FACTORS CONTRIBUTING TO LOW COST SHARING COLLECTIONS IN HEALTH SERVICES IN MUNICIPAL COUNCILS IN TANZANIA:
THE CASE OF KINONDONI MUNICIPAL COUNCIL

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THE CASE OF KINONDONI MUNICIPAL COUNCIL

By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for Award of the Degree of Master of Accounting and Finance (MSc A&F) of Mzumbe University

2013

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University a dissertation entitled: **Factors contributing to low Cost Sharing Collections in Health Services in Municipal Councils: A case of Kinondoni Municipal Council**, in partial fulfillment of the requirements for award of the degree of Master of Science in Accounting and Finance of Mzumbe University.

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I, Rose Pantaleo Mutale, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any university for a similar or any other degree award.

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DEDICATION

This dissertation is dedicated to God the Creator of the universe, my husband and children for their incredible support during production of this academic work.

ABBREVIATIONS AND ACRONYMS

CHF	-	Community Health Fund
DMO	-	District Medical Officer
HSR	-	Health Sector Reforms
KMC	-	Kinondoni Municipal Council
LAF	-	Local Financial Memorandum
LGA	-	Local Government Authority
LGFA	-	Local Government Finance Act
LGRP	-	Local Government Reform Programme
NHIF	-	National Health Insurance Fund
PMO-RALG	-	Prime Minister's Office-Regional Administrative and Local Government
WEO	-	Ward Executive Officer

ABSTRACT

The study investigated factors causing low revenue collection from health service cost sharing in municipal councils in Tanzania. Kinondoni Municipal Council in Dar es Salaam was taken as the case study. The study population involved patients from different health service provision points which are operated by Kinondoni Municipal council. The health service provision points include hospitals, health centre and dispensaries. The locus population for this study was Mwananyamala and Sinza hospitals, Magomeni heatlth centre and Kimara and Mbezi dispensaries.

The study sample constituted 141 patients which were obtained through purposive and convenience sampling design. Data were collected using questionnaires, interviews and observation. Secondary data was collected using documentary sources.

The study findings reveals that common factors for low revenue collections through cost sharing are: lack of adequate sensitization of people on the importance of cost sharing in health service provision, fraud done by council employees and recruitment of personnel to carry out the task of revenue collections who are not professional accountants. Other factors include low income among citizens, poor control systems within the council and the act of employees entrusted with running of the programme to waive cost sharing charges for some people who are not eligible for the same. The study concluded that the perceptions of patients towards cost – sharing is positive, it is further concluded that various factors contribute towards low collections of revenue through cost sharing.

The study recommends that deliberate efforts be taken to rectify the situation by setting aside adequate resources for sensitization campaign progrmmes, recruiting the right personnel to carry out the collection task, improve control systems to curb fraud, abstain waives. Should the above recommendation be taken on board, revenue collections from health service provision cost sharing will increase.

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CHAPTER ONE
INTRODUCTION

1.1. Background Information

Governments increasingly face an acute fiscal challenge of rising medical expenditures especially due to aging population and expansion of coverage spending growth for Medicare (Anderson and Hussey, 2000). Resources are scarce. Scarcity means that each society must make important decisions regarding the consumption, production, and distribution of goods and services as a way of providing answers to the following basic decision; the mix of medical goods and services that should be produced in the health economy, the specific health care resources that should be used to produce the chosen medical goods and services and the receiver of the medical goods and services that are produced (Santarre and Neun 2010). Some of the increase in health care spending is attributable to demographic changes. On the other hand, the real increase in spending on prescription drugs, office-based visits, hospitalizations, and all other personal care. The aging population and expanding spending on medical care has resulted into inadequacy of provision medical services (Anderson and Hussey, 2000). Given the increased spending in health care, governments found themselves unable to generate adequate fund to provide necessary social service like health service. In view of the same, citizens are required to share the cost of health services provision.

The cost-sharing policy in the Tanzanian public health service system was introduced in July 1993 as part of economic recovery and structural adjustment programmes aiming to improve efficiency and foster sustainability in the provision of health services through community participation (Munishi, 1997) To enforce the referral system and to enable the citizens to get familiar with the cost sharing system, the Ministry of Health (MoH) planned to introduce user charges in two phases, beginning with referral hospitals and then after a few years with health centres and dispensaries.

According to the government national cost sharing policy guidelines, children under the age of five years and pregnant women are eligible for exemptions from user charges for basic services. Other groups of eligible people include those presenting illnesses associated with diabetes, cancer, meningitis, TB and leprosy, HIV/AIDS, and people attending for family-planning-related services (MoH,1994, Mbiji et al 1996) The national above deserve exemptions from user charges, the information that had also been published in most of the local private newspapers.

In order to increase coverage of health services provision in Tanzania, the implementation of cost sharing is decentralized at the level of local governments. At the local governments, health service cost sharing is entrusted to municipal councils as one of the source of revenue generation. Each council has been revisiting the taxes, fees and charges with the aim of dropping those taxes, fees and charges which are uneconomic to collect and those which border on nuisance. The development levy and livestock cess were abolished by the Government as part of the rationalization of local government sources of revenue. Councils now have to employ improved procedures of revenue collection from the remaining sources so that all the revenue estimated to be collected from them are actually collected (The Local Government Act of 1982).

Following the principle that a government should be able to raise funds for meeting the cost of running its activities including the delivery of services and financing development projects, local government authorities in Tanzania have sources of revenue which fall into two broad groups own sources of revenue from central government, Grants and council own sources (The Local Government Act of 1982). Here under is the elaboration of it.

1.1.1 Own Sources of Revenues From Central Government and Grants

Grants it deal with financing the developments projects and sources from central government subsidies the services and for paying salaries to LGAS.

1.1.2 Councils' Own Sources of Revenue

The Local Government Act of 1982 and its amendments of 2012 and the Urban/District Authority Act of 1983 empower any Local Authority to pass by-laws, which allow the Authority to charge local taxes and collect levies and fees within its area of jurisdiction.

Councils collect revenue from their own sources which fall under the following categories:

i) Various taxes imposed by the councils including property tax, service levy and rent charged for the use of council properties;

ii) Various fees imposed by councils to allow the carrying out of certain activities in their areas of jurisdiction e.g. trade license fees, intoxicating liquor license fees, registration fees for taxi cabs and commuter taxi buses; and

iii) Fees and charges levied by councils on the people who make use of services rendered by the council or those who use its facilities e.g. abattoir fees, ambulance fees and dipping fees.

The principal Act governing the financial operations of all local authorities in Tanzania is Act No.1982 and its amendments of 2012, which has purpose to make provision for sources of revenue and the management of funds and resources of Local Government Authorities, and for other matters connected to or incidental to securing the proper collection and sound management of finances in the Local Government System.

The revenue rationalization and harmonization have significant impact on the profile of Local Government revenue in Tanzania. Three significant reforms were introduced in June 2003. First, the Government of Tanzania decided to abolish the Development levy; second, the Government reiterated the maximum rate of 5% for Agricultural cess. Third, the government eliminated a number of nuisance taxes. These changes brought a significant alteration to revenue patterns from the 2003 onward (The Local Government Act of 1982).

In 2004, a major reform of business licenses was implemented, sharply reducing the yield of business license fees collected by Local Government Authorities. In fact this is a stuck point, a real problem (decrease own source revenues), hence Kinondoni Municipal council as one of Local Government Authorities need to be helped, professionally so that they can do better from their remained own source of revenue collection by assessing the factors affecting revenue collection and how they can help the Municipal to have a sustainable revenue collection.

The purpose of this study is to carry out an assessment on the factors for low cost sharing collections in health services in municipal councils. Obviously, there is various revenue sources in the councils, the study focused on factors for low cost sharing collections in health services in Kinondoni municipal council.

1.1.3 Vision Mission Statement

Every organization has a mission, a purpose, a reason for being. Often the mission is why the organization was first created to meet a need identified years ago.

1.1.3.1 Mission of Kinondoni Municipal Council

Provision of quality services to the community through effective and efficient use of resources, capability building, good governance and rule of law hence improve the living standard of people.

1.1.3.2 Vision of Kinondoni Municipal Council (KMC)

Vision of KMC is to have “a community which is motivated, dynamic, with socio – economic development”

1.2 Statement of the Problem

Cost sharing in health services was introduced by the government with the purpose of reducing the burden of health provisions to her citizens, at the same time using the collections from the same for improving quality and expanding the level of health provision to her people.

The expansion of health provision include, establishing new dispensaries, expansion of health centers and hospitals in new areas and expansion of current health services.

At the level of local governments especially in Municipal councils, the exercise was expected to enable the councils to reduce burden and improve service provisions. However in Kinondoni Municipal Council (KMC) the trend of collection has been low to the extent of impending the achievements of the objective of health services cost sharing. Low revenue collection in KMC has resulted into failure on the implementation of different health service development projects like acquisition of health provision facilities, construction of dispensaries, health centers and new hospitals. The problem has led to inefficient performance of the council in terms of quality health services provisions which also cause poor contribution to economic development at the level of municipal council and the nation at large. On the other hand poor health services provisions has resulted into poor living standard of the people in the areas served by the council.

A number of studies have been conducted about inefficient performance of Municipal councils. However the studies concentrated on sources of revenue other than cost sharing in health services. Since little attention has been paid to health services cost sharing, which is the biggest obstacle to the Municipal performance in health provision sector, the study intended to find out factors that contribute to low collection resulting from cost sharing in health services in Kinondoni Municipal Council so as to generate information that will be used as a tool for policy making, decision making and source of solutions to the problem under study.

1.3 Objectives of the Study

The overall objective of the study was to assess factors contributing to low cost sharing collections in health services in municipal councils.

1.3.1 Specific Objectives

(i) To identify perceptions of patients towards health services cost sharing in municipal councils

(ii) To examine factors towards low health service collections from cost sharing in municipal councils

(iii) To determine challenges facing the implementation of health cost sharing policy in municipal councils

1.4 Research Questions

The study was guided by the following research questions:

(i) What are patients' perceptions towards health service cost sharing policy in municipal councils?

(ii) What are the factors for low health services collections from cost sharing in municipal councils?

(iii) What are the challenges facing the implementation of health service cost sharing policy in municipals councils?

1.5 Significance of the Study

The study is in line with the Millennium Development Goal number four (4) which advocates for reduction of both infant and maternal mortality rates. The National Strategy for Growth and Reduction of Poverty (NSGRP) or MKUKUTA as in commonly known in Kiswahili also emphasizes on eliminating extreme poorly. However, this can only be done if the health of the nationals is good. Healthy citizens are likely to work hard and eliminate poverty among them. Identification of the problem facing the council in collecting sufficient revenue in health facilities will assist in addressing health problem in the council.

CHAPTER TWO
LITERATURE REVIEW

2 .1 Introduction

The first part of the chapter provides definition of key concepts used in the study. These include cost sharing and user fee. The second part of the chapter describes experiences of cot sharing in East Africa while cause s of cost sharing are explained in part three of the chapter. Causes of low collections are discussed in part four of this chapter. Implication of cost sharing on the use of public health facilities is given in part five of this chapter. The importance of cost sharing in provision of health services are explained in part six of the chapter. The perception of cost sharing in health services are discussed in part seven of this chapter. The empirical literature is reviewed on the topic is given in part eight of the chapter. The last part of the chapter provides the conceptual framework of this study.

2.2 Definition of Key Concepts

2.2.1 Cost Sharing

A provision of most health funding systems that requires the individual who is covered to pay part of the cost of health care received. Multiparty arrangement under which costs of a program or project are shared by the involved parties, according to as agreed upon (Gerller, 1987) Cost sharing is a process wherein two or more individuals or entities work together to secure savings that one alone would be unable to obtain. Such partnerships may be pursued in order to realize intended objectives, for in health increased quality of service, expansion of services to areas not currently served access to technology, reduce expenses through economies of scale , etc (Anderson and Hussey, 2000).

2.2.2 Health Care Spending

Health care spending has increased worldwide dramatically in past two decades (*Santarre and Nenu, (2010).* Some of the attributes of the increase in health care spending is demographic changes (Cutler and Muney, 2006). Despite taking care of the expanding changes in demographic, health care spending have risen very much due to increase in wages and technological advancement which have led to significant increases in labor and other production costs in the economy (such as the manufacturing sector) together have resulted in increase in service production cost in health industry.

2.2.3 User Fee collection and Expenditure

User fees are charges for health care at the point of use. User fees were intended to combat three aspects within health service sector: improving efficiency by moderating demand, containing cost, and mobilize more funds for health care than existing sources provided. (Griffrin, 1995). Cost sharing and user fee are used interchangeable to mean money one must pay in exchange for the ability to use a service. User fees generally are collected by municipal governments. For example, one may pay a fixed fee every month for sewer services. A fee charged for the use of a product or service. Unlike a tax which is imposed upon the general population, the user fee is charged to an individual only when that individual uses the product, service, or commodity. A toll charge is an example of a user fee. It is called excise tax (Yoder, 1989).

Health workers and community leaders are aware that the collection and expenditure of revenues from user charges has to follow the officially acceptable policy guidelines, although local authorities had some mandates to oversee the process in line with the decentralization policy. The government guidelines stipulate that the revenue collected from user fees must be used to improve health services at the health facility in question, although all the planned or contingency expenditure of that money at local level must be approved by the DMO's office. Each health facility has a health facility management committee, comprised of members of primary health-care committees at village and ward level, led by the village government chairpersons of the localities in which the

health facilities in question are. As per the established guidelines, the secretaries of such health-facility committees are those in charge of the respective health facilities. They are responsible not only for keeping the minutes for each committee meeting held but also for executing the committee's planned activities in liaison with the committees' chairpersons (Mubyazi, 2005). Other members of this committee include representatives from different sectors — agriculture, education, water and at least one woman to represent the women in the community. According to the explanation given by health facility staff and community leaders and then confirmed by the DMO, the facility committee normally meets to identify the priority service areas requiring user-fee funds, and send their budget plan and minutes to the DMO within the limits of the revenues collected in a specific period (Mubyazi, 2005).

