the public hospital respondents reported that they were not involved in the management of the exemption. One Nursing Officer said

"...the day-to-day management of exemption is done by the hospital management team and unless one is a member of the management team, he / she will not be involved in the management of the exemption..."

In a voluntary hospital, all the respondents reported they were not involved in the management of the exemption. An Assistant Medical Officer working at the Out Patient Department said,

" ...it is the hospital administrator who normally is responsible for exemptions...."

iii) Health provider's involvement in the exemption committee.

Among the respondents in the public and voluntary hospital, none was a member of exemption committee since there was no exemption committee in both hospitals.

iv) Do health providers suggest exemption to patients?

All health providers in the public hospital suggest exemption to patients. One senior Clinical Officer said that

> *"...we normally suggest exemption to patients whom we find unable to pay for the prescribed treatment during the ward rounds and at out patient department. Suggestions normally are accepted by the exemption team who normally came to assess those patients unable to pay..."*

In the voluntary hospital all respondents had never suggested a patient to be exempt. One Clinical Officer said,

> *".... we normally refer every patient unable to pay to the administrator for assessment...."*

v) Opinion of the health providers on the current operation of exemption

All the public health providers interviewed praised the exemption system as good although leakage, under coverage and bribery were mentioned as the main problems. One Clinical Officer said

> *".... the operation of exemption is good but there are many leakage from relatives of the health providers...."*

Another health provider, a Clinical Officer said,

".... There are chances for bribery especially to the Ten Cell Leaders when recommending patients for exemption...."

One, a senior AMO, said

".... little has been done to advertise the existence of exemption in the hospital therefore not many people who are supposed to be exempted knew the existence of exemption here...."

In the voluntary hospital, all the health providers blamed the exemption mechanism as inefficient because was administered by one person, and the system is not present all the time. One Nurse midwife said

".... more poor people are not well covered by the present operation of the exemption because one person working on exemption is not enough and the fact that the system is present during working hours only creates more obstacles for the poor..."

vi) **Opinion of the health providers to improve exemption system**

In the public hospital 7 health providers suggested that honest people should be appointed to deal with exemption. One Assistant Medical Officer said,

"...Honest people should be appointed to deal with exemption because there are cases of relatives of health providers being favored while the real poor

are missing the chance...."

Two health providers suggested on education campaign to be carried and one, a Clinical Officer said, *"....If exemption will be advertised like 'ngao', there will be a good number of poor people benefiting...".*

Another health provider, a Nursing Officer insisted on the exemption committee by saying

"...an exemption committee should be formed and deal with exemptions only...."

In the voluntary hospital, 6 of the health providers suggested the formation the exemption committee. One health provider a Clinical Officer said,

"...The formation of exemption committee will help in isolating the real poor, a work which is now under one person...."

Another health provider, an Assistant Medical Officer insisted that,

"...There is a need for government subsidy to help the exemption system in voluntary hospital because their resources are limited...."

One Nurse Midwife said,

"...Ten Cell Leaders should be involved fully in recommending the poor for exemption and the people should know that the Ten Cell Leaders are involved...".

CHAPTER FIVE

5.1 DISCUSSION

The government of Tanzania introduced user charges in public district hospitals in 1994. In conjunction with user fee, the government introduced exemption mechanism to maintain access and equity for the poor and vulnerable groups for health care. The findings from this study which was looking into the strategies for promoting access for the poor and vulnerable groups within a public and voluntary hospitals user fee systems found ineffective and inefficient of the strategies.

On accessibility to hospitals, the study shows that in a public hospital, respondents who are living near the hospital have easy accessed the facility than in a voluntary hospital. The difference that is observed is probably that the voluntary hospital receives patients from Mwanza city and other areas along the high way to Sengerema where the voluntary hospital is located. The exempt patients in the public hospital are steadily increasing in number each year, from 1998, this could have been caused by a high rate of leakage and under coverage that have been found to be a problem in the hospital. A study conducted in Dar-es-Salaam City Hospitals, (Hussein, 1995) also found a high type 1 error, which means, when the non-poor receives benefits intended for the poor.

Concerning the prices of services, the study found high prices in the voluntary hospital compared to those of the public hospital and this can probably be an explanation of the low turnover of the patients in a voluntary hospital. The fact that,

being in rural area, the voluntary hospital is faced with a competition from government owned health facilities, which provides free health care around the catchment area that may have an impact of reducing attendances in the voluntary hospital. The high pricing structure in voluntary hospitals than in the public hospitals were also reported by Msamanga et al (1996).

On respondents who were aware of the existence of exemption system, they were few in number in both public and voluntary hospitals. However, it was found that little has been done to inform the public on the existence of exemption since there were no any posters, flyers and any advertisements or announcements on walls found in both public and voluntary hospitals surroundings, that would be one of the sources of information on the existence of the exemption mechanism to the public. Few who were aware of the existence of exemption (35.5%) for public and (26%) for voluntary, got that information from the radio and health workers. A study by PHR*plus* (2000) reported similar findings, that radio and health workers was the main source of information to most of the respondents in a study done in Korogwe district on health financing policy reform in Tanzania.

