PROCESS EVALUATION OF TEMPORARY EXEMPTION IMPLEMENTATION FOR EMERGENCY CASES IN ST. AUGUSTINE MUHEZA DESIGNATED DISTRICT HOSPITAL

PROCESS EVALUATION OF TEMPORARY EXEMPTION IMPLEMENTATION FOR EMERGENCY CASES IN ST. AUGUSTINE MUHEZA DESIGNATED DISTRICT HOSPITAL

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A research report Submitted to School of Public Administration and Management of Mzumbe University in partial fulfillment of Requirements for the Award of Masters of Science Degree in Health Monitoring and Evaluation of Mzumbe University.

2019.

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled "**Process evaluation of temporary exemption implementation for emergency cases in St. Augustine Muheza designated district hospital"** in partial fulfilment of the requirements for award of the degree of Master of Science in Health Monitoring and Evaluation of Mzumbe University.

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DECLARATION AND COPYRIGHT

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

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Finally, special appreciation is to my family; my children and my wife Esther whom they devoted a lot of time praying for me and remained resilience with endless endurable during my home absences for data collection and execution of this study.

DEDICATION

I dedicate this thesis to my beloved little brother Jeremiah Gaspar for his support, patience love and encouragement, which continually strengthens me. Also my wife Esther Sengovi for all the unconditional support constantly given has been an inspiration and to all my friends for their prayers.

LIST OF ABBREVIATIONS

A&E	Accident and Emergency Department
CHF	Community Health Fund
HOP	Hospital Operational Plan
CT	Computerized Tomography
DDH	Designated District Hospital
DED	District Executive Director
DPO	District Police Office
ED	Emergency Department
EMS	Emergency Medical Services
ER	Emergency Room
ESI	Emergency Severity Index
EW	Emergency Ward
GNP	Gross National Product
HSBF	Health Sector Basket Fund
HSR	Health Systems Reform
ICU	Intensive Care Unit
IPD	Inpatient Department
MRI	Magnetic Resonance Imaging
NIC	National Insurance Corporation
OC	Other Charges
OPD	Outpatient Department
RTA	Road Traffic Accident
RTI	Road Traffic Injury
SAM	St. Augustine Muheza
UHC	Universal Health Coverage

ABSTRACT

This study was set to evaluate temporary exemption implementation for emergency cases at St. Augustine Muheza designated district hospital. A temporary exemption is the process in which patients who have no money for covering health services at the point of service delivery, after being assessed by a social welfare officer, have a chance of receiving services under loan agreement so that such money to be settled on later. The main purpose is to ensure accessibility to health services regardless of the ability to pay.

The general objective of the study was to evaluate temporary exemption implementation for eligible emergency cases and its effect on sustainability in revenue collection.

The study was meant to answer the following research questions: How is the guideline for cost-sharing policy in the area of temporary exemption to emergency cases are being implemented at St. Augustine Muheza designated district hospital?; How the follow-ups of un-paid bills from patients who received temporary exemptions are being conducted?; How verification of payments which have done by clients who were given temporary exemptions, and are already at their homes are conducted? and; What are the factors facilitating or impinging the payment of bills by temporarily exempted patients at St. Augustine Muheza hospital?

The study applied a descriptive cross-sectional design, in which participants were selected through purposive and convenient sampling techniques. Documentary review, in-depth interviews and focus group discussions were used for data collection. A total of 34 respondents participated in the study whereby 8 health workers involved in one FGD, and the rest 26 (both health workers and community members) participated in the in-depth interviews. The content analysis method was used to analyse data from field.

The overall results revealed that about 2% of the total patients admitted at St. Augustine Muheza designated District hospital per year received temporary exemptions, and for three consecutive years only 3.5 out of 94.6 million were paid as temporary exemption bills. The low payment of bills was due to the lack of follow-

up strategies at the hospital, absence of social welfare department and lack of community sensitization.

This study documented that, St. Augustine Muheza designated district hospital have no mechanisms for bills payment, lack of social welfare officers, and lack of community sensitization are some of the factors influencing the low payment of bills that led the hospital to operate under budgets.

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CHAPTER ONE

INTRODUCTION.

1.1 Background.

In 1978 world leaders, international organizations and health authorities gathered in Alma-Ata (now Almaty), Kazakhstan, and released the Declaration of Alma-Ata on Primary Health Care, which remains a landmark document in the history of global health. The Alma-Ata Declaration established a standard of public commitment to making community-driven, quality health care accessible, both physically and financially, for all. This was the forerunner of the Global Strategy for Health for All by the Year 2000 that was pursued by WHO and its partners for the rest of the 20th century, and of Sustainable Development Goal (SDG) 3: "Ensure healthy lives and promote well-being for all at all ages" by 2030 (Ghebreyesus & Fore, 2018).

Immediately after independence, 1961, the Government of Tanzania aimed at building her human capital by isolating factors that were launched as "major enemies of development": ignorance, diseases, and poverty. Disease as an enemy was fought by a massive increase in health facilities and low primary health care training institutions, most of them owned by the government. Alongside the public sector existed the non-for-profit health facilities, mostly owned by Faith-based Organizations. Tanzania went through a severe economic crisis in the 1980s, which adversely affected the management and financing of basic social services including health care services (Shole, 2015).

In December 1993 the Ministry of Health formulated a guideline for implementation of the cost-sharing policy at health facilities, that was reviewed in 1997 to ensure access of healthcare to vulnerable groups, including emergency cases. The guideline was meant to guide service provision to ensure accessibility and responsiveness to the health needs of the people. The guideline recognizes the presence of groups of people who should receive the permanent exemption as well as a waiver from paying for treatment bills. These groups include pregnant women, all under-five children, people suffering from chronic diseases such as Tuberculosis and epidemic diseases, elderly people of 60 years and above, and poorest people. The rest are required to

contribute to health service charges through direct out of pockets or insurance schemes. But if patients in this group who require emergency health services do not have money for covering their treatment charges while at the hospital, the room is provided for requesting temporary exemption permit, in which such bills can be settled either immediately after the discharge or few weeks or months later. (MoH, 1997).

However, experience has shown that although hospitals attends many clients who must pay through user fee, it operates under budgets due to high un-paid bills from emergency cases which were given temporary exemptions but on later fail to repay their bills that lead the hospital to run under budgets.

Provision of temporary exemptions basing on the guideline of cost-sharing policy should start with emergency service delivery regardless of ability for payment, what is important is to serve life first, then other procedures follow. A Social welfare officer will then sort-out patients who are eligible for permanent exemption or waiver. The rest will be assessed whether they can pay for services. Before or after patients' discharge, follow-ups for unpaid bills must be conducted, whereby implementation of payment are to be conducted through hospital bank accounts, cash office, or through mobile money transfer. Then payment verification must be done by an Accountant through bank statements as well as by preparation of monthly and quarterly financial reports (MoH, 1997).

The study was focused on the implementation of temporary exemption for emergency cases to enable patients under emergency care to get treatment first and later on, make some arrangements for payment of treatment charges. Therefore the issue is either patient under emergency care to pay for treatment charges or to receive a permanent or temporary exemption.

St. Augustine Muheza DDH have various sources of fund that enhances the operationalization of annual activities within the hospital, namely user fee, HSBF, income from various generating activities, NHIF, O.C and donors. Out of these sources, user fee and NHIF are the main sources that finances many activities both recurrent and development projects. For example, the annual budgets from 2015 to

2017 show that shares of user fee out of other sources of fund were 39.14%, 43.18% and 46.97% respectively. Under this source of fund, when collected effectively it can improve many services such as maintenance and procurement of fuel for vehicles and other equipment, rehabilitation and construction of new buildings, procurement of medicines and other supplies as well as for capacity building to service providers.

The main challenge is that St. Augustine Muheza DDH receive and provide medical treatments to emergency cases, but most of the patients who received temporary exemptions did not settle their treatment charges. For example, in 2017 the hospital provided temporary exemptions to 1,385 patients under emergency care with the value of Tsh. 94,655,547.52 as treatment charges, but only 111 patients (8.01%) settled their bills valued at Tsh. 3,535,271.15, leaving behind Tsh. 91,120,276.37 unpaid (96.3%) (SAM CHOP, 2017). The table below provides the summary.

Table 1.1: Amount of money in which St. Augustine Muheza DDH has incurred in 2017 to patients under emergency care versus amount not settled.