2. 3 Cost sharing in East Africa

2.3.1 Tanzania

2.3.1.1 The history of health cost sharing in Tanzania

For a period of almost thirty years, health services delivery used to largely a prerogative of the state, only a limited number of private-for-profit health services were provided in major towns of the country. After independence, health care facilities were re-directed towards rural areas and free medical health services were introduced except for Grade I and II. In 1977 private health services for profit was banned under the Private Hospitals (Regulation) Act and the practice of medicine and dentistry prohibited as a commercial service. This Act had negative implications on health services in the country (URT, 2003)

However, after a series of major economic and social changes, the Government adopted a different approach to the role of private sector. New policies were developed that looked favorably on the role of the private sector. The importance of the private sector in health care delivery was further recognized with an amendment to the Private Hospitals (Regulatory) Act, 1977 which resulted into the establishment of the Private Hospitals (Regulation) (Amendment) Act, 1991 URT, 2003)

2.3.1.2 Health Sector Reforms

The Ministry of Health appraised the health sector performance with the intention of raising strategies to improve quality of health services and increase equity in health accessibility and utilization. This appraisal came up in the report named "Proposals for Health Reforms, Ministry of Health, 1994 (HSR)". The reforms are in the following dimensions: managerial reforms or decentralization of health services; financial reforms, such as enhancement of user-charges in government hospitals, introduction of health insurance and community health funds and public/private mix reforms such as encouragement of private sector to complement public health services. They also include organisational reforms such as integration of vertical health programmes into the general health services; health research reforms such as establishment of a health research users fund and propagation of demand oriented researches in the health sector (URT, 2003).

2.3.1.3 Objective of health sector reforms programme

- Improve access, quality and efficiency of primary health (district level) services.
- Strengthen and reorient secondary and tertiary service delivery in support of primary health care.
- Improve capacity for policy development and analysis, development of guidelines for national implementation, performance monitoring and evaluation, and legislation and regulation of service delivery and health professionals.
- Implement a human resource development programme to ensure adequate supply of qualified health staff for management of Primary, secondary and tertiary services.
- Strengthen the national support systems for personnel management, drugs and supplies, medical equipment and physical infrastructure management, transport management and communication.
- Increase the financial sources and improve financial management.
- Promote private sector involvement in the delivery of health services.
- Within the sector-wide approach, develop and implement a system for donor involvement, co-ordination, monitoring and evaluation.

In early 2004, Research for Poverty Alleviation (REPOA) commissioned ETC Crystal to examine the equity implications of health sector user fees in Tanzania, with particular reference to proposed and actual charges at dispensary and health centre level. This year, 2005 Tanzania will review its Poverty Reduction Strategy. With the findings of the user fee study, REPOA aims at making a valuable contribution to the review process and provide country-specific insight into one of the most debated issues in health financing (REPOA, 2005).

A few years after the country had gained political independence from colonialism, the Tanzanian government launched the Arusha Declaration in 1967. Under this declaration, all major social and economic sectors were nationalized. In relation to health, one of the purposes of the Arusha Declaration was to ensure universal access to social services to all the citizens, the majority of whom were (as they still are) poor and rural. The perople regarded as being poor were those who could hardly pay for their essential needs, such as health and education (Mubyazi, 2005).

The Arusha Declaration was followed by the Decentralization Act of 1972. This was aimed, among other objectives, at building regional, district and village capacity to effectively participate in decision making, planning and implementing activities for their own development, health in particular. The government banned the private for-profit medical practice in 1977 and continued to finance and provide health services free of charge to all citizens seeking care from government health facilities. However, mission health facilities continued to operate as private not-for-profit organizations by charging their patient clients, as they had been doing even before independence (Gilson, 1997).

Due to poor national economic performance, escalating costs of public health care service provision, emergence of pandemic diseases such as HIV/AIDS and changes in patterns of other diseases, the government's ability to continue providing free health services to all citizens decreased.

Consequently, establishing other resource bases for financing health services was viewed as a means of improving the availability and quality of health care delivered in the country (MOH, 1994), as is also advocated elsewhere in the world (McPake, 1993).

In July 1993 a cost-sharing policy was launched in the Tanzanian public health sector. User fees began to be implemented in phases at referral, regional, and district hospitals for some services that had previously provided free of charge. According to the government's health sector reform policy agenda, cost-sharing was planned to be extended to health center and dispensary levels so that communities would participate in financing their health care needs through formal and informal risk pooling mechanisms (MOH, 1996).

The inadequate performance of primary health care delivery systems in Tanzania, like many other sub-Sahara African countries is a critical issue in contemporary health sector reform strategies, research, and policy debates. The key question is, what changes are necessary at the organizational and process or functional levels of the health sector in order to enhance the performance of the primary health care provision within the districts under decentralized hierarchies. There has also been concern about the contents and direction health sector reforms should take, the level to which they should extend (national, district, or village level), who will benefit from reform, and whether the primary health care guidelines developed by the World Health Organization (WHO) will be effectively and successfully implemented, taking into consideration the capacity of management at various levels in the health sector (Green, 1992).

The primary goal of the Tanzanian health sector reform is to improve the population's health through better health sector planning and management that would consequently contribute to a reduction in the government's health budgetary constraints. Despite several previous studies, little information is available concerning the real impacts or implications of the recent and current health sector reform strategies on the health conditions of the population.

In any health system, the poor and high health risk groups are the most likely or sensitive groups disadvantaged by interventions that "touch" their health in any way (Shafto, 1976).

Following the introduction of user fees at public health facilities in Tanzania, several studies were conducted to assess the impact of such fees on people's health seeking behavior, including their utilization of alternative health facilities (private and public). Some of the studies attempted to look at the impact that the introduction of fees in public/government health facilities had on the private health care utilization by the communities in the catchment areas (Wyss et al, 1996). According to Sparke, (1996), notwithstanding variations in the results and discussions presented, the studies justify what is already reported from other studies in developing countries—that user charges have some deterrent effects on health care seeking behavior of the poor population groups. Unfortunately in Tanzania, none of the previous studies had looked at and reported on the impact of health care charges on patients suffering from specific illnesses, such as malaria, which is endemic in many areas but is not currently exempted from fee charges. According to the WHO, there is an increasing research and policy concern in sub-Saharan Africa that some malaria patients might need to be considered for exemptions from user fee payments.

According to the literature, populations living in different epidemiological, cultural, and socio economic settings are likely to have different preferences of health providers, different willingness and ability to pay for basic needs, and different utilization of basic and non-basic services. This is a very important point to be considered by decision makers in any social sector such as education and health.
The health care sectors in several sub-Saharan African countries have traditionally used alternative options or mechanisms of payment; some have been introduced in recent years and others are still being considered as part of the strategies for reforming their health care financing policies (Sparke, 1996).

As was described above, Tanzania has been implementing patient user fees in Government hospitals and private health facilities since 1993, and mission health facilities are reported to have been charging patients since before independence in 1961. Some researchers have found that mission health care providers sometimes accept in-kind (non-monetary) payment, such as casual labor, from patients who cannot promptly pay in cash (Mujinja and Hausmann, 1997).

Even if such mission providers have succeeded in mobilizing such in-kind payments, the key questions arising are (i) What kind of in-kind payments are preferred (ii) How and to what extent have they been used in Korogwe district? (iii) To what extent do communities who are the users, and health facility owners or staff who provide services, accept such payment mechanisms? (iv)How do the communities in this study distinguish the poor—from the poorest to the less poor, and from the rich—and how do they suggest the poorest could be protected from health care charges? (v) What were peoples' attitudes towards the government policy to charge for publicly provided health care, and what did they suggest as an alternative or should have been done instead?. The study obtained ethical clearance by the National Institute for Medical Research on behalf of the Tanzanian Ministry of Health before it started to be implemented. Readers may ask why the study assessed alternative means or mechanisms of payment for health care employed or preferred, and the ways these means or mechanisms would be implemented. It is because findings may be useful not only to those with academic interests, but also to decision makers at various levels in the health care system, particularly those who have little opportunity to read up-todate research reports and publications relating to health care financing policy reforms in Tanzania (Mujinja and Hausmann, 1997) .

In its "agenda for reform" policy initiated in 1987, the World Bank advised African and other developing countries to establish alternative payment mechanisms in order to increase accessibility, efficiency, equity, and effectiveness in their health care delivery systems.

This advice originates from an economic hypothesis (sometimes empirically verified) that user fees paid in cash deter utilization of health care by the lowest-income population groups. Following UNICEF's Bamako Initiative of 1988, various countries in Africa and the rest of the developing world started to establish alternative community financing mechanisms in their health care systems (Green, 1992).

In Tanzania, the most popular and traditional mechanism of payment has been user fees paid directly by patients at public and private health facility counters. Although at public/government hospitals they were introduced in recent years, evidence that user fees having some negative impact on patient attendance at public hospitals in Tanzania has increasingly been documented as will be cited later in this report. Other mechanisms considered include drug revolving funds, community health funds (CHFs), and health insurance schemes. CHFs had been advocated as a prepayment mechanism and alternative to user fees particularly for those living in rural areas and who might face difficulty in paying cash for health care services at the point of delivery (MOH, 1994).

The Tanzanian government, with assistance from the World Bank, established a community health fund scheme that was piloted in several districts in the country. The annual membership fee for the people who voluntarily join such a scheme is 10,000 Tanzanian shillings (Tsh) per member. However, the government and the World Bank subsidize this by contributing Tsh 5,000 for each citizen who becomes a member of the CHF scheme; members contribute the remaining Tsh 5, 000. This entitles them to receive the scheme-defined package of medical care free of additional charge. The government is in the final arrangements to start implementing a national health insurance scheme for civil servants and some of their dependants. This is a typical compulsory health care prepayment system under which civil servants who, according to the existing statutory requirements, automatically become members and are obliged to contribute a certain premium through their payroll salaries; the government contributes an equal amount for each member.

All these schemes (direct fee for service, prepaid CHF and national health insurance) are formal mechanisms intended to involve communities in financing their health care needs, which consequently are envisioned to enhance efficiency, coverage, and equity of the existing health care delivery systems. In the public sector context, the new payment mechanisms established would contribute towards reducing the government's burden of being the sole provider and financier of public health services (MOH, 1994).

Non-monetary means of payment (payment in kind) proposed by some Tanzanians include farm crops, casual labor, animal products, and other household property, depending on what the persons concerned would wish to dispose. In Tanzania, for example, it had been reported that some mission health facilities have accepted in-kind payment from poor people, particularly those who claimed and seemed to have no ability to afford the cost of their medical care needs by paying in cash terms. Other poor have been given piece of work (casual labor) estimated to be equivalent to the cost of care they had been provided. There are those who strictly prefer payment in monetary terms to non-monetary payments but suggest that such cash payments be made by installment by those with low ability to pay. The idea behind this suggestion is that, if people who face difficulties in paying the full charge of their health care needs in money terms were allowed to pay by installment, few people would complain of not affording fees on medical services (Mujinja and Hausmann, 1997)

2.3.2 Kenya

Cost sharing is variously called by such terms as user fees, co-financing, and cost-recovery. In Kenya, the introduction of user fees was the first reform in the health sector. As part of health sector reforms, cost sharing in public health facilities was meant to improve the provision of quality health care services. Funds generated from user fees would supplement government's diminishing expenditure allocated to health care services and, therefore, would ensure continued provision of health care services through supply of drugs and medical equipment, as well as in maintaining and expanding health facilities (Mbugua et al, 1995).

Health sector reforms in Kenya were tailored to meet Kenya's health sector policy goal of providing accessible, affordable and efficient health care services to all Kenyans. Before their implementation, it was feared that health reforms would marginalise the poor and vulnerable in accessing health care. However, the government of Kenya took care of this concern by introducing the system of waivers and exemptions (Gilson, 1997).

Under exemptions, certain categories of patients were automatically exempted from user fees. These included those seeking family planning, children under five years, sexually transmitted disease patients, and those suffering from HIV/AIDS. Exempting children under five years was in realization of the fact that such children have a low immunity development, which predisposes them to sickness. Indeed, statistics on malaria morbidity attests to this fact, as children under five years are the most affected both in terms of morbidity and mortality (Mbugua et al, 1995).

On the other hand, waivers were supposed to take care of those who could not afford to pay for health services because of their inabilities. Waivers and exemptions were put under the care of medical staff and social workers at the hospitals who were charged with the responsibilities of assessing the financial position of patients and waiving part or all of their bills. This paper discusses the impact of health sector reforms, especially user fees, on Kenya's health policy objective of "Health for All' (Owino, 1997).

2.3.3 Uganda

According to Whitehead (2001) at the end of the 1980s, Uganda emerged from two decades of political and social upheaval with an underequipped and understaffed health service. Cost sharing was introduced in public facilities shortly after decentralization in 1993. The intention was to lessen the impact of irregular payment of low health worker salaries, alleviate drug shortages, and strengthen community management of facilities. In some areas, guidelines and training for cost sharing management were developed.