The exempt patients in a public hospital were found to be increasing steadily and those in a voluntary hospital were somehow static. The fact that many people work on exemption system in the public hospital than in the voluntary hospital make the exemption mechanism in a public hospital to look attractive than in a voluntary hospital where one person work on exemption. It is likely that people in a voluntary hospital find exemption process long and cumbersome because there is one person

handling people who are sick. This could discourage sick people from requesting exemption. Oester (1998) in a study done in Dar es Salaam public hospitals also established that the exemption system was long and has bureaucratic tendencies in its management.

The documentary review of the patients attendance show that there is a higher loss of revenue in public hospital compared to the voluntary hospital. This could be due to the big number of exemption given in the public hospital. However, interestingly there is a significant drop of loss by half in the year 2000 and a continuing steady decreasing for three years. The explanation for this is probably that now there is the capitalization of hospital pharmacies, which force the hospital pharmacies to charge each item of drugs by 50% of the market price from the previous charges of Tsh 40, and this increases the revenue collected. Another explanation could be the results of the national workshop for exemption management, which involved the administrators and accountants of all public hospitals in the country. This workshop involved training on revenue targeting and financial control in government hospitals, which was conducted in the year 2000. Probably this helped to minimize the loss.

Workshop to train health workers on management could be encouraged to improve skills for managing finances in public hospitals. A study by Vogel as quoted by Barbara McPake (1993) found that administrative capacity to be crucial in raising the revenue and in their study Russell and Gilson (1997) found that health workers lacked skills and time to accurately and consistently assess people's ability to pay.

This study shows that voluntary hospital users spend a little more than public hospital users in all cost categories. This finding can be explained by the fact that prices in the voluntary facility were higher than in a public hospital. A study by Newbrander and Sacca (1996) on cost sharing and access to health care for the poor, equity experience in Tanzania, also established that prices for care in voluntary hospitals to be higher than public hospitals.

The fact that this study found that 6% of the respondents in public hospital and 17.4% in the voluntary hospital had to borrow money in order to pay for their health care, implies that some respondents had difficulties in paying for health care and that they would need and benefit from exemption. A study on user charges on non-governmental organization hospitals in Tanzania conducted by Mujinja and Mabala (1992) reported that some of the hospital users had experienced difficulty in paying for health care and sometimes had to work for the hospital in different capacities to compensate for treatment costs when their illnesses had improved. In this study, respondents who found difficulties in paying for health care at the voluntary hospital had to deposit a collateral security in order to be granted exemption and bring the payment after recovery.

About 46% and 55.3% of respondents in both public and voluntary hospitals respectively, found the price for health care reasonable. This finding differs with Msamanga et al (1996) study that found the user fee was moderately expensive. Probably the explanation for this difference is that the methodology of the two

studies differs, the Msamanga et al study also interviewed communities on issues related to pricing and user fees in public and private health facilities.

Health providers of the public hospital are involved in management and day to day monitoring of exemption more than those of the voluntary hospital through their hospital management team and in their routine clinical work and could suggest exemption to patients. Probably this makes the exemption system of the public hospital better than that of a voluntary hospital. Msamanga et al (1996) findings differ from those of this study, because they found the exemption system in voluntary hospitals better than the public hospitals.

Loss of revenue due to exemption and high type I and II errors were found and mentioned by administrators to be the problems that affect effectiveness and efficiency of exemption system in both hospitals studied. Possible explanations were lack of enough trained staff to work on exemption and lack of advertisement on the existence of exemption to the public.

Government subsidy to help the voluntary hospitals whose revenue is not enough to run the hospital and the exemption system was suggested by health providers. This study found a decline in revenue in the voluntary hospital therefore there is a need for these facilities to be helped to improve quality of health services delivery and consequently improve the functioning of the exemption mechanism.

CHAPTER SIX

6.1 CONCLUSION.

In conclusion, the study has shown that the strategies implemented by the public and voluntary hospitals are not well strategized and hence not very effective and efficient in identifying the poor in user fee system.

The presence of exemption mechanism in both public and voluntary hospitals is not well known to the people due to the fact that little has been done to advertise its presence. The exemption procedure is ineffective in isolating the poor as is associated with long process, leakage and under coverage. The procedure used have been found to be inefficient since it is associated with high loss in funds in the public hospital and in voluntary hospital difficult in running the system due to financial constraints.

In both public and voluntary hospitals there were no purposeful efforts geared at training people to work on exemption, and hence no motivation to improve effectiveness and efficiency of managing the system. In voluntary hospital, little has been done to involve health providers on management of exemption, which again increase its inefficiency and ineffectiveness.

6.2 RECOMMENDATIONS

To reduce inefficiency and ineffectiveness of the system, the following are therefore recommended:

1. Deliberate measures are needed to be taken by the hospitals to advertise the presence of exemption mechanism in their hospitals.

2. The public should know the process of exemption and the involvement of ten cell leaders in recommending exemption.

3. Hospitals should have exemption committees, which will oversee the day to day running of exemption.

4. A need to have trained non-medical personnel in exemption instead of using medical staffs.

5. A need for a government to subsidize the voluntary hospital in order to make them able to run their exemption systems.

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