TEMPORARILY EXEMPTED PATIENTS	TOTAL VALUE OF MONEY EXEMPTED	PATIENTS SETTLED THEIR BILLS	AMOUNT SETTLED	PATIENTS NOT SETTLED	AMOUNT NOT SETTLED
1385	94,655,547.52	111	3,535,271.15	1274	91,120,276.37

Compiled by the Researcher, 2019.

Hospitals also have no strategies for making sure that such bills are settled, as a result health facilities are overwhelmed by emergency services that are adding low value in terms of facility revenues.

Therefore this study evaluated implementation of temporary exemption for emergency cases at Muheza Faith-Based Hospital to explore the reasons why there is high un-paid treatment costs.

The study enabled government to meet its stewardship goals in providing emergency health services, and at the same time increases revenue collections from patients who are eligible for user fee contribution for sustainable provision of emergency health services to its clients.

1.2 Statement of the Problem

Cost sharing in Tanzania started in 1993, it intended to reduce government spending and encourage self-reliance (Shole, 2015). Since the cost-sharing policy guideline is based on the assumption that with improved revenue collections, good working environment, supply of medicines and other medical equipment will improve the performance of health system, and therefore win back patients. This fact is contrary to the current situation at St. Augustine Muheza DDH in which the hospital is operating under budget due to high un-paid bills. Hence, discrepancy or gap of the study.

The flow of patients who visit St. Augustine Muheza DDH per year is huge compared to financial resources that are required to run the activities. For example, from the year 2015 to 2017 the number of patients range from 38,597 to 110,862 (DHIS2 2015, 2016 & 2017). Out of these patients, about 2% were temporarily exempted from paying the treatment charges. This is according to cost-sharing policy guideline that provides a room for those patients who doesn't have money for treatment costs while receiving health services to get temporary exemption without affecting the quality of services. But out of those patients who were temporarily exempted, about 85% of them left the hospital without settling their treatment bills

According to comprehensive hospital operational plans (CHOP) of St. Augustine Muheza DDH for 3 years, demonstrate that budgets of user fee versus actual revenue collections show a large gap between planned budgets versus actual collections. From financial year of 2015/2016 up to 2017/2018 the percentage of user fee collections were 17.64%, 16.83% and 20.57% respectively (SAM CHOP 2015/16, 2016/17 & 2017/18). These were very low amount of collections that cannot manage to finance the annual planned activities in the hospital. Therefore it might be assumed that, high un-paid bills from temporary exemptions may be one among contributing factors towards failure in collection of revenues to meet planned budgets. That being a case, this study evaluated the conduct of temporary exemption implementation as whole with a specific focus on emergency cases to observe the real gaps in as far as adherence to temporary exemptions conduct guidelines is concerned.

1.3 Evaluation Questions and Objectives.

1.3.1 Evaluation Questions.

1. To assess the implementation of temporary exemption to eligible emergency cases at St. Augustine Muheza DDH and its effect.
    i. How many emergency cases attended at St. Augustine Muheza DDH per year?
    ii. How is the guideline for cost-sharing policy in the area of temporary exemption to emergency cases are being implemented at St. Augustine Muheza DDH?
    iii. How the follow-ups of un-paid bills from patients who received temporary exemptions are being conducted at St. Augustine Muheza DDH?
    iv. How the follow-ups to motor vehicle insurance as well as to health insurance companies on unpaid treatment bills are being conducted at St. Augustine Muheza DDH?
    v. How payments of the treatment charges from emergency cases who were discharged from the hospital are being conducted at St. Augustine Muheza DDH?
    vi. How verification of payments which have done by clients who were given temporary exemptions, and are already at their homes are conducted at St. Augustine Muheza DDH?
2. To which extent is the guideline for cost-sharing policy in the area of temporary exemption to emergency cases are being implemented at St. Augustine Muheza DDH?
3. What are the factors facilitating or impinging the payment of bills by temporarily exempted patients at St. Augustine Muheza DDH?

1.3.2 Evaluation Objectives

1.3.2.1 General Objective

To evaluate temporary exemption implementation for eligible emergency cases at St. Augustine Muheza designated district hospital and its effect on sustainability in revenue collection.

1.3.2.2 Specific Objectives

i. To determine the level of emergency cases admitted at St. Augustine Muheza DDH eligible for temporary exemption.
ii. Examine implementation procedures of the guideline for cost-sharing to emergency cases eligible for temporary exemption.
iii. To examine compliances or overlap of implementation procedures of the guideline for cost-sharing to emergency cases eligible for temporary exemption.
iv. Determine the extent to which temporarily exempted patients fulfil the guideline requirement in paying back the cost.
v. To examine factors facilitating or impinging payment of bills by temporarily exempted people.

1.4 Significance of the Evaluation Study.

Health facilities usually receive and provide treatments to patients who might need emergency health services, among these patients; some may have not enough money to cover for health charges at the point of service delivery that requests for temporary exemption, but at later have to pay the bills. However, most of the patients who received temporary exemptions are not willing to settle their treatment charges. At the same time, most hospitals do not have strategies for dealing with the management of temporary exemption charges as a result, it may affect the sustainability of the emergency services delivery to patients under emergency care in terms of low revenue incomes.

Therefore there was a need for this research to be conducted because repayment of temporary exemption bills might bring about changes on availability, composition, conduct and improved health facility's revenues.

The study also, aimed at ensuring the health facilities and other stakeholders serve the people under temporary exemption with service that satisfies them and takes necessary measures that will help to solve the challenges they face during health service provision. The weaknesses, which are identified during service provision, may help the government to develop strategies, which will have a positive impact on policy implementation.

1.5 Description of the policy guideline to be evaluated.

1.5.1 Introduction.

Tanzania, like many countries in sub-Saharan Africa, faces the twin pressures of a tight public health care budget and the need to improve access to health services, especially for the poor and those working in the rural areas and/or the informal sector. As part of wider reforms in health care financing, Tanzania introduced user fees in 1993. This followed the failure of the government to provide free health care to all its citizens through tax financing due to the increase in treatment costs, the emergence of pandemic diseases such as HIV/AIDS and the overall poor performance of the economy (Mtei & Mulligan, 2007).

Therefore, the implementation of temporary exemption under the cost-sharing policy guideline in health facilities creates the fairness environment between those who can pay for health service charges and those who cannot pay.

1.5.2 Stakeholders Analysis.

Stakeholder's analysis was carried out to identify persons or organizations who can be positively or negatively impacted by the temporary exemption being implemented.

In the implementation of the temporary exemption under the guideline of policy for cost-sharing at health facilities to patients under emergency care, the main stakeholder is a **Ministry of Health Community Development Gender Elderly**

and Children (MOHCDGEC). MOHCDGEC as a designer and owner of the policy for cost-sharing formulate the procedures for implementation of various programs including temporary exemption guideline. The Ministry is responsible for the overall management of the guideline in the implementation of policy for cost-sharing at health facilities in the area of temporary exemption to vulnerable groups. The Ministry is further participating in supervising and ensuring that the implementation of temporary exemption is carried out.

Council Health Management Team (CHMT): Temporary exemption program is managed from the district level. They are primarily responsible for ensuring that the implementation of the guideline for a policy of cost-sharing at health facilities are carried out. CHMT is also a supportive supervisor of the guideline implementation.

Health Facilities: Health facilities are responsible for implementing the policy for cost-sharing under emergency care. They provide emergency health services to their in-patients as well as temporary exemption to those who require.

Health Workers: This is a workforce necessary for the provision of healthcare based on the guideline of policy for cost-sharing at health facilities. They include doctors, nurses, technologists, and administrators. They must be knowledgeable enough to provide temporary exemptions as well as on strategies for follow-ups of all unpaid treatment bills.

Patients under emergency care: These are victims who require emergency health care services. They are divided into three groups namely, those who should be permanently exempted basing on the policy (under-five children, pregnant women, people suffering from chronic diseases and elderly people), those who should be waived basing on their economic status and those who should pay through direct out of pockets or through medical insurance cards.

In this study, I was based on those who must pay for health services through various methods, whereby among these, some of them might be granted temporary exemptions, due to lack of money on that time of service delivery and therefore required to settle their bills on later.

Motor Vehicle Insurance organizations: These are firms responsible for providing financial coverage to their insured party (medical payments). Motor insurance protects the driver, the passengers, and their vehicle.