Some communities set their own fees and managed revenues, fees were usually US$ 0.25–0.45 per new visit. In Kabarole district, cost sharing reduced outpatient attendance by 21.3%, but at remote facilities, utilization increased (Whitehead, 2001). Both health workers and community members viewed the cost-sharing strategy as successful. Usually, the health unit management committee (HUMC), elected from the community, decided allocation of cost-sharing revenues. Up to half of funds supplemented health worker salaries, and the balance was used to clean and maintain the facilities and purchase additional drugs and supplies. The cost-sharing supplement could equal 50–150% of a worker's regular salary (Whitehead, 2001)

With the 2001 election campaign, President Museveni abolished cost sharing in the public sector, and fees were stopped in March 2001. This was influenced by a report that cost sharing was leading to unnecessary suffering and even death. To compensate for the loss of cost-sharing revenue and potential consequence on drug availability, the Ministry of Health introduced a supplemental buffer fund of 7 billion Uganda shillings (US$ 5.5 million) from the World Bank-supported district health services project (DHSP). This represented an increase of 22% to the ministry's drug budget for 2001 (Whitehead, 2001).

2.4 Causes of Cost Sharing

Over the years, Kenya's health policy was designed to achieve the following objectives, to increase coverage and accessibility of preventive and promotive curative health services especially in rural areas. Consolidate urban and rural curative and preventive/promotive health services, i.e. rural-urban referral system. Increase emphasis on Maternal-Child Health (MCH) and Family Planning (FP) in order to reduce morbidity, mortality and fertility through related public health education programmes. Strengthen the Ministry of Health's Health management capabilities, with emphasis being placed at the district level in order to take care of management problems such as facility management, drug supply, and transport and equipment maintenance.

Increase inter- sectoral coordination between the Ministry of Health and other ministries such as agriculture, water, education, social ser-vices, information and NGOs. Increase alternative mechanisms for financing health care programmes. Improve and expand the National Health Insurance. In pursuing the above health care objectives, the Government of Kenya targeted achievement of its long-term goal of Health for All by the year 2000 (Owino, 1997).

The government realized that this objective would be achieved if citizens lived within a radius of ten kilometers of the nearest health facility, and if primary and preventive health care services were extended countrywide. As a result the Government of Kenya pursued various initiatives. It constructed new health facilities in 'under-served' areas and upgraded existing ones. Grants were provided to church or mission hospitals to complement the government in providing health care services. The government made efforts aimed at ensuring that essential medical supplies and equipment were made available through the construction of depots in strategic locations. It encouraged and promoted community and NGO participation through grants for capital development. Training opportunities and career development for health personnel were expanded through the government's continuing education and on-the-job refresher and residential training programmes (Quick and Musau, 1993).

2.5 Low Collections

Resources generated by user fees and their use at hospital, district council and PHC levels. The study team found that reliable, transparent user fee income data for district, hospital and PHC level were difficult to obtain. Based on what information is available, the team concludes that revenues raised from user fees at the hospital level have been lower than what has been projected. Furthermore, the data reflect huge variations between facilities and a decline in the revenues from cost sharing. The reasons of the reported decline are unclear. The data reflecting the contribution of user fees and CHF to the health budget at district council level show huge variations as well.

The reported user fee income proportion for the district health budget was on average 10.5% (Quick and Musau, 1993). The study team could not establish how the income from cost sharing and the CHF was re-distributed by the council to PHC facilities or priority areas. A worrying finding was that some council did not spend all health resources in the health sector. The study team observes an urgent need for: (1) more accurate and comprehensive record keeping at local council level, and (2) more costing and tracking studies to obtain a better insight into cost sharing and expenditures and to adequately inform policy making (Quick and Musau, 1993).

Revenues fell significantly and consistently during the 10 months between the initial implementation of fees in December 1989 and the suspension of the outpatient fee in September 1990 (Figure 1). The decline seems to relate almost entirely to the absence of management systems and controls and to the lack of support from providers and patients, since it does not relate to the fall in utilization (which occurred in the first month), or to fee structure changes, such as the exemption of civil servants. Moreover, this decline occurred despite a large increase in July 1990 of the daily inpatient reimbursement rate paid by NHTF (Quick and Musau, 1993).

Following the introduction of the new management systems at provincial hospitals between June and December 1991, and at district hospitals in May/June 1992, revenue began to climb steadily. From April- June 1991 to the same quarter in 1992, provincial hospital revenue increased three-fold, and from October-December 1991 to the same quarter in 1992, district and sub district hospital revenue doubled.

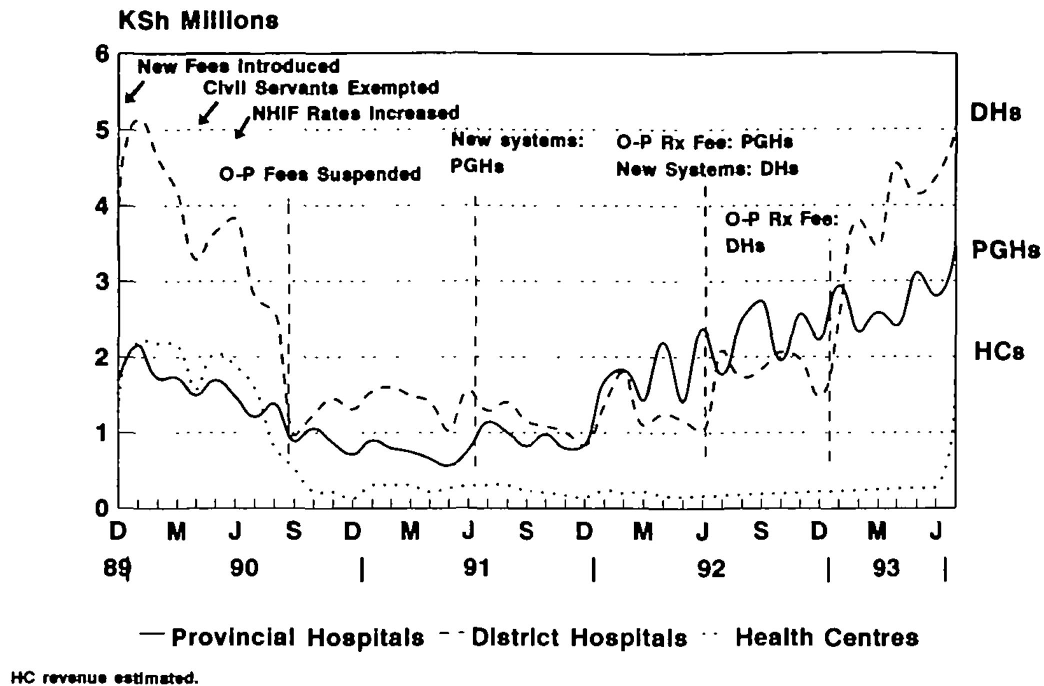


Figure 1. Monthly cost sharing revenue by level of facility, December 1989 to June 1993

Revenue fluctuations after December 1991 relate mostly to irregular NHIF reimbursements.) The increases were primarily due to the new systems, since there was no major fee or exemption change during the period, and increased NHIF revenue was due more to greater volumes of claims rather than to the April 1992 increase in the daily reimbursement rate. As a result of systems, fee and NHIF rate changes, total revenue from all facilities increased from KSh 35 million in FY 1990/91 and KSh 33 million in FY 1991/92 to KSh 70 million in FY 1992/93, and to KSh 130 million (US$ 2.6 million) in FY 1993/94. Much of the increase in revenue resulted from improvements in NHIF claiming, in particular at provincial and district hospitals. In the period January-June 1993, inpatient revenue from NHIF claims and cash fees totalled 62 % of total revenue at provincial hospitals and 48% at district hospitals. Outpatient treatment fees, by contrast, only represented 21% of total revenue at provincial hospitals and 28% at district hospitals.

At sub district hospitals, NHIF revenue was a less significant part of total revenue because member occupancy levels were less and claiming efficiency was worse (Quick and Musau, 1993).

Figure above shows revenues by source for the three types of hospital. An analysis carried out in early 1993 indicated that automatic exemptions were resulting in significant foregone revenue. The data showed that 54.3% of outpatient pharmacy items and 42.2% of outpatient laboratory tests were for exempt patients and that about 20% of inpatients were exempt. The cost of outpatient exemptions alone was estimated at KSh 56 million in FY 1993/94, nearly half of which was for children age 6 to 15 and civil servants – the two groups for which no clear public health argument existed for exemption. The reduction of the exemption age for children to five years and the removal of the exemption for civil servants, both in October 1994, eliminated these subsidies. Civil servants received a new medical allowance in place of free services. On the other hand, less than 1 % of all patients received an official waiver due to poverty, although this probably understates services to the poor, since some are covered by automatic exemptions and others are included in the significant number of inpatients not accounted for. The amount of cost sharing revenue being generated provided significant additional funding at the facility and district level. By FY 1993/94 cost sharing revenue was estimated to be equivalent to about 37% of total Treasury-funded non-staff recurrent expenditures at provincial hospitals, 20% at district and Lab 6% sub district hospitals, and 21 % at health centers. Successful hospitals have been able to collect more from cost sharing than the cash funding they receive from the government (i.e. the non-staff, non-drug recurrent allocation) (Quick and Musau, 1993).

2.6 Effects of the Economy on the Recent Slowdown in Health Spending

According to The Henry J. Kaiser Family Foundation (2013) health spending has been growing at historically low levels in recent years. The Office of the Actuary (OACT) in the Centers for Medicare and Medicaid Services reports that national health spending grew by 3.9% each year from 2009 to 2011, the lowest rate of growth since the federal

government began keeping such statistics in 1960. Estimates from the Center for Sustainable Health Spending at the Altarum Institute suggest that the slowdown largely continued into 2012, with health spending growing by 4.3% last year. The Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey shows similar moderation, with premiums in employer-sponsored health plans increasing by 4% in 201.

2.6.1 A Statistical Model of the Effects of the Economy on Health Spending

Researchers at the Kaiser Family Foundation and the Altarum Institute's Center for Sustainable Health Spending developed a statistical model to track how the growth in national health spending varies with macroeconomic indicators, using estimates of national health spending from OACT for 1965 to 2011 and estimates of health spending for 2012 from Altarum (The Henry J. Kaiser Family Foundation, 2013).

This model allows us to go back in time and assess how much changes in the economy as a whole are associated with increases in health spending, in effect generating a "reverse forecast." It also allows us to forecast what could happen to the growth in health spending in the future assuming the economy recovers as expected.

Two macroeconomic variables were found to be highly predictive of the growth in health spending in any given year:

- Inflation in the current year, as measured by the Gross Domestic Product (GDP) deflator, as well as inflation in the prior two years.
- The growth in real GDP in the current year, as well as GDP growth in the prior five years.

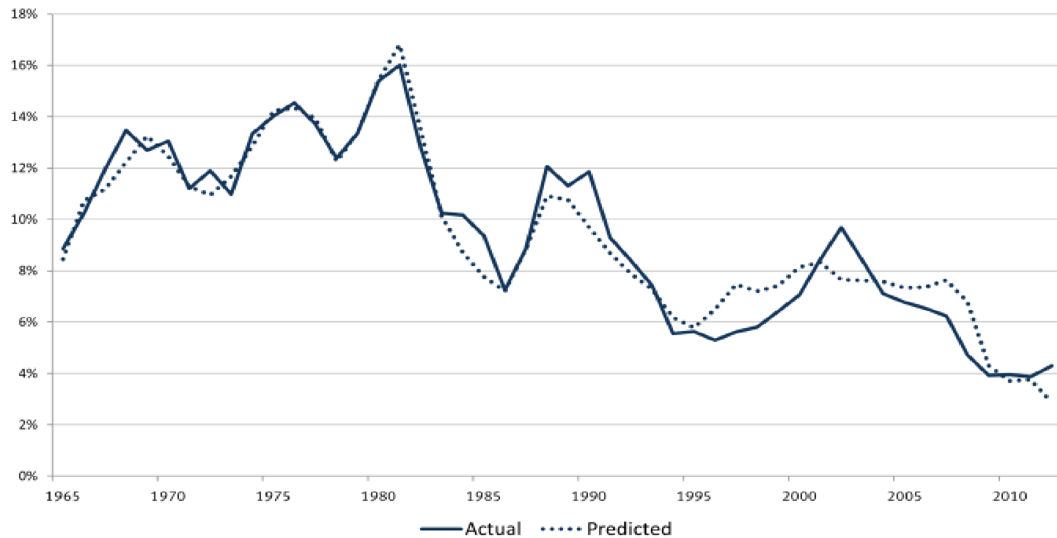
These variables explain over 85% of the variation in health spending growth rates from 1965 through 2011 (The Henry J. Kaiser Family Foundation, 2013).It is not surprising that inflation and GDP are significant drivers of health spending growth. Changes in real GDP reflecting recessions and periods of economic growth are primarily a function of changes in consumer spending, so it makes sense that consumers will also respond to

broader economic changes by adjusting spending on health care as well. This could be a very direct response (e.g., that consumers use fewer health care services as their incomes lag and they cut back on spending of other goods and services as well). It could also be an indirect effect (e.g., employers cutting back on health benefits or fewer people working and more people uninsured during recessionary periods) (The Henry J. Kaiser Family Foundation, 2013).

Perhaps more surprising, we found that these effects are quite slow to develop, with changes in GDP filtering through the health system over a six year period (including the current year). There are a variety of possible explanations for this lagged effect, including:

- Most people are insured, and insurance has an economically protective effect in shielding people from the full cost of health care.
- Consumers may perceive health care as a necessity in a way that is different from other economic goods, and therefore cut back on health spending only after exhausting other ways of trimming household budgets.
- Employers may not make immediate changes to health benefits in response to changes in GDP.
- Hospitals (which account for a large share of health spending) are quite deliberate in their decision-making processes regarding whether to expand or contract services and capital expenditures.
- Legislated changes in spending under Medicare and Medicaid may require an extended process of debate before any substantial adjustments are made. In fact, as unemployment rises and incomes fall, Medicaid costs tend to go up as more people become eligible for the program, though states in response may react by cutting back on eligibility or payments to providers.