Health Insurance Organizations: The firms provide access to discounted medical care. They protect members from the cost of medical treatment, and therefore wellbeing support.

Close Relatives: These are relatives to patients under emergency care who are responsible for taking care of their fellows while patients are admitted as well as when they are at home. They are responsible for providing moral support to their patients.

Community: The community members are responsible for providing moral support to the patients under emergency care as well as to those who were injured immediately after the accident occurred. Good Samaritans can also provide support by taking accident victims to hospitals.

Table 1.3: Summary of Stakeholders Analysis.

Stakeholders	Role in the program	Interest in the program	Role in the assessment	Means of communication	Level of importance
MOHCDGEC	Policy and guideline formulators for implementation of temporary exemptions	Knowing the gap in implementation of guideline for temporary exemptions.	Making some rectifications of policy and guideline where necessary.	Website, News releases, Email based and Print detailed report	High
CHMT	Management of the guideline of policy for cost sharing in the area of temporary exemption.	Knowing the gap during implementation of guideline.	Tracking the implementation of the guideline.	Written reports and meetings.	High
Health Facilities	Implementation of temporary exemption activities.	Availability and use of the guideline.	Tracking the implementation of the guideline.	Written reports and meetings.	High
Patients under emergency care	Settle treatment charges.	Availability of emergency services basing on guideline.	Requesting for exemption permits.	Request forms and oral conversations.	High
Motor Vehicle Insurance Organizations	Settlement of treatment bills	Information about vehicles and membership of Casualties.	Tracking bills for members.	Emails, Written reports.	High
Health Insurance Organizations	Settlement of treatment bills	Information about membership of Emergent patients.	Tracking bills for members.	Emails, Written reports.	High
Close Relatives	Taking care for patients.	Information about provision of temporary exemptions.	Follow-ups on temporary exemption permits.	Mobile phones and through oral conversations.	Medium

Community such as Good Samaritans	Providing moral support to people involved in accidents.	People involved in accidents supported.	Communication with authorities.	Mobile phones and through oral communication.	Low

Source: Compiled by the Researcher (2019).

1.5.3 Expected Effects/ Objectives.

Implementation of temporary exemption has evaluated. This is one of the section in **t**he guideline for implementation of cost-sharing policy document at health facilities. The guideline provides a permit to some of the utilizers to receive health services without paying for, and without affecting the quality of services. The main purpose is to make sure that:

1. Every citizen receive health services regardless of his/ her economic status.
2. To reduce burden of medical treatment bills to citizens, especially on chronic diseases.
3. To reduce under five mortality.
4. To protect vulnerable group.
5. To reduce effects which can lead to maternal as well as infant mortality.
6. To protect marginalized group and elderly people (page 17 of the guideline).

Therefore, this study has based on objective number one above.

According to the guideline, the section of temporary exemption (section 5.2) provides that, patients under emergency care who deserves for temporary exemptions should not be; under five, pregnant women, 60 years of age and above, should not have chronic diseases such as Tuberculosis or Leprosy, and should not be poor (MoH, 1997).

A temporary exemption, therefore, is the mechanism provided by a guideline to clients who can't pay at the moment of receiving health service but should pay on later. What is needed is the client to make a request, in which decision must be made after hospital management has been satisfied that a client deserves for temporary exemption.

An official person who is responsible for providing exemptions will make some assessment about the economic status of a patient by conducting an interview, his/ her physical addresses as well as other contacts, and therefore will recommend if he/ she deserves for temporary exemption. But what is happening on the ground is that some of the patients under emergency care who were given temporary exemptions are not willing to settle their bills. On the other hand, it seems that some of the service providers are not aware of the guideline for implementation of cost-sharing policy, particularly in the section of temporary exemption which provides a room for those in-patients who doesn't have money on that time for their treatment charges. Therefore, as a result, some of the patients are always treated free of charge while they are supposed to pay for services. What is required are those patients to be guided on procedures for requesting temporary exemption permits so that to settle the bills on later (MoH, 1997).

For emergency cases which granted temporary exemption permit, and who have been referred to higher authorities for more health management must be provided with referral letters together with exemption letters to enable them to be attended unconditionally.

The duration for temporary exemption will last for the period of the current condition, if a client came for the second visit for a further problem will be required to request for another exemption permit if he/she still deserves (MoH, 1997).

1.5.4 Major Strategies.

Temporary exemption must be given to patients under emergency care basing on the ability to pay, although on later, patients who granted such exemptions should repay their bills, either through their relatives' initiatives utilizing out-of-pockets or by themselves in terms of an insurance scheme or by other means. This is insisted because temporary exemption permit should be regarded as health facility revenues.

1.5.5 Activities and Resources.

The guideline insists health workers to provide services first to emergency cases regardless of the ability to pay, and then after their medical treatment, Social welfare officer should come and make an assessment on whether a patient can pay. Patients

who are eligible for cost-sharing will be required to pay when they have money at that moment, but if they don't have, should request for temporary exemption.

Patient's ability to pay is the major concern of service providers because it affects the provision of emergency services within the facility, and that's why making follow-ups on unpaid charges is a very important assignment.

Hospital management staff should also make follow-ups to motor vehicles insurance companies such as National Insurance Corporation (NIC) and other public and private health insurance companies to pay for medical service bills for road traffic accident casualties if such vehicles and casualties follow under their membership.

According to guideline, the following are temporary exemption procedures for in-patients:

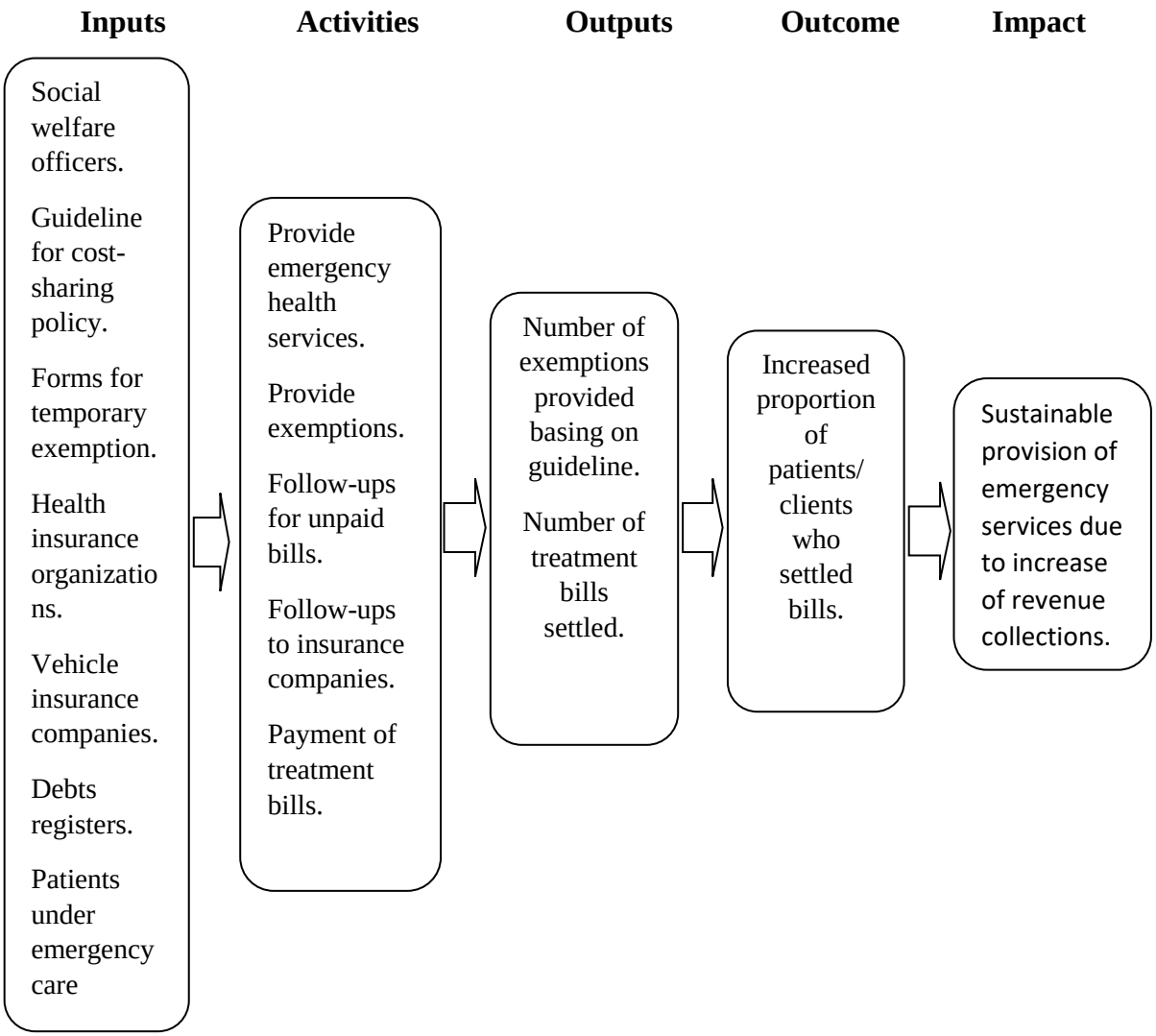
1. The clinician or a nurse who took care of a patient will request for temporary exemption. The request will be addressed to a Social welfare officer or any other officer who is responsible for temporary exemptions.
2. If the patient deserves, hospital management will provide a permit for temporary exemption.
3. A special form for temporary exemption will be used. The form is also considered as a financial document for revenue in the hospital.
4. When a patient who was admitted, after he/she discharged, his/her exemption number must be noted in the in-patient's debts register for follow-ups.

Therefore service providers should adhere to the above procedures during the management of patients under emergency care who deserves for temporary exemptions.

1.6 Logical Model.

A logical model shows relationships between the inputs of the policy guideline, main activities, or components, the associated output, outcome and the impact.

Figure 1.1: Logical model



Source: Compiled by the Researcher (2019).

CHAPTER TWO

LITERATURE REVIEW.

2.1 Introduction.

This chapter visits a wide range of literature available from various sources to help in the conceptualization in broader perspectives and identifying gaps within the framework of existing literature. The literature review focuses on process evaluation of the guideline for implementation of temporary exemptions at health facilities, in way of shaping this evaluation to know areas of concentration in identifying what was known in this area and the methodological approaches used to generate that knowledge and its relevance. In addition, the literature review help in informing the study or evaluations of other similar studies conducted in different contexts and allow comparisons or learn from them.

2.2 Responsibility of Governments in provision of social services.

The health of every human being is the major factor that determines power of someone to think and act upon a piece of work. A human being is the centre of all development; the human condition is the only final measure of development in any society. Governments are responsible in making sure that citizens in their respective countries are provided with social services. These services may be provided to people using two ways; free provision through public subsidization or through the contribution from both citizens and respective governments for the purpose of bringing about community development. Considering that governments in Sub-Saharan Africa, including Tanzania, have the social responsibility to assure the availability to their population of quality and affordable social services including health. Tanzania used to provide basic social services to all citizens free of charge. The government was the major provider of all health care services, and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee (Shole, 2015).

2.3 Health care financing

Financing health care is a prominent political issue and a priority for the health sector throughout the world. In industrial nations, reform has focused mainly on containing costs. In developing countries, reform has been motivated by growing demand for better health care at a time when government, faced with shrinking resources, can no longer honor its traditional commitment to provide "free" care for all (Leighton, 1995).

According to the economic crisis in the 1980s, costs for health services were increased. However, shortage of budget of the government and high population growth caused the government budget especially of the health sector to be dependent to the donors. This caused the health services to be not sustainable, and the community failed to own them properly. For this situation, in 1993, the government decided to participate its community in cost sharing for their health services. The aim of this policy is to expand source of fund for health services in order to stabilize and develop source of revenue for the service provision and minimize dependent of the government on donors (URT, 2011).

2.4 Effects of Underfunding of health services.

The health care sector faced severe underfunding that affected the quality and provision of health care services. Underfunding of the health care delivery system at all levels led to, among others: shortage of drugs, equipment and medical supplies; overall deterioration of the physical health infrastructure including electricity supply, water and sanitation at the health care facilities; poor management and regulatory framework; and very low wages and other incentives for health care workers, which resulted in low staff morale. In the process of implementing the Health Sector Reform (HSR) proposals, a number of policies, guidelines, Acts and programmes have been developed and implemented in Tanzania. All these were and are aimed at improving the quality and quantity of health services and increase in equity in health accessibility and utilization (Shole, 2015).

Payments for health services, in the form of user charges, are likely to present a barrier to access. Yet, a shortage of resources at the facility level is a contributor to

failure to deliver quality services, and this also presents a barrier to access (Lagarde & Palmer, 2008).

2.5 User fee as a goal of preserving equitable access to services.

In many developing countries formal or informal user fees for health services are widespread and tend to account for a significant share of the financing for non-personnel costs. Thus, health systems in developing countries have come to rely on user fees. Yet where there is a lack of provisions to confer partial or full waivers to the poor user fees may lead to inequity in access to medical care. The dilemma, then, is how to make a much needed system of user fees compatible with the goal of preserving equitable access to services (Bitran & Gedion, 2003).

Universal coverage and a reorientation towards primary health care is an international goal. Financial risk protection is a cornerstone of universal coverage along with access to care. Health spending through out-of- pocket payment (OOP) is not always easy to cope with. Households may encounter financial hardship and poverty as a result. Indeed, effective and equitable health systems and universal coverage ensures that citizens are able to access needed care without suffering financial hardship. As such all strategies in moving towards universal coverage need to fundamentally address financial risk protection (Saksena & Durairaj, 2010).

When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in “financial catastrophe” for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education. Three factors have to be present for catastrophic payments to arise: the availability of health services requiring out-of-pocket payments; low household capacity to pay; and lack of prepayment mechanisms for risk pooling (Xu, Evans, Carrin, & Aguilar-Rivera, 2005).

Cost-sharing in Tanzania was intended to reduce government spending and encourage self-reliance. Since the cost-sharing policy guideline is based on the assumption that with improved revenue collections, a good working environment, payment of fringe benefits to health workers, a good supply of medicines and other medical equipment will improve the performance of the health system, and therefore

win back patients. This fact is somehow contrary to hospitals, in which the hospitals are operating under budgets due to high un-paid bills, hence discrepancy of the study.

2.6 Financing Mechanisms as a strategy to improve health services in Tanzania.

Since 1993, the Government of Tanzania (GOT) initiated a health sector reform process to better utilize health resources and improve access to Primary Health Care (PHC). This process included the introduction of several private financing mechanisms in the form of user fees in public facilities and private health insurance schemes that pooled resources in effort to improve health services and alleviate financial risk to individuals. In 1999 GOT introduced the Community Health Fund (CHF) which targets the poor and those living in rural areas. In 2001 it introduced the National Health Insurance Fund (NHIF) for civil servants. More recent financing mechanisms include the Social Health Insurance Benefit (SHIB), under the National Social Security Fund (NSSF), private insurance, and other micro-insurance schemes. All these financing reforms are aimed at improving availability and accessibility of health care to all groups of people in the country, rural and urban (Musau & Chee, 2011).

2.7 Purposes of the Guideline for Cost sharing Policy at Health Facilities.

The guideline for implementation of cost sharing policy at health facilities in the area of temporary exemption provides a permit to some of the utilizers to get health services without paying for, and without affecting the quality of services. Main purpose is to make sure that: Every citizen receive health services regardless of his/ her economic status, to reduce burden of medical treatment bills to citizens- especially on chronic diseases, to reduce under five mortality, to protect vulnerable group, to reduce effects which can lead to maternal as well as infant mortality, and to protect marginalized group and elderly people (MoH, 1997).

Provision of temporary exemptions basing on guideline should start with emergency service delivery, then a Social welfare officer will sort out patients who should be permanently exempted or waived. The rest will be assessed whether they can pay for services at that moment. Those who cannot pay at that particular time, they can be provided with temporary exemptions. Before or after patients' discharge, follow ups

for unpaid bills must be conducted, in which payment can be done through hospital bank accounts, cash office, or through mobile money transfer such as Tigopesa. Then payment verification must be conducted through bank statements as well as through monthly and quarterly financial reports (MoH, 1997).

2.8 Emergency and Emergency Medical Services.

Emergency care covers a spectrum of activities, including: prehospital care and transport; initial evaluation, diagnosis and resuscitation; and in-hospital care (Reynolds, 2007).