Chart 1: Health Spending Growth, Actual vs. Predicted



Source: Analysis by the Kaiser Family Foundation and the Altarum Center for Sustainable Health Spending.

In effect, analysis finds that health spending fully responds to changes in the economy, but that the effect is gradual and cumulative rather than immediate. For example, a 1% change in real GDP ultimately a produces a 1.49% change in health spending. The effect is greater than 1.0 because health spending over time grows faster than the economy as a whole, leading to a greater share of GDP devoted to health (The Henry J. Kaiser Family Foundation, 2013).

Chart 1 shows the growth in health spending for the period 1965 to 2012, as well as what the model predicts health spending would have been based solely on inflation and changes in real GDP. This chart illustrates the striking relationship between health spending and the economy, with health spending growth cycling up and down over time closely in sync with macroeconomic measures (The Henry J. Kaiser Family Foundation, 2013).

2.6.2 How much of the Recent Slowdown in Health Spending is Due to the Economic Downturn?

For the past four years, health spending growth has been at its lowest level in five decades. There has been much discussion about how much of this slowdown is due to the great recession. This is not just interesting from an historical perspective, but also highly relevant in considering how long the slowdown may last. A casual examination suggests that there is more going on here than just the recession, since the slowdown in costs predated the recession and has continued after it. However, because GDP and inflation influence health spending with a significant lag, the effects of economic cycles on the health system are not always apparent from looking at such simple relationships (The Henry J. Kaiser Family Foundation, 2013).

Our analysis indicates that that economic growth influences health spending on a lagged basis over a period of six years, and inflation does so over two years. Inflation was quite similar in the years running up to 2002 and 2012, but real GDP growth was quite different. Real GDP growth averaged 3.4% per year during the period 1997-2002, but just .8% from 2007-2012.

As a result, our analysis suggests that much of the decline in health spending growth in recent years was fully expected given what was happening more broadly in the economy. For example, in the three years 2001-2003, annual health spending growth rates averaged 8.8%, the recent peak in the curve. Annual growth rates have been steadily declining since then and have averaged 4.2% from 2008 to 2012, a decline of 4.6 percentage points from the peak. But, based on patterns of real GDP changes and inflation, our model predicts that the growth rate in health spending would have been expected to decline by 3.6 percentage points over that same period. In other words, about three-quarters (77%) of the recent decline in health spending growth can be explained by changes in the broader economy (The Henry J. Kaiser Family Foundation, 2013).

2.6.3 Are We in a Period of High or Low "Excess" Health Spending?

While economic factors explain the vast majority of the recent slowdown in health spending, they do not explain it entirely. To quantify how much of the slowdown might be due to structural changes in the health system that could persist for some period of time, we estimate the amount of "excess" health spending growth over time (The Henry J. Kaiser Family Foundation, 2013).

Historically, "excess" growth in health spending has been measured by how much faster (or slower) health expenditures are rising relative to GDP. Over the long term, from 1960 to 2011, health spending has grown by an average of 2.6 percentage points faster than GDP. Over the last 20 years, the average "excess" has been 1.6 percentage points. Any time this "excess" growth is greater than zero, it means that the health sector is growing as a share of GDP (The Henry J. Kaiser Family Foundation, 2013).

One challenge with this measure is that it is quite volatile. For example, when GDP falls precipitously during recessions, health spending typically does not immediately move in lockstep (as our statistical model confirms), leading to a very large gap between health and GDP. This is an accurate measure of how much faster the health care system grew than the economy as a whole in any given year, but the results are largely driven by GDP and are not a good indication of how the health system is performing from a cost perspective. For example, in 2009 health spending grew at about GDP+6, but this was clearly not indicative of any longer term trend (The Henry J. Kaiser Family Foundation, 2013).

Some have sought to correct for this volatility in GDP by instead looking at the gap between health spending growth and what is known as "potential" GDP (PGDP) as an indicator of "excess" growth in the health system. PGDP estimates what the nation's economic output would be if labor and capital resources were fully employed, and it is consequently relatively insensitive to business cycles. Therefore, using PGDP to measure "excess" health growth may provide a better indicator of longer-term trends. However, looking at the gap between health spending and PGDP has almost the opposite

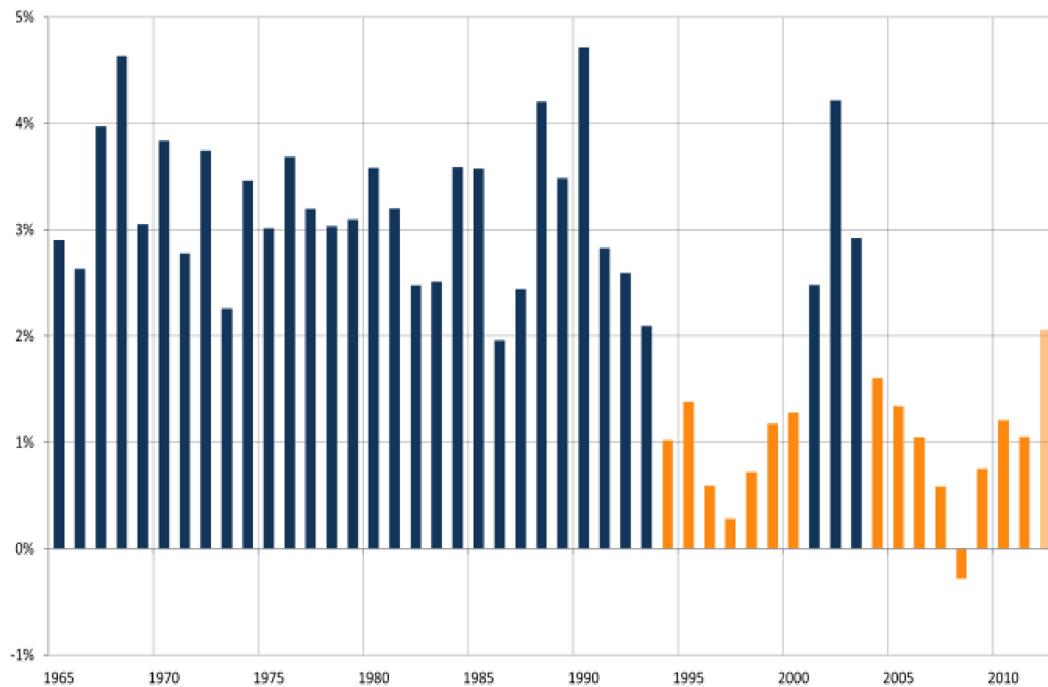
problem of looking at GDP during economic downturns, “excess” health spending will appear unnaturally low because the growth in health expenditures tends to drop while PGDP remains relatively constant (The Henry J. Kaiser Family Foundation, 2013).

To compensate for the deficiencies in these rough measures of “excess” health spending, we instead developed an improved measure (using our statistical model) that adjusts for temporary fluctuations in health spending and GDP growth caused by the lagged effect of business cycles and inflation. This measure, in effect, estimates how health spending is growing relative to the economy as a whole, independent of business cycles. **[3]** Chart 2 presents year by year estimates of “excess” health spending growth using this approach, with orange bars illustrating periods of sustained low growth (2012 is shaded differently since it is based on a preliminary estimate of spending) (The Henry J. Kaiser Family Foundation, 2013).

As the chart shows, health spending grew significantly faster than the economy throughout the 1960s, 1970s, and 1980s, with “excess” growth averaging 3.2% over the period. That long-term trend first broke in about 1993, likely due to the threat of health reform during the debate over the Clinton Health Security Act and the subsequent rapid rise in managed care enrollment. “Excess” growth remained low through the rest of the 1990s averaging just less than 1% at which point it spiked for a few years as a backlash against managed care ensued and hospitals consolidated. This spike was short-lived, lasting through 2003, and the rest of the decade and the early years of the new millennium have looked very much like the 1990s (with “excess” growth averaging about 1%). It may be too soon to identify the changes that have led to the slowdown in “excess” growth since 2004. Some of it could be attributed to the ongoing effects of various forms of managed care. Through the 1980s, the vast majority of people with private insurance were in relatively unmanaged insurance models, including conventional fee-for-service plans and loosely organized preferred provider organization (PPO) type arrangements. Since then even following the backlash against managed care various forms of utilization management and plans with defined networks are the norm in employer-sponsored insurance.

These arrangements have also grown in Medicare and Medicaid as well. However, deductibles and other types of patient cost-sharing have also increased in recent years, dampening use of services. Some point to greater sophistication of information technology systems to track and manage health services and changes in the delivery system as possible sources of system wide savings as well (The Henry J. Kaiser Family Foundation, 2013).

Chart 2: Excess Health Spending Growth Adjusted for GDP and Inflation



Source: Analysis by the Kaiser Family Foundation and the Altarum Center for Sustainable Health Spending. Figure for 2012 is estimated.

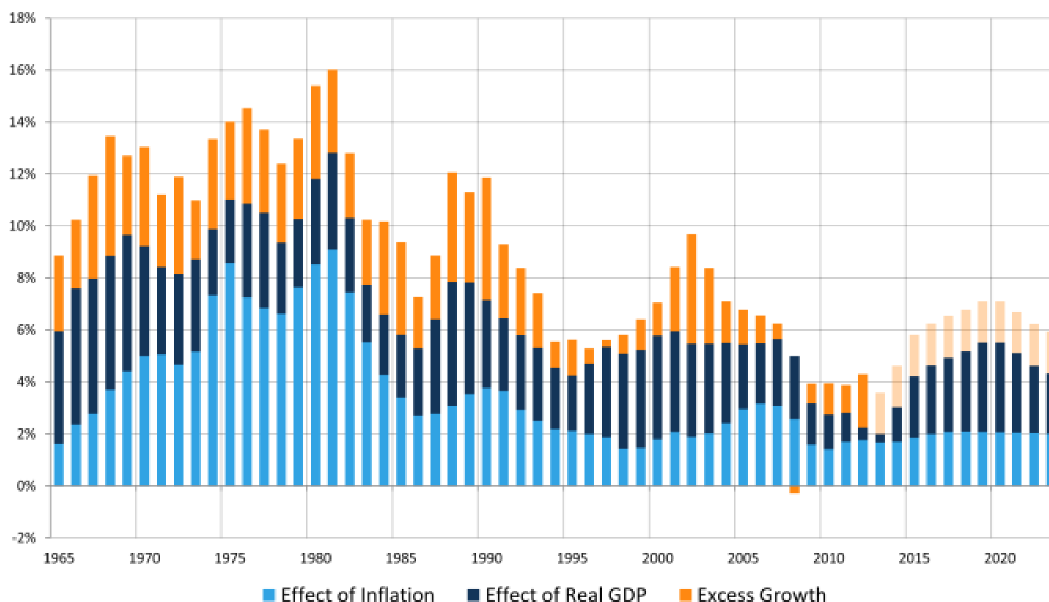
There is no way of knowing for certain whether this slowdown will persist and for how long, though the trend since 2008 has been generally upward. However, the major elements of the ACA – including significant cost savings in Medicare and the creation of new health insurance exchanges have in general not yet been fully implemented, and could dampen growth in the future (The Henry J. Kaiser Family Foundation, 2013).

2.6.4 What May Happen to Health Spending if the Economy Recovers?

From a policy perspective, understanding patterns of health spending in the past is primarily of interest as a guide for what may happen in the future. Our statistical model can be used to forecast health spending in the coming years, based on assumptions about how quickly the economy recovers (The Henry J. Kaiser Family Foundation, 2013).

Chart 3 shows historical growth in health spending by year broken down by the components of that growth as estimated by our statistical model: the effects of real GDP and inflation (current and lagged), as well as "excess" health spending growth. The chart also illustrates what could happen to health expenditures over the next decade based on CBO's forecast of GDP and inflation. However, future spending depends critically on not only the economy, but also on the level of "excess" growth in the health system (The Henry J. Kaiser Family Foundation, 2013).

Chart 3: Actual and Projected Growth In Health Spending by Component



Source: Analysis by the Kaiser Family Foundation and the Altarum Center for Sustainable Health Spending.

The stacked light and dark blue bars in Chart 3 show how health spending growth rates are expected to climb as inflation and especially GDP ramp up as the economy recovers. Our analysis suggests that the lagged effect of the economy alone, i.e., no change upwards or downwards in “excess” health costs will gradually add 3.5 percentage points to the annual growth rate in health spending by 2019 (The Henry J. Kaiser Family Foundation, 2013).

However, how fast health spending will ultimately grow also depends on the level of “excess” in the health system. If the “excess” rate of growth is 1.6 percentage points over the next 10 years – the average for the last 20 years and what preliminary estimates suggest it has been over the last couple of years – then health spending growth could remain roughly flat for the next couple of years but reach 7.1% by the end of the current decade (compared to an estimated 4.3% in 2012). This is illustrated by the orange bars in Chart 3. Even under this scenario, though, we would not see a return to the double-digit increases of the late 1980s and early 1990s, assuming inflation and real GDP growth remain relatively modest and “excess” health spending does not rise further (The Henry J. Kaiser Family Foundation, 2013).

National health expenditures totaled an estimated $2.8 trillion in 2012, so even a small difference in the growth rate can lead to substantial differences in spending over time. For example, lowering the growth rate by one percentage point on average over the next decade means that total health spending would be almost half a trillion dollars lower than expected 10 years from now (The Henry J. Kaiser Family Foundation, 2013).

These projections are intended to be illustrative rather than precise. They do not account for an expected one-time increase of two to three percentage points in health spending growth as more people become insured under the ACA. Nor do they explicitly include substantial future savings in Medicare under the ACA or potential spillover to the private sector of Medicare pilot projects to reform delivery system incentives which could help to hold the overall level of “excess” growth down.

In fact, Medicare spending per capita is expected to grow slower than GDP per capita over the next decade (The Henry J. Kaiser Family Foundation, 2013).

2.7 Implication of Cost-sharing on the use of public health facilities

Whether or not cost recovery in health services helps or prevents poor people from accessing health services. The general consensus, as supported by recent empirical evidence, seems to be that even the poor are willing to pay for high quality of health services. This has been interpreted as implying that charging of user fees, if accompanied by improvements in quality, can be justified and will not have a negative impact on equity (Akin and Hutchinson, 1999).

In Bangladesh, even poor patients are reported to have bypassed free or very cheap government institutions and traveled further to more expensive establishments that offered acceptable quality (Akin and Hutchinson, 1999). Similarly, in Egypt, the poor have been shown to avoid public facilities that provide services of low quality in favor of private ones where service provision is better, suggesting that Government should focus on financing rather than direct provision of health services (Nandakumar, 2000).

Introduction of user fees in Mauritania in 1992 is reported to have not only helped to improve the quality of health care but also improved facilities and ability to invest in upgrading and training. In Niger, no evidence for serious reductions in access or increases in cost could be found when investigating the impact of implementing direct user charges which were combined with insurance payments and improved service quality. In fact, higher utilization of formal care, which is surmised to be due to improvements in quality, is reported to have outweighed any possible decrease in utilization due to increased costs (Akin and Hutchinson, 1999).

Introduction of user fees is found to receive broad support if such fees eliminate the often significant charges and bribery that are usually levied unofficially, in which case the negative impact on equity is likely to be limited.

In Cameroon, higher quality implied that increases in health fees did in fact constitute a reduction in the effective price of health services and led to increased utilization of such services, with no visible negative impact on the poor (Litvack and Bodart 1993). While there appears to be ample evidence on a benign or even positive impact of the introduction of user charges for health services, other contributions to the literature paint a less positive picture (Evans, 1984).

In Zaire, for example, charging for health services has been associated with a direct decline in use (Huber, 1993). In Ghana, even though increased cost recovery was perceived to be associated with increased quality of general health delivery, services, and drug supplies, it nonetheless led to higher levels of self-medication and other behaviour aimed at cost saving by the poor (Asenso-Okyere, 1998).

On equity grounds, user fees on health care can lead to disappointing results because they inhibit the poor from accessing health services much more than they inhibit the non-poor. In Kenya, for example, (Collins, et al, 1996) find that introduction of use fees led to a reduction in outpatient registration of about 27% in provincial hospitals and higher reductions in district and lower level health centers. New and Collins, 1999) report that 91% of households in Kenya knew of someone who failed to seek health care because of cost. There were also massive reductions in the percentage of female patients and the unemployed seeking treatment (Evans, 1984).

Even where user fees have been well designed, enforcement can be problematic and criteria for exemption which are often used to mollify the impact of such measures on the poor are not always implemented in the way they were designed. Finally, credit constraints may constrain the ability to access fee-based services even in a situation where there is a clear willingness to pay by a specific group although informal insurance networks. A review of three country cases finds that the goals of cost recovery policies were rarely fully accomplished and that, even where there was a positive change in quality, equity may have suffered (Gilson, 1997).

In practice, the ability to respond to these needs is often constrained by data availability. Lack of data on service provision at the facility level makes it difficult to ascertain the extent to which the expected improvement in service quality has indeed materialized. Aggregate data on users that lack information on their socio-economic characteristics makes it difficult to identify the poor and thus assess how they have been affected by reforms of health financing. Inability to control for other factors such as the provision of infrastructure complementary to health services makes it difficult to assess the trade-offs involved and decide whether government should invest in health related services rather than, say, improving water supply (Hausman et al., 2000).

2.8. Importance of Cost-sharing in Provision of Health Services.

The importance of cost sharing in provision of health services includes; is one of the government source of fund, increase efficiency, increase equity and reduces the burden of government in health plan as explained below;

2.8.1 One of the government source of fund

User fees are one of the few feasible ways of raising revenue to bridge the health sector resource gap in resource-poor environments. There are other ways of raising revenue: increased donor funding; increased private philanthropy; economic growth and a consequently increased tax base; taxes on health-damaging products such as tobacco and alcohol; or increasing the share of government expenditure spent on health. However, none of these is likely to be achievable in the developing world, especially in Sub-Saharan Africa, in the near future (Hausman et al., 2000).

2.8.2 Increased efficiency

User fees, if well designed, should mean that resources are used more efficiently within the health system. They discourage unnecessary use, and can create incentives for providers and patients alike to shift the focus towards cost-effective high-priority care for disease prevention; they can also, via differential pricing, move the delivery of care

away from expensive hospital-based treatment to more cost-efficient primary healthcare (Hausman et al., 2000).

2.8.3 Increased equity

If the income they generate is used to improve service quality, user fees could have positive equity outcomes. Even with user fees, a public health system that delivers high-quality care close to where people live would offer poor people cheaper and better care than they would be able to get in the private sector.

2.8.4 Reduce the burden of government in health plan

- Reduces government cost by mandating that participants share the burden of their health care costs.
- Targets assistance and subsidies to the poorest of the uninsured population.
- Can be used as a policy tool to regulate participation levels.

2.9 Health Services Cost Sharing Perception

According to Patricia et al (2004) on their study reviled that, there are two main reasons for introducing cost sharing. First, to reduce excessive use of health services facilitated by health insurance, with a view to increasing efficiency and containing overall expenditure on health care. Second, to raise revenue for the health system, particularly in countries where public budgets are under pressure or funding health care through other means is politically sensitive. While this may lower equity in funding, equity in the receipt of benefits would be preserved if the revenue raised were targeted at poor people or otherwise used to reduce inequality in the system.

Neoclassical economists claim that the use of health services exceeds socially beneficial levels when health care costs are fully covered by insurance. Insurance reduces the marginal cost to individuals of using health services by effectively lowering the price of these services to zero. Consequently, insured individuals will make use of as much health care as they would if the health care were free – the core issue of moral hazard.

Cost sharing restores the price signal negated by insurance, thereby combating the social welfare loss arising from this excess use. In economic terms, excess use does not refer exclusively to the use of services that are either unnecessary or potentially harmful. Nevertheless, it is often argued that the existence of a price signal will selectively discourage the use of health services that provide little value to the individual and prevent the negative effects of consuming too much health care (REPOA, 2005).

The case for cost sharing therefore rests on the assumption that it will enhance micro-efficiency (more effective care) and macro-efficiency (contained costs) if it does not lower health status or lead to increased consumption of other health care resources. Cost sharing can also be used to encourage more cost-effective patterns of use, by conveying price signals to individuals and providers. However, the diverse nature of health care services and the existence of information asymmetries in the market have led some economists to question both the appropriateness of using the neoclassical model to measure welfare loss and the ability of cost sharing to achieve efficiency gains. Arguments about inefficiency arising from excess use are based on the assumption that individuals are well-informed about their own need for health care and are able to distinguish between effective and ineffective treatment (Gilson, 1997).

Moreover, the neoclassical model assumes that supply and demand are independently determined, but because providers are usually better informed than patients, often acting as their agents, they have considerable potential to influence the type and quantity of health services used. In practice, most decisions about the use of health services are made by providers and are not based on patients' assessments of potential benefits.

The neoclassical model also fails to take into account the travel, time and psychological costs that individuals may incur when using health services.

2.10 Empirical Literature Review

The Kenya experience shows that a well-managed programme of cost sharing can contribute significantly to the funding of government health services. However, the experience has also shown that a successful cost sharing programme requires gaining public and provider acceptance, collecting and retaining significant levels of additional revenue, protecting vulnerable groups, and achieving visible quality improvements, especially with regard to drugs and medical supplies. Such a programme also requires careful design and testing of fee structures and management systems, implementation in phases, and considerable training and supervision. The resources needed to carry out such a major, sustained, long term effort are significant, but without such commitment, even a well-designed cost sharing policy may fail during implementation (Mwabu et al.1995).

According to Kinemo and Ngilangwa (1999), the poor financing of councils in its own development projects, is due to unstable revenue base, which has led to the public dissatisfaction and criticism on the performance of councils in the provision of social services and development activities. Due to that it was revealed that local authorities in Tanzania could not collect enough revenue to meet their obligations as required; therefore there is a need of assessing the efficiency and effectiveness of revenue collection procedures so as one way of solving out the problem of poor revenue collections.

Semboja and Therkilden (1992) revealed that local authorities in Tanzania were not able to collect enough revenue to finance the operations and maintenance of the basic facilities in their localities. Due to these problems, additional funds to support the councils were provided by central Government. They pointed out some causes of poor revenue collection in local authorities as follows:

i. The administration of revenue collection has generally been poor.
ii. Certain potentially important new sources have not yet been exploited.

iii. There has not been sufficient political and administrative support from central Government, to tax a population accustomed to" free''. public service since 1967.

As evidenced from the above empirical review, different researchers have analyzed various setbacks and solutions concerning revenue collection in Local authorities. Implicitly, they aimed at recommending on the best ways of exploiting councils revenue sources in order to improve critical financial condition caused by lack of revenue. However, establishing a council sustainable financial situation is not a simple task. It requires the Council to be creative, innovative and to practice modern ways of exploiting revenue sources. This study therefore, attempted to assess factors causing low cost sharing collections in health services in municipal councils.

2.10.1 Cost Sharing Perspective

The introduction of the CHF has not provided the expected benefits for poor people. There are a number of constraints the study team thinks should be urgently addressed, including the delays in the introduction of the CHFs and the weak management at the district and lower levels. More importantly, the study team found that poor people often cannot afford to pay the CHF premium because it is too high and has to be paid at once. If membership of the CHF becomes compulsory and poor people are not effectively exempted from paying CHF premiums and co-payments, the impact of the CHF can be disastrous and lead to double exclusion of poor people. Another issue of concern is related to the link between user fees and the CHF. According to the CHF Act, the user fees paid at public health centres and dispensaries form a source of income to the CHF. The premium paid to the CHF will receive WB matching funds, putting pressure on the PHC facilities to raise income through user fees. This indicates a complicated dilemma since it means that if user fees will be suspended or abolished at PHC level, the CHFs will not be able to take off as planned and will not receive part of their required resources. This points to the need to assess the mix of financing mechanisms and their interactions, rather than look at them as stand-alone policies (Evance et al., 2001).

According to Litavak (1995) study on User Fees as a Form of Cost Sharing In Developing World it was revealed that immediately after user fees were implement there were declines in rural health use due to their inhabitants' inability to afford the fees for treatment. The service utilization has dropped by more than 25% and outbreak of serious health conditions and higher infant mortality was observed in many provinces
The resulting inequality was reinforced by the substantial inequalities in government health spending between poorer and better-off provinces These inequalities reflect the low share of central government health spending in the national total and a set premium rate, instead of a risk-based premium, user charge system currently being in place.

According to Mubyazi, (1998) who conduct research in Korogwe on cost sharing control mechanisms between April 1999 and April 2000 malaria being the case study. More specifically, the study looked at the existing mechanisms of payment for health care poor and vulnerable groups delivered in private and public health facilities. In addition, it assessed alternative mechanisms of payment for health care suggested by and acceptable to either the health care users or the health care providers or both.

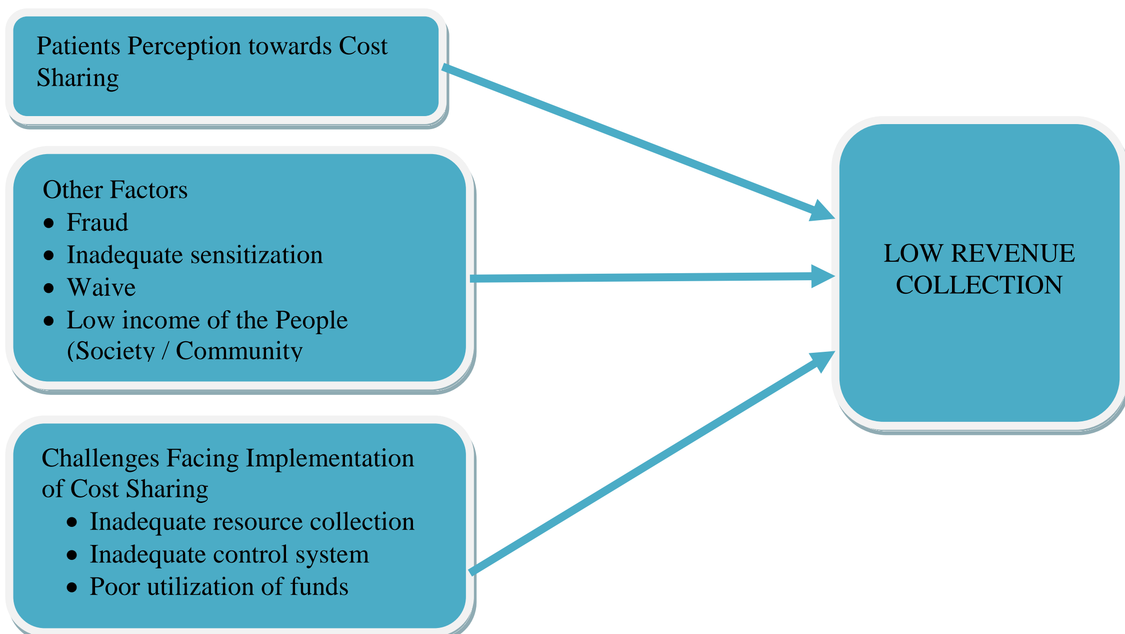
Malaria was used as a tracer disease for the study of community health care seeking behavior because of its relatively dominant public health importance. Information was collected through various types of interviews and review of health facility day-to-day routine service records. The views presented in this report may be useful not only in Korogwe district but also elsewhere in Tanzania where the community is the target of district health management and health care delivery programs. Although too many people in the developing world the term "health sector reform" may sound like a new policy or ideological terminology, its process and practice in Tanzania are historical (Mubyazi, 1998).