An Emergency Medical Services System (EMSS) is the planned configuration of community resources and personnel necessary to provide immediate medical care to patients with sudden or unexpected illness or injury. An EMSS can be local, regional or statewide (Razzak & Kellermann, 2002).

The purpose of emergency medical care is to stabilize patients who have a life-threatening or limb-threatening injury or illness. In contrast to preventive medicine or primary care, emergency medical care focuses on the provision of immediate or urgent medical interventions. It includes two major components: medical decision-making, and the actions necessary to prevent needless death or disability because of time-critical health problems, irrespective of the patient's age, gender, location or condition (Razzak & Kellermann, 2002).

2.9 Emergency Severity Index (ESI).

The Emergency Severity Index (ESI) is a tool for use in emergency department (ED) triage. The ESI triage algorithm yields rapid, reproducible, and clinically relevant stratification of patients into five groups, from level 1 (most urgent) to level 5 (least urgent). The ESI provides a method for categorizing ED patients by both acuity and resource needs. The purpose of triage in the emergency department (ED) is to prioritize incoming patients and to identify those who cannot wait to be seen. The triage nurse performs a brief, focused assessment and assigns the patient a triage acuity level, which is a proxy measure of how long an individual patient can safely wait for a medical screening examination and treatment. The ESI is intended for use

by nurses with triage experience or those who have attended a separate, comprehensive triage educational program. Inclusion of resource needs in the triage rating is a unique feature of the ESI in comparison with other triage systems. Acuity is determined by the stability of vital functions and the potential threat to life, limb, or organ. The triage nurse estimates resource needs based on previous experience with patients presenting with similar injuries or complaints. Resource needs are defined as the number of resources a patient is expected to consume in order for a disposition decision (discharge, admission, or transfer) to be reached (Gilboy & Tanabe, 2011).

2.10 Features of Emergency Department.

An emergency department (ED), also known as an accident & emergency department (A&E), emergency room (ER), emergency ward (EW) or casualty department, is a medical treatment facility specializing in emergency medicine, the acute care of patients who present without prior appointment; either by their own means or by that of an ambulance. The emergency department is usually found in a hospital or other primary care center. Due to the unplanned nature of patient attendance, the department must provide initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention. The emergency departments in hospitals must operate 24 hours a day, although staffing levels may be varied in an attempt to reflect patient volume.

When you first arrive at the emergency department, a triage nurse will assess how sick or injured you are. You will then been seen by an appropriate healthcare professional – this may be a doctor, a nurse practitioner, an allied health professional or a mental health worker, depending on your problem. How quickly this happens will depend on how busy the emergency department is and how urgently you need treatment. The medical staff who may treat you in the emergency department include: Emergency physicians, registrars, hospital medical officers, or interns. You may also see other specialists and healthcare professionals who can help with your treatment, such as: Nurses, Allied health professionals, such as physiotherapists, occupational therapists and emergency department pharmacists. Others are Mental

health emergency care team, who can conduct mental health assessments, Care coordinators, who work with hospital staff, general practitioners and other professionals, to make sure you receive high-quality treatment (Bache & Armitt, 2018).

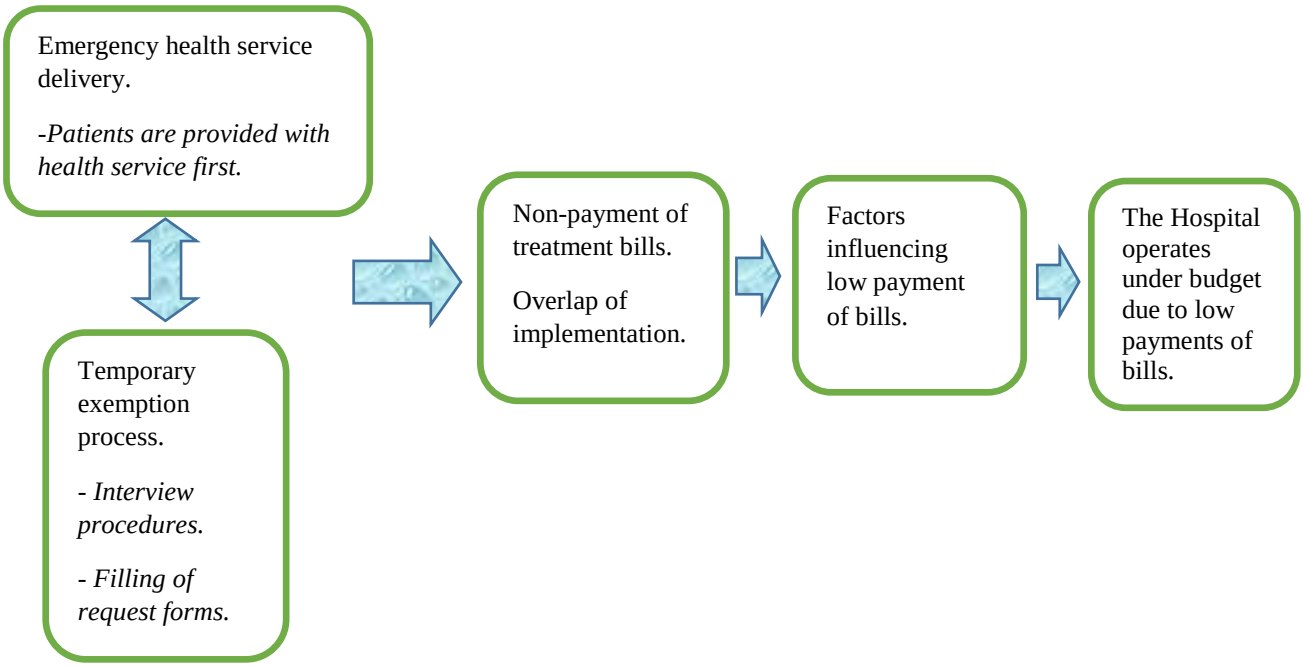
As part of your diagnosis and treatment, you may be sent for tests such as x-rays or scans. Technicians, such as radiographers or sonographers, and radiologists. They may use a range of diagnostic imaging techniques such as: X-ray, Computerized Tomography (CT) scan, Magnetic Resonance Imaging (MRI) scan, Ultrasound, and nuclear medicine. You may also need blood tests while you are in the emergency department. These are sent to the pathology service where laboratory staff do the blood tests and then send back to specialist doctors for review (Bache & Armitt, 2018).

If you don't need to be admitted to hospital after your treatment in the emergency department and are discharged directly from there, you will be provided with advice and a discharge plan if necessary. This plan gives instructions for your recovery and outlines any ongoing services you may need. You may also be given other information about your condition, such as a fact sheet. In spite of the emergency beds forming only a fraction of the hospital beds, road traffic accident casualties consume a relatively large proportion of the hospitals resources. There is a requirement to ascertain the cost incurred in providing emergency care treatment to the patients coming to the hospital (Garg & Gupta, 2016).

2.11 Conceptual Framework

This conceptual framework which underlies the research design is guided by the literature review and the aim and objectives of the study.

Figure 2.1: Conceptual Framework



Source: Compiled by the researcher, 2019

From figure 2.1 above shows that emergency service delivery should be conducted first, then temporary exemption processes (i.e interviewing patients to verify if they can pay bills after discharge and filling of request forms) follows.

The two processes have made the hospital operate under budget because of the non-payment of treatment bills and overlap of implementation procedures and, that the study was looking for factors influencing the low payment of bills.

CHAPTER THREE
EVALUATION METHODS

3.1 Study Area.

Muheza is one of the nine Districts in Tanga Region. It has a total area of 1,974 square kilometers and a total population of 204,461(2012 census) whereby male 100,843 (49.3%) and female103, 618 (50.7%), the number of household is 47,920 with household size 4.3. Muheza District is divided into 4 divisions comprising 33 wards, 135 villages and 522 hamlets (District Health profile,2016).

Muheza District is located in Northeastern Tanzania. The district lies west south of Tanga City, and bordered by Mkinga to the north, Pangani in the south and Korogwe District to the west. The study was conducted at St. Augustine Muheza designated district hospital, one of the faith-based hospitals in Tanzania where temporary exemption to patients under emergency care is being implemented. The bed occupancy is 330 beds (SAM CHOP,2018).