2.11 Conceptual Framework

This study assumed that insufficient revenue collectors at health facilities contribute in not getting enough revenue. It is further assumed that those responsible for collecting revenue in health facilities do not follow the laid down procedures. The study further assumes that lack of accountability on the collected revenue contributes to poor performance of health facilities. More over, it is assumed that lack of follow up by management on how the collected 1revenue is accounted contribute to mismanagement of the collected revenue. It is also assumed that the use of the collected revenue before they are entered into the books of account contribute to waste of revenue. It is further assumed that lack of cooperation between revenue collectors and in charges of health facilities contribute to insufficient collection of revenue. These assumptions are summarized in figure 1.

Figure 1: Conceptual Framework

Independent Variables **Dependent Variables**



CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Introduction

The first part of this chapter provides research design. The second part of the chapter describes area of the study while population and sample are explained in part three of the chapter. Sampling techniques and sample size are discussed in part four of this chapter. Data collection methods are given in part five of this chapter and the last part of the chapter provides how data were processed and analyzed.

3.2 Procedure

Procedure is an operational blue print which the researcher used in completing the study. It accounted for the variables considered in this study, sources of data and the sample involved in the study, data collection procedure followed by the researcher, selection of the analysis tool, study management plan (Kombo and tromp, 2006). The procedure for this study is as depicted in the following sections of this chapter.

3.3 Research Design

Research design is a structure research – glue that holds together all the elements of the study (Gill and Johnson, 1997). A design, therefore, is the structure used to plan on how the entire major parts of the works together to address the central research problem (Kombo and tromp, 2006). The researcher applied case study (descriptive and diagnostic research studies). This type of research design was chosen because enabled the researcher to study thoroughly the problem under the single Congregation of the Hospitals, Health Centers and Dispensaries in Kinondoni Municipal council. The design was selected because it is less expensive when compared to survey or experiment designs. The design is flexible because makes it eases data collection through the use of different methods such as questionnaire, in depth interviews, focus groups etc.

In fact, the design is in line with conceptual structure within which research is conducted; as Kothari (2004) defined it as the blue print for collection, measurement and analysis of data

3.4 Area of Study

The study was conducted in Hospitals, Health centers and Dispensaries run by Kinondoni Municipal council in Dar es Salaam. The study decided to select Kinondoni Municipal Council because it was easier to collect data since the researcher works with the council.

3.5 Population and Sample

The term population refers to the set of individuals, cases or events having certain characteristics or attributes of interest of study (Kothari, 2004). Moreover Kombo and tromp (2006) population express population as group of objects or items from which samples are drawn for measurement. Gupta and Gupta (2011) state and specify population as the total of items or units in any field of inquiry/research. For this study, population refers to all elements from which data were collected; which included patients from hospitals, health centre and dispensaries. In view of the same, this study involved infinite population, thus, the researcher could not establish the total elements from which data were drawn.

Table 3.1 depicts service provision point and status from which data were collected.

Table 3.1 Study Population Distribution

Service provision point	Status
Mwananyamala	Hospital
Sinza	Hospital
Magomeni	Health centre
Kimara	Dispensary
Mbezi	Dispensary

Source: Field Study, 2013

3.6. Sampling Technique and Sample Size

Sampling is the procedure a researcher uses to gather people, places or things to study. It is a process of selecting a number of individual or object from a population such that the selected group contains element representative of the characteristics found in the entire group (Orodho and Kombo, 2002). A sample size is a small group of people or elements selected from the total population to represent the whole population (Nichols, 1991). The process of obtaining the sample for this study involved purposive sampling where the researcher purposely identified respondents who knew they can read and understand the questions and had adequate information about the problem under study. Therefore respond/fill in the questionnaires accordingly. For the case of convenience sampling, the researcher to collected data based on availability (arrival) of patients at the service provision points. In view of the same, patients were selected basing on availability and who clearly understand the concept of cost sharing. Thus, the sample involved 141 elements. The composition of the sample was as indicated in the table below

Table 3.2 Sample Size

Service provision point	Respondents	percentage
Mwananyamala		
Sinza	37	26.2
Magomeni	38	26.9
Kimara	20	14.2
Mbezi	24	17.1
	22	15.6
Total	**141**	**100.0**

Source: Field Study, 2013

3.7: Data Collection Methods

The study employed different methods of data collection. The kinds of data collected were categorized in two broad types. The types were primary and secondary data.

3.7.1: Primary Data Collection Methods

Primary data were collected using the following tools:-

3.7.1.1 Questionnaires

Questionnaires were developed, pre-tested and distributed to respondents. This was the major toll of primary data collection which was supplemented by interviews and observation methods. The method was selected because suited the environment / setting of the study where respondents were busy attending patients to the extent that they could not get adequate time to respond to interview questions before they were interrupted by patients. In this regard, questionnaires were distributed to the respondents who filled them at their own convenient time. Questionnaires were distributed to doctors and nurses who by the nature of their duties the can not have adequate time for interviews. The questionnaires contained both structured and semi structured questions that focused to collected adequate data from the respondents. The questionnaire used is attached as Appendix 1.

3.7.1.2 Interview

Interview method involved top managers, councilors, and local community/ village leaders. These persons are normally busy with big matters at their work places.

The study found that these people are also very busy to have adequate time to fill questionnaires. In view of this, the researcher collected the data from these people through interview. Interview guide as attached in Appendix 2.

3.7.1 .3 Observation

Under the observation method the information is sought by way of investigator's own direct observation without asking from the respondent. This is also termed studying by looking intensively. The Researcher has kept in mind things like:

What should be observed?

How the observation should be recorded?

The Researcher did observation in three critical areas of cost sharing collection.

i. Registry section
ii. Pharmacy
iii. In report writing and banking the amount collected during that period

3.7.2 Secondary Data

Documentary review guide were used as an instrument during data collection from different documents. This involved reviewing Municipals documents, such as manuals, reports and other publications. Secondary data involved collecting data from numerous sources, community members, waste workers, administrators etc. Another sources for provision of secondary data included books, publications, reports, local newspapers, and data from Health Department.

The secondary data obtained from various sources will be used for enhancing the understanding of the problems, rules and laws pertaining to waste management etc. and also for triangulation and verification of the primary data collected that is ascertaining the reliability of the primary data collected.

3.8 Data Editing, Processing and Analysis

3.8.1 Editing

Editing is the process of cleaning and making data free from inconsistencies and incompleteness. Thus, editing consists of scrutinizing the completed research instruments to identify and minimize as far as possible errors, incompleteness, misclassification and gaps in the information obtained from respondents (Gupta and Gupta 2011). In this study data editing was done by examining answers to all questions at one time and examining all the responses given by the respondents. Data editing was carried in two stages; in the field (field editing) and off the field.

3.8.2 Data Processing

The collected data were processed through classification and tabulation. Data classification is the process of converting large heterogeneous data into small groups of homogeneous data, for developing meaningful relationship. Hence the data are arranged in groups based on common characteristics. Tabulation is presentation of data in tables for clear and easy understanding.

After editing the collected data, the researcher classified and tabulated them for purpose of developing meaningful idea and relationship in relation to variables under study.

3.8.3 Data Analysis

Data were analyzed using both qualitative and quantitative techniques. The analysis based on the research questions and objectives. The findings were presented in tabular chart and graph formats in order to enhance ease understanding of the same. Quantitative data are in the forms of tables, charts, and graphs while qualitative data are in the form of description of ideas and opinions.

CHAPTER FOUR
DATA PRESENTATION, ANALYSIS AND FINDINGS

4.1 Introduction

The first part of this chapter presents the characteristics of the respondents in terms of age, sex, and their levels of education and the location of receipt of health service. The second section discusses patients' perception towards health service cost sharing in municipal councils. The chapter further discusses factors for low revenue collections from health service cost sharing in municipal council. The last part presents the challenges facing the implementation of health service cost sharing policy in the council. In the process of analysis of data, both qualitative and quantitative data analysis technique were applied. Interpretations have been provided to support information in the tables.

4.2 Characteristics of Respondents

The respondents' characteristics were personal and situational characteristics which were expected to influence the factors contributing to low cost sharing collections in health services. These characteristics were examined basing on age sex, and level of education.

4.2.1 Age

Information about age of respondents was generated in order to establish the picture of nature and characteristics of the respondents and whether it influences low revenue collections from cost sharing in the provision of health services in Kinondoni Municipal council. Form their responses, the study found that 29.8% were aged between 18 to 30 years old, 34.0% were between 31 -40, 26.2% ranged between 41 - 50 and 10.0 were above 51 years of age. Consider the table 4.1 below.

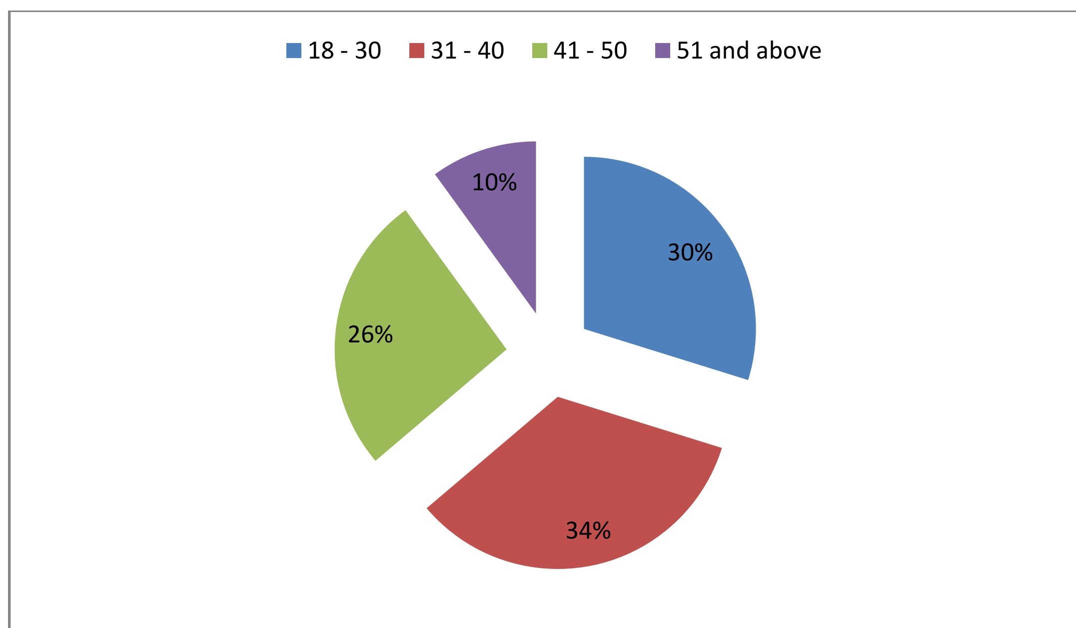
Table 4.1: Age

Age	Frequency	Percent
18-30	42	29.8
31-40	48	34.0
41-50	37	26.2
51 and above	14	10.0
Total	**141**	**100**

Source: Study Findings, 2013

The same information is shown using pie chart as indicated below in figure 2 below

Figure 2. Age of Respondents



Source: Study Findings, 2013

4.2.2 Sex of Respondents

The study also wanted to establish sex that attended and receive health service in the centre run by Kinondoni municipal council. The study reveals that female attends and receives health service in the centre more than male. In view of the same, the study reveals that majority of the respondents (64%) were female and minority (36%) were male, as presented in Table 4.2 below.

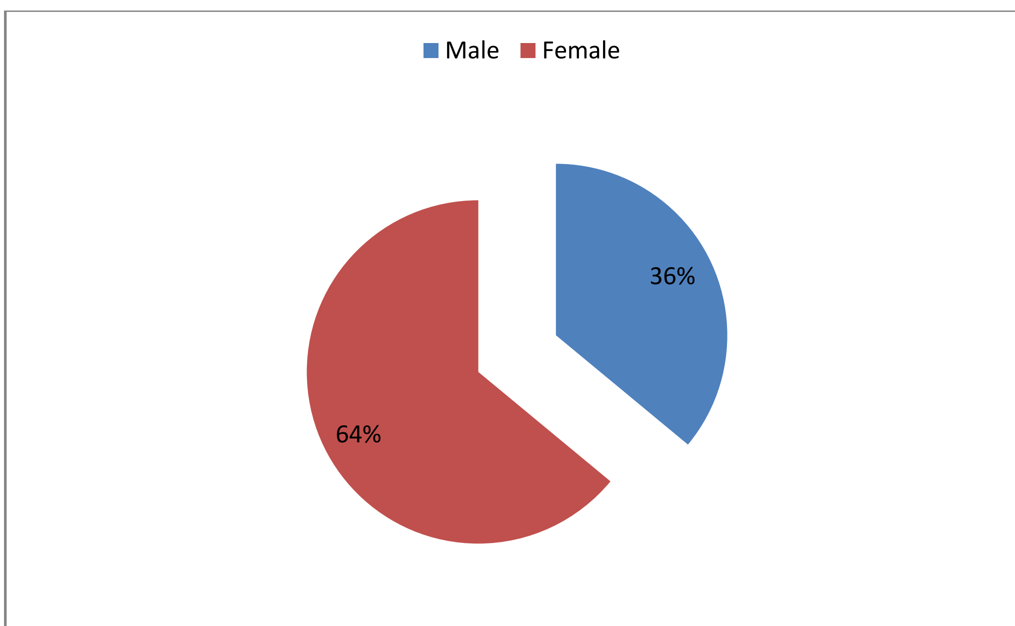
Table 4.2: Sex of Respondents

Sex	Frequency	Percent
Male	51	36
Female	90	64
Total	**141**	**100**

Source: Study Findings, 2013

The same information is shown using pie chart as indicated in figure 3 below

Figure 3. Sex of Respondents



Source: Study Findings, 2013

4.2.3 Education of Respondents

Level of education was another important aspect of the study. The study was further interest in knowing the distribution of respondents according to their levels of education. The purpose of revealing the levels of education of respondents was to establish whether the level of education was one of the factors influencing the awareness of cost sharing. The study reveals that certificate and diploma holders have high awareness of cost sharing as they constituted 35.5%, followed by university degree holders 25.5%, primary

education 21% and last group is secondary certificate holders which 17.7% have least awareness of health service provision cost sharing. Consider table 4.3 below

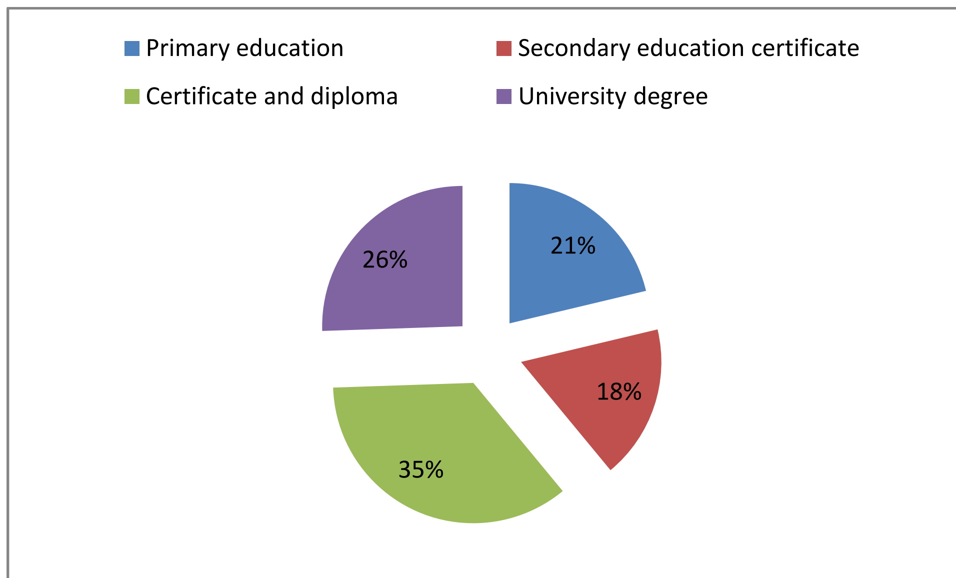
Table 4.3: Education Level of Respondents

Level of education	Frequency	Percent
Primary education	30	21.0
Secondary education certificate	25	17.7
Certificate and diploma	50	35.5
University degree	36	25.7
Total	**141**	**100**

Source: Study Findings, 2013

The same information is shown using pie chart as indicated below in figure 4 below.

Figure 4. Education Levels of Respondents



Source: Study Findings, 2013

4.2.4: Location of Respondents

The researcher was also interested in knowing the locations from which respondents receive services, and if the locations have influence in low revenue collections from cost sharing exercise. Hence the study was conducted in the following hospital locations;

Mwananyamala, Sinza, Magomeni, Kimara and Mbezi. The study found that Sinza hospital has highest number of patients involved in costs sharing which constituted 26.9% followed by Mwananyamala, 26.2%, Kimara 17.1%, Mbezi 15.6% and Magomeni 14.2%. Since the highest numbers of respondents are from Sinza it is expected that they are participating more in health services cost sharing and thus they are more aware of the policy. The distribution of respondents according to hospital locations were as indicated in table 4.4 below

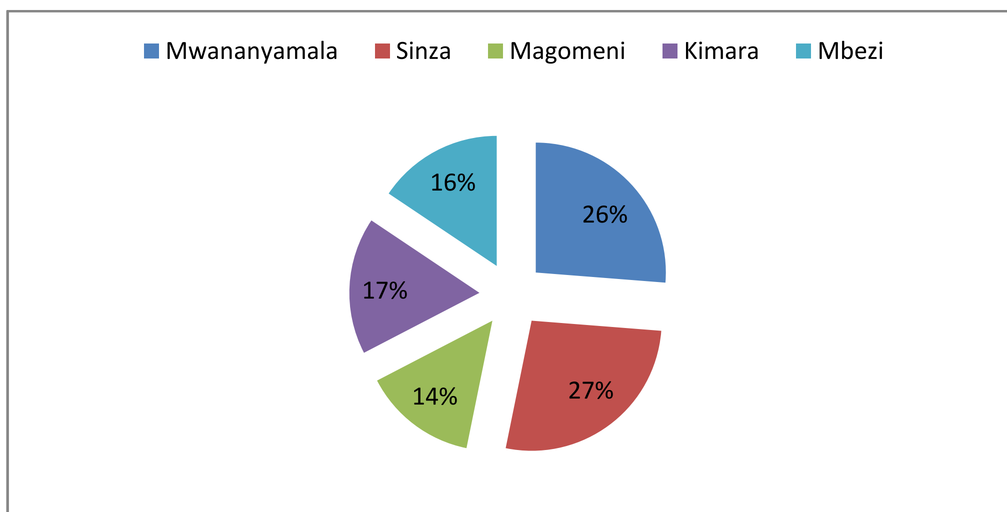
Table 4.4 Distribution of Respondents According to Location of Health Service Provision Point

Service provision point	Frequency	Percentage
Mwananyamala	37	26.2
Sinza	38	26.9
Magomeni	20	14.2
Kimara	24	17.1
Mbezi	22	15.6
Total	**141**	**100.0**

Source: Study Findings, 2013

The same information is shown using pie chart as indicated below in figure 5 below

Figure 5. Location of Respondents



Source: Study Findings, 2013

4.3 Patients' Perception Towards Health Service Cost Sharing Policy

The study wanted to establish patients' perception towards health service provision cost sharing in hospitals, health centres and dispensaries which operated by Kinondoni municipal council. In order generate information about patients' perceptions towards heath service cost sharing, the researcher posed the following statement which respondents were requires to respond either "YES" or "NO" " *The policy of cost sharing in provision of health services in hospitals and health centres operated by municipal council is good".* Thereafter they were required to provide reasons to support their answers. Table 4.5 below indicates the responses.

Table 4.5 Patients' Perception Towards Health Service Cost Sharing Policy

Service provision point	Respondents	YES	Percentage	NO	Percentage
Mwananyamala	37	16	43.0	21	56.0
Sinza	38	13	34.0	25	68.3
Magomeni	20	14	70.0	6	30.0
Kimara	24	16	66.7	8	33.3
Mbezi	22	9	40.9	13	59.1
Total	**141**		**50.9 (average %)**		**49.1 (average %)**

Source: Study Findings, 2013

From table 4.5 above, the study found that;

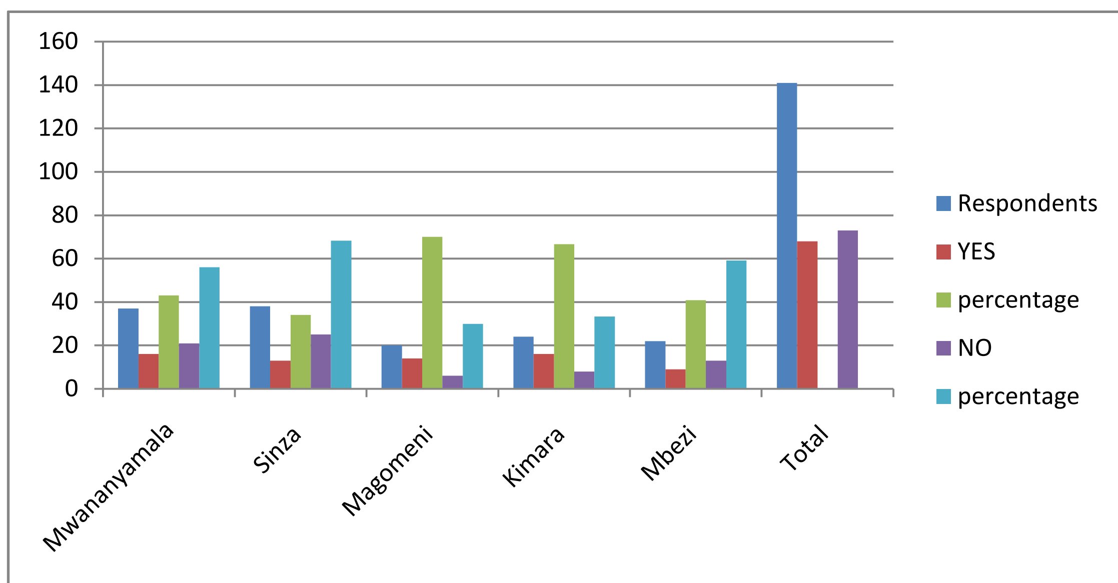
- At Mwananyamala hospital, 43.0% had positive perception thus; they perceived the policy of cost sharing in health services as good while 56.0% had negative perception thus; they perceived the policy as bad.
- At Sinza hospital, 34.0% had positive perception thus; they perceived the policy of cost sharing as good while 68.3% had negative perception hence, they perceived the policy as bad.
- At Magomeni hospital, 70.0% had positive perception hence, they perceived the policy of cost sharing as good while 30.0% had negative perception hence, they perceived the policy as bad

- At Kimara health centre, 66.7% had positive perception hence they perceived the cost sharing policy as good while 33.3% perceived the policy as bad hence negative perception
- At Mbezi health centre, 40.9% perceived the policy as good while 59.1% perceive the policy as bad

From the information above the researcher developed percentages averages for both YES and NO responses from all the centres. From the averages of the percentages, the study found that majority responses (50.9%) had positive perception about heath service cost sharing. However, those with negative perception (49.1%) have an influence on low revenue collection in municipal the council.

The same information is shown using a bar graph as indicated in figure 6 below

Figure 6. Patients' Perception Towards Health Service Cost Sharing Policy



Source: Study Findings, 2013

4.3.1 Reasons Developed For Perceptions Towards Health Service Cost Sharing Policy

The study established the reasons for both positive and negative perceptions. Table 4.6 indicates the responses from the patients.

Table 4.6 Reasons for Perceptions Towards Health Provision Cost Sharing

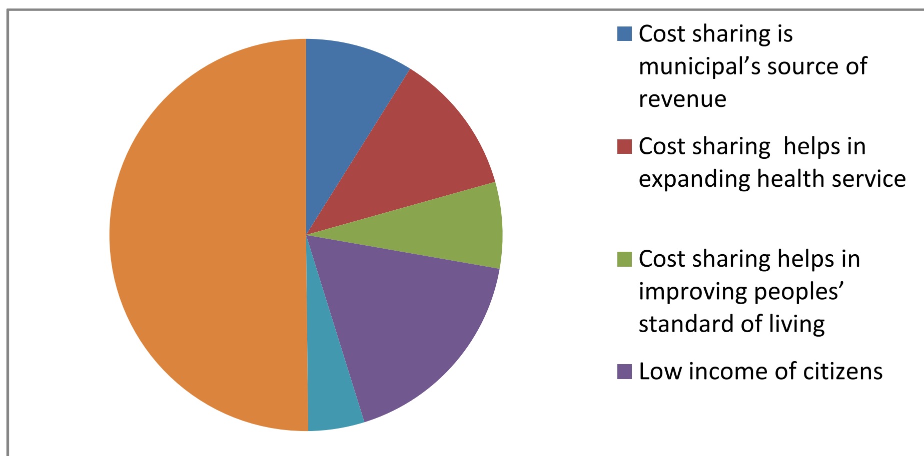
	Reasons in summary	**Number of respondents**	**Percentage**
Positive perception	Cost sharing is municipal's source of revenue	25	17.7
	Cost sharing helps in expanding health service	33	23.4
	Cost sharing helps in improving peoples' standard of living	20	14.2
Negative perception	Low income of citizens	49	34.8
	Poor utilization of the collection due to fraud	13	9.2
	Total	**141**	**100**

Source: Study Findings, 2013

From table 4.6 above it was the found that the biggest reason (23.4%) for positive perception towards health service cost sharing is that cost sharing helps improving and expanding the coverage and accessibility of health services in area which were not served before. On the other hand the biggest reason (34.8%) for negative perception towards health cost sharing is low income of the people in the council.