Due to its location, casualties and other emergency cases from other places such as Pangani, Korogwe, Mkinga and Tanga city might be brought to St. Augustine Muheza hospital. It was selected because the facility is among the hospitals that receive a large number of emergency cases in the country. It was also a convenient place for the researcher to conduct his study. Given these criteria St. Augustine Muheza designated district hospital was selected purposively.

3.2 Evaluation Period.

The research was conducted in June to July 2019 following the approval from Muheza district executive director's office. Data was collected from St. Augustine Muheza designated district hospital where temporary exemption services for emergency cases are provided. The exercise of interviewing relatives to in-patients who are under emergency care and service providers was conducted continuously for (10) ten days.

3.3 Evaluation Design.

Descriptive cross sectional design was used for this study. Cross sectional study involves the detailed description and analysis of temporary exemption implementation for emergency cases at St. Augustine hospital.

3.4 Evaluation Approach.

A process evaluation examines the extent to which a program is operating as intended by assessing ongoing program operations and determining whether the target population is being served. Such an evaluation helps program staff members identify needed interventions and change program components to improve service delivery. Often collects information, such as: Details of program operation, Intensity and quality of services provided, Context and community in which a program is delivered, Demographic characteristics of program participants collaborative partnerships, and Staffing and training (Bowie & Bronte, 2008).

For the purposes of this evaluation, a process evaluation approach was applied since the evaluation intended to determine whether temporary exemption activities have been implemented basing on the cost-sharing policy guideline. It gives answers to questions such as: How is the guideline of cost-sharing policy are being implemented, how follow-ups on unpaid bills are being conducted, how payments from treatment charges are being conducted, and what are the barriers/ facilitators to implementation process. It shows how the guideline of cost-sharing policy is working, and whether the guideline is accessible or acceptable to its target population.

3.5 Focus of Evaluation and Dimensions.

This evaluation focused on patients who have been admitted and treated under emergency care. The evaluation considered service providers' knowledge and skills on the provision of temporary exemption services to clients who are in need. It also evaluated factors facilitating or impinging payment of bills by temporarily exempted patients.

3.6 Populations and Sampling.

3.6.1 Target Population.

This is the group of individuals from which the sample of respondents has drawn. For the sake of this study, the target population of the study was health workers from St. Augustine Muheza designated district hospital and community members in Muheza district council.

3.6.2 Study Population.

The study population was staff members of St. Augustine Muheza designated district hospital from different departments namely: Administration department, surgical wards (male and female), theater, Intensive Care Unit (ICU) and casualty room. Others were community members and close relatives to in-patients under emergency care. These respondents were obtained purposively because they have rich information from the subject matter under the study.

3.6.3 Study Units and Sampling Units.

The study units were Medical Officer-in-charge, Hospital health secretary, Hospital matron, clinicians and nurses from surgical wards, clinicians and nurses from the theatre department and health personnel from the casualty room. Others were Accountants, NHIF/User fee coordinators, clinicians and nurses from ICU and close relatives to in-patients under emergency care.

3.6.4 Sample Size.

The study sample consisted of 34 respondents, distributed as follows: Health workers who are also implementers of the cost-sharing policy guideline were selected from various departments which deal with emergency health services, and community members who are beneficiaries of the policy selected from among the relatives to the in-patients under emergency care.

The researcher collected data until all the necessary information required for this study was gathered. All necessary documents essential for responding to the evaluation questions were also analyzed until adequate information was obtained (saturation).

3.6.5 Sampling Technique.

3.6.5.1 Purposive sampling

The purposive/judgmental sampling technique used to select staff members such as the Administrators, Accountants, Medical Officer-in-charge, Health secretary and the Matron as they had required information about the implementation of the cost-sharing policy. Others were clinicians and nurses from surgical wards, theatre, casualty room and Intensive Care Unit (ICU).

3.6.5.2 Convenient Sampling

It is a non-probability sampling technique whereby respondents are selected based on their availability and accessibility during the study. According to Miles and Huberman (1994) convenient sampling is useful in observing a specific quality of certain event or phenomena which happen in a given situation. In this evaluation, this type of sampling technique was applied to obtain beneficiaries of the temporary exemption policy (close relatives to in-patients) who were available at the area of service provision; that is, out of 34 respondents were 6. This technique was employed in consideration of the context of data collection in the study as it dealt with community members as well.

3.6.6 Descriptions of Evaluation Participants.

Medical Officer in-charge of hospital is the chairperson of the Hospital Management Team (HMT) who is responsible for management of all activities in the hospital, as well as a secretary of the hospital board. He/ She supervises the implementation of cost sharing policy in the hospital.

Hospital Health Secretary is the secretary of Hospital Management Team (HMT) who is responsible for providing temporary exemption permits.

Hospital Matron is among of the members of Hospital Management Team who is responsible for sensitizing nurses to assist in hospital revenue collections.

In-charge of Surgical ward is responsible for submitting temporary exemption requests for in-patients who unable to pay for surgical health services.

Theatre in-charge is among of the members of Hospital Management Team who is responsible for management of Theatre activities.

Clinicians and Nurses at casualty department, theatre and at surgical wards are health workers responsible for day-to-day activities including screening of patients to determine their relative priority for treatment (triage).

Accountants are responsible in collection of all types of revenues from patients, and prepares the financial reports in monthly, quarterly and annually basis.

NHIF/ User fee coordinator is responsible in coordinating all health insurance and user fee activities in the hospital.

Community members are relatives to in-patients who are under emergency services. They are responsible for taking care to their patients as well as for post- payment of monies which were loaned to their relatives.

3.7 Validity and reliability issues

3.7.1 Validity of evaluation

Validity is the extent to which a study variable is measuring what it is intended to measure. It estimates how correctly the data obtained in a study represents a given variable for the study (Mugenda & Mugenda, 2004). It refers to the accuracy or correctness of the findings. To ensure the validity of this evaluation the following approaches suggested by Creswell (2007) and Patton (2001) were used;

i. Extended engagement with a participant and continual observation in the field promoted a sense of worthiness and identified the missed information;

ii. Triangulation techniques; – the evaluator employed multiple but complementary sources (sources triangulation) involved application of different data collection techniques i.e. interview, focus group discussion and documentary review, investigators triangulation (involved two data collectors), and theories triangulation to provide corroborative evidence (the

study reviewed literature both theoretical and empirical so as to come up with strong conclusion);

iii. Peer review technique: the data collection tools were sent to 3 people who had experience in temporary exemption services for emergency cases to review tool contents if capable to capture adequate information to answer evaluation questions; and

iv. Provide a rich and thick descriptions to allow readers to a decision regarding transferability; during analysis and discussion of evaluation findings; the reviewed theories and empirical literature were used to provide detailed information that promoted a clear understanding of the context under study. Therefore the researcher provided the evidence that it could be applicable.

3.7.2 Reliability of evaluation

Reliability is a common term used to explain the extent to which data collection tools and methods used in a particular study can yield consistent results in repeated trials. It estimates the level of which data collection tools will provide the same results or data in repeated trials (Mugenda & Mugenda, 2004). It refers to consistency with which the research will produce the same results if repeated. To ensure reliability the following approaches suggested by Creswell (2007) were used:

i. Adhere to the research process trail;

ii. Adhere to the theoretical process to guide data collection, analysis, and interpretation;

iii. Employ interview guide during interview sessions to obtain qualitative data;

iv. Appropriate samples were involved; and

v. Pre-test study was conducted to test the applicability of the interview guide if it provides information to answer the main evaluation questions.

3.8 Data collection tools

3.8.1 Development of Data Collection Tools

3.8.1.1 Primary data

These were gathered from health workers as well as community members who were close relatives to in-patients under emergency care at St. Augustine Muheza designated district hospital through interviews and focus group discussion. The interview method was conducted to 19 health workers and 6 community members, while focus group discussion (FGD) was conducted to one group that consisted of 8 health workers.

3.8.1.2 Secondary data

The researcher was able to obtain information or data which had already been collected. It was important to use the secondary data as they had been passed through some statistical process and proved to be valid.

The documentary review was done from different departments of the hospital as the researcher requested to see various documents namely: temporary exemption request forms, debts registers, and temporary exemption registers. Others were HMIS registers, bank statements, and cost-sharing policy guideline. The researcher observed the amount of fund which was temporarily exempted versus amount which was settled, list of conditions which was regarded as emergency conditions, and a number of hospital visits both out-patients and in-patients.

3.8.2 Data Collection Field Work

The researcher with one trained research assistant did data collection from participants. The research assistant was recruited to assist the researcher and oriented on the objective of the evaluation, interview as well FGD guide, ethics, protocol and administrative issues.

3.9 Data management and analysis

The collected data from the field through audiotape was transcribed and compared with the field notes. The transcription of recorded FGDs and Interviews was done

within 24 hours and given unique identity for data analysis. The recorded transcription was translated from Swahili to English. The transcription was read repeatedly to ensure the quality of data and acquire the sense of overall data. Then loaded into ATLAS ti version 8.2.4 for analysis. Content analysis was done, coding and finally the report was generated.

3.9 Validity and Reliability of the study.

3.10 Ethical Issues

Ethical approval was sought from different institutions required to provide the approval for this study. The first Institution was Mzumbe University through Ethical Clearance Committee, which provided ethical approval by writing an approval letter to respective District Executive Director (DED). The permission for collection of data was obtained from Muheza District. All participants was informed about the purpose of this study and assured that participating in this study was solely voluntary and verbal consent was provided. Furthermore, all data collected was kept in a safe place anonymously and only given a special identity to help during analysis. Privacy was maintained during data collection to give participants the freedom for expressing themselves without external or internal interferences. Audio taped and paper based data was carefully stored in manner that wouldn't allow any unauthorized persons to access.

3.10 Limitations of evaluation

The evaluation study design, which is cross sectional study, a qualitative approach is difficult to generalize its findings to other settings. The findings that was generated are contextual and hence can only be applicable to St. Augustine Muheza DDH. However, the fact that it cannot be applicable to other setting doesn't affect importance of undertaking the evaluation since it has potential implication in becoming a base for further studies on evaluation of the implementation of cost sharing policy in Tanzania and other countries.

CHAPTER FOUR

PRESENTATION OF FINDINGS

4.1 Introduction

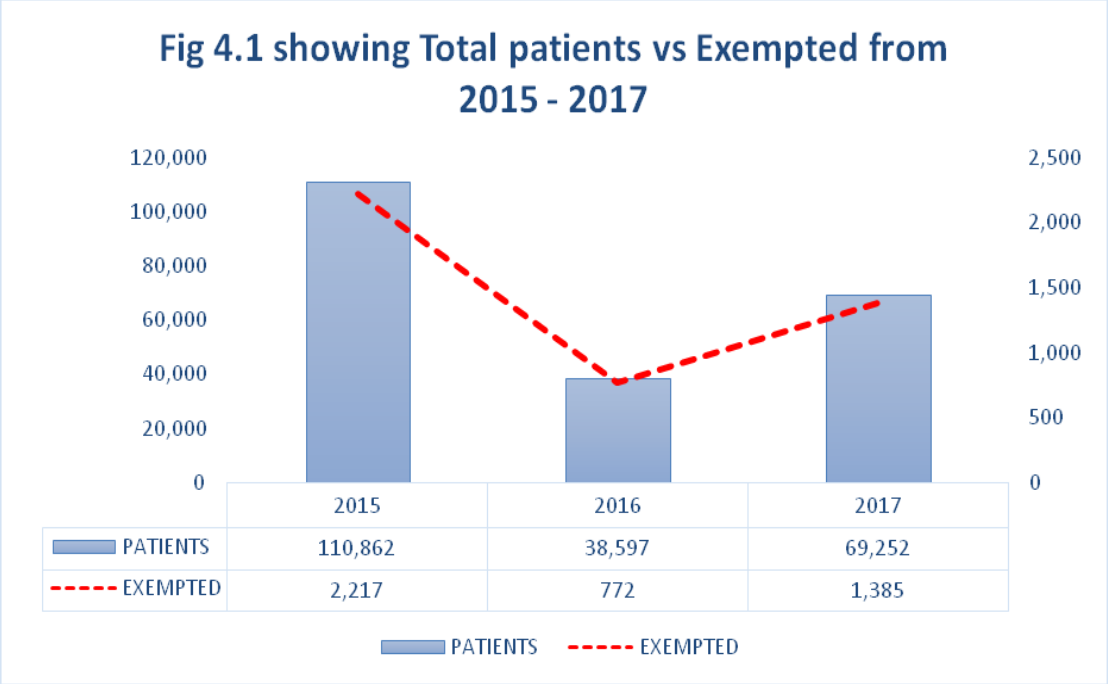
This chapter represents the study findings and data analysis in the exploration of the process evaluation of cost-sharing policy for emergency cases, focusing at temporary exemptions in St. Augustine Muheza designated district hospital. The total of twenty eight health workers and six community members was involved in the study and participated in an in-depth interview as well as in Focus Group Discussion. All respondents were interviewed at the point of service delivery. Five of these health workers were departmental in-charges and top management staff of the hospital. Various hospital documents namely CHOPs, debt registers, and financial books from the year 2015 to 2018 were reviewed.

Table ……..: Characteristic of respondent by categories.

Na.	VARIABLE	NO. OF RESPONDENTS
1	Hospital Administrators	1
2	Medical Officer Incharge	1
3	Hospital Health Secretary	1
4	Hospital Matron	1
5	Accountants	2
6	NHIF/User fee coordinator	1
7	HMIS coordinator	1
8	Clinicians	5
9	Nurses	15
10	Community Members	6
	TOTAL	**34**

4.2 Determine the level of emergency cases admitted at St. Augustine hospital and accessibility to health care.

Patients under emergency care who have temporary exemptions usually receive health services like other ordinary patients; there was no any kind of discrimination at the point of service delivery to patients who have temporary exemption permits.



Source: HMIS and documentary review.

From the figure above, it shows that St. Augustine Muheza designated district hospital receive many patients, in which out of these, about 2% are treated under a temporary exemption.

> *"All patients have equal rights when receiving health services, whether has paid for or not. Always service provision comes first, while other things like procedures for payment of charges come later"(Nurse on duty from the theatre).*

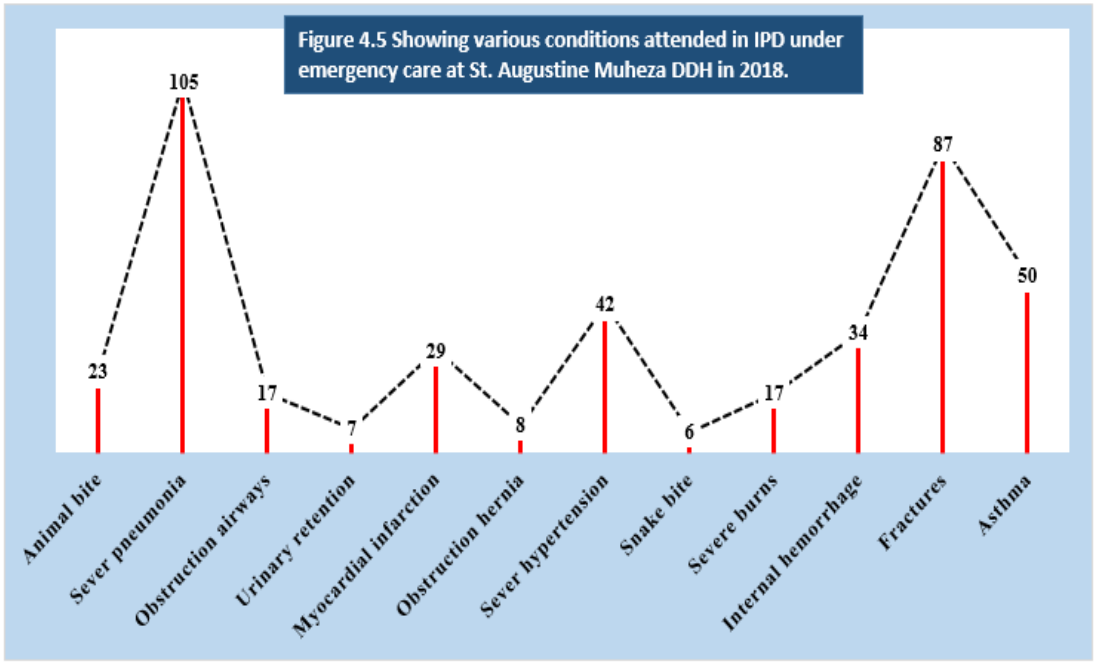
> *"If patients who under emergency care are not elderly people aged 60 years and above, or not pregnant women, not under-five children, not poor people or are not suffering from chronic diseases like Tuberculosis or HIV/AIDS,*

they must pay for health services. Now if such patients do not have money when at service delivery, what we usually do, is to grant temporary exemptions so that such bills to be settled on later. But all in all, we provide health services first to serve life, and later on, we establish payment procedures". (Principal Health Administrator).