The same information is shown using a bar graph as indicated in figure 7 below

Figure: 7. Reasons for Perceptions Towards Cost Sharing in Health Services



Source: Study Findings, 2013

The reasons in the table above are further expanded/ elaborated as follows;

4.3.1.1 Other Reasons Developed For Positive Perception Towards Cost Sharing in Health Service Provision

- It is the source of revenue which helps in improvement of health service provision in terms of medicines, different hospital equipments, expansion of infrastructure like wards, laboratories, administration buildings, etc. This is true because it is the role of stakeholders to support the government in improvement of social services; health services being among the social services.
- Improvement of living standards of the people through prevention and curing different types of diseases which in turn keep citizens in healthy conditions
- From keeping away people from being attacked by diseases, the same helps in promoting economic development of the nation

4.3.1.2 Reasons Developed for Negative Perception Towards Health Service Cost Sharing Policy

The study found that the following were the reasons developed for negative perception towards cost sharing in health service provision

- Tanzania is a poor country, so are her citizens. In view of that, most of the citizens are living below the poverty line, hence they cannot afford meeting the fees charged as cost sharing expenses for health services
- Poor planning in utilization of the funds generated from the exercise of cost sharing. Thus sometimes they money are spent on activities other than the intended one or benefit few people instead of the majority in the society

4.4. Factors for Low Revenue Collections from Health Service Provision Cost Sharing

The researcher wanted to establish the factors for low revenue collections from cost sharing exercise. To generate information, open ended question *"What could be the reasons for low revenue collections from cost sharing exercise?"* Respondent were required to list a number of reasons for the low revenues collections in the council. Table 4.7 below portrays frequency responses for the question.

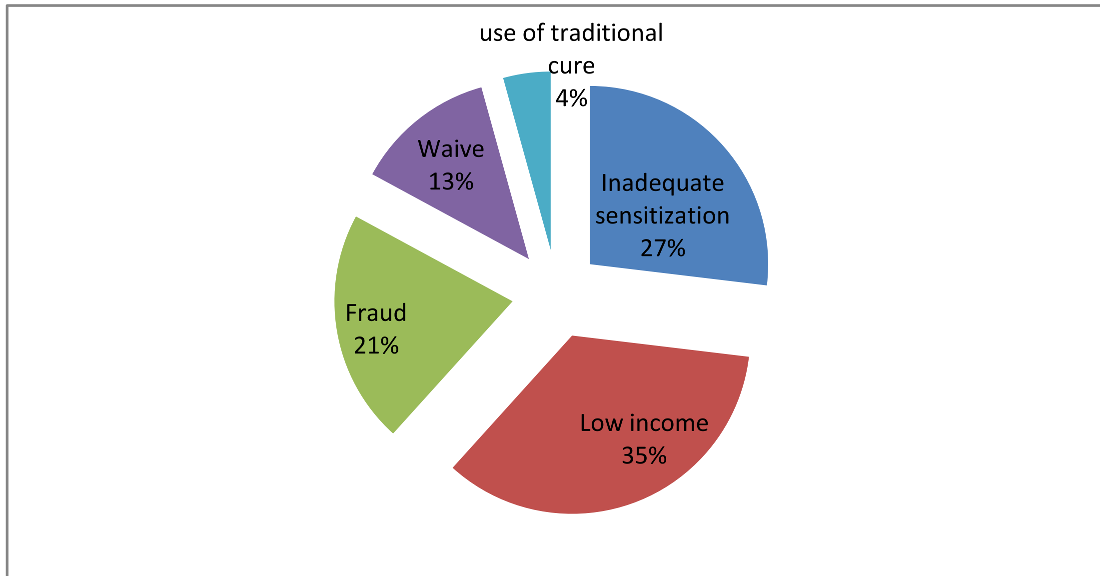
Table 4.7: Factors for Low Revenue Collections from Health Service Provision Cost Sharing

Responses	Number of respondents	Percentage
Inadequate sensitization of the policy	38	26.9
Low income of the people	49	34.8
Fraud done by employees in municipal council	30	21.2
Waive	18	12.8
Habit of not using hospital service (the use of traditional medicine)	6	4.3
Total	**141**	**100.0**

Source: Study Findings, 2013

Table 4.7 above shows that the biggest factor for low revenue collection from cost sharing is low income of the people which constitute 34.8%. However, low income of the people is not the factor alone than influence low revenue collection but other factors as indicated in the table above have positive influence for the low revenue collection.

Figure 8. Factors for Low Revenue Collections from Health Service Provision Cost Sharing



Source: Study Findings, 2013

4.5 Challenges Facing the Implementation of Health Service Cost Sharing Policy

The study wanted to know the challenges facing the implementation of health service cost sharing policy. The purpose of establishing the challenges was to learn if the challenges have influence on low revenue collection from the programme. The study found that the biggest challenge (37%) poor control system to prevent fraud. However there are other challenges that are contributing factors for low revenue collections. The factors are poor utilization of funds (27.4%), in adequate resources for policy and programme sensitization (22%) and inadequate knowledge in collection and reporting of the revenues. Table 4.8 indicates the responses about challenges facing cost sharing practice in Kinondoni Municipal Council.

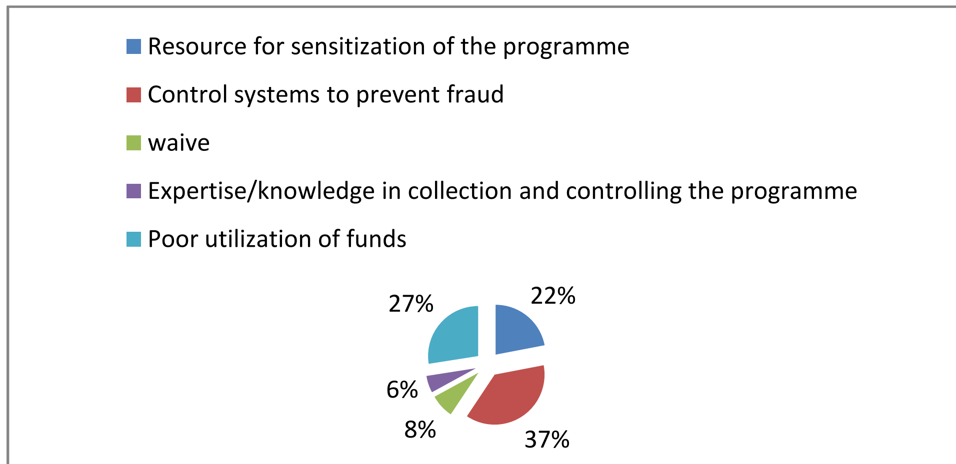
Table 4.8 Challenges Facing Cost Sharing in Kinondoni Municipal Council

Challenges	Number of respondents	Percentage
Resource for sensitization of the programme	20	22
Control systems to prevent fraud	34	37
waive	7	7.7
Expertise/knowledge in collection and controlling the programme	5	5.5
Poor utilization of funds	25	27.4
Total	**91**	**100**

Source: Study Findings, 2013

The same information is shown using a bar graph as indicated in figure 9 below

Figure 9. Challenges Facing the Implementation of Cost Sharing Policy



Source: Study Findings, 2013

CHAPTER FIVE
CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The study concludes that patients have positive perceptions towards health cost sharing policy in health provision points in Kinondoni Municipal council. The study reveals majority of the respondents supported the policy and its implementation. The study further shows that the factors poor revenue collections from cost sharing exercise are many but the basic ones are low income of the people, inadequate sensitization of people about the importance of cost sharing in the whole aspect of health service provision, municipal council employees' fraud, waive and traditional cure of different diseases. Pertaining to the challenges facing the implementation of the policy, the study found that the biggest challenge is poor planning and utilization of the collected revenue as some funds are allocated for use other than the intended purposes. Other challenges are inadequate or lack of resource for sensitization of the policy as well as the programme among the citizen, waive and insufficient knowledge of collecting and reporting the same to the authority.

5.2 Summary of the Findings

a) Patients Perception towards Cost Sharing

The study found that patients had positive perception toward cost sharing as 50.9% reflected acceptance of cost sharing in health services.

b) The study found that the factors that contribute towards low revenue collection from cost sharing include; inadequacy sensitization of the policy of cost sharing, low income of the people, waive and the habit of the people not using hospital services.

c) The study found that the challenges for the implementation of cost sharing include; inadequate sensitization of the policy, inadequate control systems to prevent fraud, limited knowledge / skills in the collection and reporting of the collections and poor utilization of funds.

5.3 Recommendations

Based on the findings of the study, the following recommendations are essential;

a) **Municipal Management Should**

i. Ensure adequate funds are set aside for the purpose of planning, designing and implementation of sensitization programmes and campaigns so as generate more awareness of the importance of health service cost sharing. By doing so the council will raise awareness to a large number of the municipal dwellers. In view to the same, awareness will enhance majority of the community members to willingly participate in the programme the situation which ultimately raise revenue collections.

ii. Ensure there are adequate controls mechanism set to track and prevent fraud among staff members who are entrusted with the running of the exercise. The control systems may include electronic receipts delivery machines, which eliminates manual receipts writing and issuing procedure. Manual system of issuing receipts for cost sharing has a lot of weaknesses through which collecting and reporting officers can engage in fraudulent actions. Fraudulent actions are among the factors that contribute to low revenue collections from cost sharing exercise. Should the management decide to have electronic control systems in place, systems will reveal weak areas in both processes of collecting and reporting of the collections, hence the systems will avoid fraud which eventually help the council to increase the revenue collections generated from cost sharing practice in the council

iii. Reduce bureaucracy in the whole process of implementing cost sharing policy. This can be done by ensuring all necessary matters for ensuring the policy is in move and in right track are in place and accomplished in the time required. For example, when it comes to the issue of approving funds /budgets for different activities such as sensitization campaigns,

training of staff, improvement of health service under the cost sharing programme, the management should play it part at the right time. The management should also reduce bureaucracy in recruiting the right personnel to engage in the exercise operations. It noticed that, in most municipal councils, when it is time for recruitment, some of management member tend to practice nepotism in make employees available for the council activities. Some of these employees lack qualification at the same time are tasked with activities relating to health service cost sharing. In view of this situation, the fail to perform at the expected levels.

iv. Citizens should be encouraged use modern health services (hospital services) rather traditional ones. More use of the hospital services instead of traditional treatments will increase revenues generated from cost sharing

b) Municipal Employees

v. The management should ensure members of staff are well trained in their respective areas of their expertise so as to ensure good provision of services to the extent that service receivers enjoy the fruit of the policy of cost sharing. Excellent service provision will enhance increase in the use of health services which in turn will increase revenue collections from the exercise.

vi. Those employees who are entrusted to oversee the exercise of health service provision cost sharing should adhere to their profession ethics. Ethical behaviours tend to capture trust from service users. Trust in the service providers influences repeat use of services. in this aspect, revenue collections will increase.

vii. Municipal employees should be transparent by revealing both the true levels of collections and reporting the correct information about revenue collection from the exercise. By doing so the revenue collected will raise.

viii. Waive of payment from the exercise of costs sharing is restricted to children and old aged people who cannot afford the charges. Unfaithful employee do extend waive to people other than the aforementioned ones. The situation tends to reduce the collections. To prevent the problem from keeping happening, professional ethics workshops, seminars and trainings should be planned and implemented to remind and revive the employees mind set towards their professional ethics. professionals such as accountants, auditors, doctors, etc should be the target groups for the workshops and seminars

ix. Increase employees' incentives for the purpose of reducing fraud. Increase in pay and allowances may lead to staff satisfaction thus reduce the level of fraud and at the same time increasing the level of revenue collections from cost sharing practice

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APPENDICES

Appendix1: Questionnaires

QUESTIONNAIRES FOR KINONDONI MUNICIPAL COUNCIL

(To be filled by Management, Doctors, Accountants, Staff Incharges/Supervisors and Local community leaders)

Dear Respondent:

I am Rose Pantaleo Mutale a Master degree Student from Mzumbe University conducting a research on "Assessment on the Factors for low cost sharing collections in Health services in Municipal councils" A case of Kinondoni Municipal council, as partial fulfillment of Masters of Science in Accounting and Finance (Msc. A&F) programme.

Kindly assist me to respond the question below as much accurately so as to reach reliable, validity and objective conclusions. The Information given by you will be treated confidential and under purely for academic purpose.

PART I: GENERAL INFORMATION

Gender: Male ☐ Female ☐

Age ………………..

Education level

(i) Primary ☐ (iv) Certification ☐

(ii) Secondary ☐ (v) Diploma ☐

(iii)Degree ☐

PART II: STAKEHOLDERS PERCEPTION ABOUT HEALTH SERVICES COST SHARING

(i) Health services Cost sharing policy good? Do you agree?

Strongly Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

(ii) The amount charged as cost sharing is affordable?

Strongly Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

(iii) What do you think could be the reasonable charge?....................................?

(iv) The systems used to collect and control the cost sharing revenue is adequate

Strongly Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

(v) The personal entrusted in running the project have adequate knowledge, skills and experience

Strongly Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

(vi) The methods used to collect cost sharing revenue are use friendly

Strong Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

(vii) The money collected from cost sharing revenue properly utilized

Strongly Disagree ☐ Disagree ☐

Agree ☐ Strongly Agree ☐

PART III FACTORS FOR LOWER REVENUE COLLECTIONS

(i) Is the sensitization of health service cost sharing policy adequately done?...

(ii) What do you think could be the reasons of poor revenue collections in municipal
councils?...

(iii) What are the challenge of the implantation of cost sharing practice?

(a) …………………………………………………………………

(b) …………………………………………………………………

(c) …………………………………………………………………

(d) …………………………………………………………………

(e) …………………………………………………………………

(f) ………………………………………………………………

What are your suggestions about the proper ways of implementing health service cost sharing policy?

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Thank you for your cooperation

Appendix 2: Interview Guides

1. Is health services Cost sharing policy well?
2. Are the amount charged as cost sharing is affordable?
3. What do you think could be the reasonable charge?
4. The money collected from cost sharing revenue are properly utilized
5. What do you think could be the reasons of poor revenue collections in municipal councils?