"Oooh…. This hospital usually attends many emergency cases from within Muheza DC as well as outside, for example, last year, according to IPD register, about 75% of cases in surgical female and male wards were from outside Muheza DC. It seems that many people prefer St. Augustine Muheza hospital rather than other public health facilities, maybe due to its nature, i.e faith-based, and being a faith-based hospital it is a symbol for kindness and good customer care". (HMIS coordinator).

The study discovered that the hospital considered issues of equity and fairness during health service delivery, whereby all patients who visited the hospital were attended accordingly.

St. Augustine Muheza hospital on average, admit about four hundred patients under emergency care per year. The figure below shows visits to emergency cases attended in 2018.



Source: DHIS2 2018

From the table above, it shows admission of emergency IPD cases attended by the hospital in 2018, aged between above five years and below sixty years of age.

4.3 Examine implementation procedures of the guideline for cost-sharing to emergency cases eligible for temporary exemptions.

All respondents who interviewed about the implementation of cost-sharing policy guideline during the provision of temporary exemption to patients under emergency services, urged that they didn't do so. Most of them have even said that they have never seen such a document.

One senior nurse from surgical male ward insisted that such document were not available at the hospital, so what they do was just applying some experiences.

> *"We usually grant temporary exemptions to our clients even though no one knows its insights. What we always hear from our bosses is about cost-sharing policy only, but we have never seen it. May be Hospital Health Secretary knows much on this". (Said senior nurse from the surgical male ward).*

The Nursing Officer-in-charge of the hospital said that the hospital has created its own procedures used for the provision of temporary exemption for patients under emergency care. These procedures are: The patient must first be in need of emergency services, secondly the patient must possess the bail from within the hospital staff members, thirdly the Village/ Mtaa in which the patient comes from must be well known and therefore his/ her Village/ Mtaa chairperson must sign the document before the permit is granted. But when the researcher asked whether he can see such document, the respondent said that such procedures are not written anywhere, but many health workers- especially those who are senior staff knows about it.

> *"A few years ago those procedures were well known to every staff, but as days go on, people have forgotten. So we need refresher training for health workers so that to orient ourselves in such procedures". (Senior clinical officer from the surgical male ward).*

Medical Officer-in-charge of the hospital said that sometime even if the patient is willing to settle his/ her treatment charges after his/ her discharge, the hospital authority may opt to put such patient in the permanent exemption scheme, worrying that he/ she will not settle such bills while at home. The hospital Authority has claimed that many Tanzanians are not faithful enough to settle hospital bills without external forces while they are at their far homes. Therefore, to avoid such follow up disturbances, the hospital usually decides to give permanent exemptions to such patients, even if the hospital operates under loss.

> *"Making follow-ups on treatment charges for patients who are about to be discharged is not a big deal compared to the one who is already discharged because we just communicate with his/ her relatives who are around the hospital taking care of their patients and ask them to make any means so that the bills are settled before their departure, and most of them usually responded positively, but the only problem here is lack of follow-up strategies". (Nurse on duty from the male surgical ward).*

"Usually making follow-ups to patients who are still admitted in the ward is an easy assignment compared to those who are already discharged and they are at their far homes. But we fail even in this easy task because the hospital lacks Social welfare officers who are responsible for such follow-ups, therefore most of the discharged patients who were temporarily exempted left without paying their bills". (Senior Accountant).

When the close relatives to the in-patients under emergency care interviewed on how they perceive the cost-sharing policy and if they know the procedures to follow when requesting temporary exemptions, they responded as follows:

"Oooh…. Probably I think the implementation procedures are well known by doctors and nurses only. But we heard that the hospital always provide permanent exemptions to pregnant mothers. Why don't they decide to include also emergency services into this category? Our service providers earn monthly salaries, that is why they cannot feel any pinch. Nowadays a household's economic situation is very weak, so some of us get meals only once per day, can you imagine!". (1st Close relative to in-patient).

"Let me ask you! How many activities have been exempted by the government from paying income tax or fees? For example, we have a free education in this 5th phase of the government leadership, in which parents have been exempted from paying school fees from primary level up to ordinary secondary education, why the government fails to do some difficult decisions even in this issue? It is very unfair!" (2nd Close relative to in-patient).

"I think those implementation procedures are meant for service providers only, not for clients. But I always ask myself, diseases, like those which are treated under emergency care always came when the household has nothing to cover for health service costs, as a result, family members struggle in searching of fund for repaying the charges. Some can even decide to sell household properties such as farms and livestock to settle such charges. This

is not good because if such condition happens again, it is obvious that the family will not have another property to sell. Now, why the government fails to work on this so that to relief its citizens from health service charges catastrophe". (3rd Close relative to in-patient).

From the above responses, it shows that the hospital does not follow the implementation procedures of temporary exemption to patients who are in need, which might lead to complaints from stakeholders of both sides (i.e service providers and communities). Service providers are also granting temporary exemptions to non-eligible clients that are contrary to the cost-sharing policy guideline.

In the case where the patient who was under intensive care has dead, the relatives of a deceased person once they arrive at the hospital, before taking their dead body for burial, the hospital authority must inform them about the treatment charges offered to their relative, and must settle such bills before they allowed to take their dead body.

"Usually, road traffic accident casualties who were admitted at ICU if passed away, their relatives came at the hospital for picking up their dead bodies, but before leaving the hospital, they must settle all the treatment bills about their dead bodies, and the experience have shown that they usually pay without any complaints. If at this point the payments fail, humanity can take place and then permanent exemption offered". (Nurse on duty from ICU).

The St. Augustine hospital being the faith-based organization is doing well in applying humanity for few instances in which those patients who promised to pay on later, but in an unfortunate, they died before paying such bills. Therefore when the relatives of the deceased have no money for paying the loan, the hospital usually forgives the relatives.

When few respondents asked about the procedures on how to manage patients under emergency services, who are members of health insurance companies, whether public or private, but who have lost their membership cards, they said that such cases are rare. But if they occur, it might be difficult to handle based on health insurance membership without cards or other evidences, because the health insurance

companies will not accept such requests since they will not have all supporting documents necessary for payments.

> *"We don't know how to go about, but I think health insurance companies might not accept such requests because, how can one requests for payment while some of the information are still missing? For example, if the check number of the employee will not be filled well in the request form, or can a hospital staff make follow-ups on the private health insurance company which is at other places like Dar es salaam or elsewhere? So to avoid such inconveniencies, we just put such patients under permanent exemption category". (NHIF coordinator of the hospital).*

If patients under emergency care are casualties of road traffic accidents, and the track which has involved in such accident is insured, the respondents argued that it is not possible to make follow-ups to the owner of the vehicle or to the insurance company itself because such cases are traffic cases which involves Police force.

> *"What I believe is that it will be very difficult to be paid our money from such companies because it might involve many procedures before you get your rights. I think it can even take 3 to 5 years before you receive the payment check" (Hospital Matron).*

Most patients who granted temporary exemption permits were always not coming back for repayment of their treatment charges, but few of them come back and settle their bills.

> *"Usually few faithful clients who were given treatment basing on temporary exemption permits came and settle their bills. What they do was just to go to CRDB Fahari huduma agent and make the payments, then after this process, they make some calls to the hospital administrator to inform him/ her about such repayments". (Hospital Health Secretary).*

When the researcher wanted to know if the hospital conducts any means of tracking payments that are done by loaners, the Health secretary responded that the hospital

does not conduct any verification on amounts of money paid by clients who were temporarily exempted from paying for health services.

> *"Oooh, here we don't have any means of verification since we have more than one sources of fund, it might be difficult to do cross-checking the money paid by clients who were temporarily exempted, because our clients are free to deposit cash any time, and printing of bank statements every time is expensive. So we rely only on believing on Holy cross in Jesus name ha ha ha haaa!". (Hospital Health Secretary).*

4.4 Examine compliances or overlap of implementation procedures of the guideline.

Most of the respondents who interviewed on the compliance or overlap of implementation procedures of the guideline for cost-sharing policy to emergency cases eligible for the temporary exemption, said that they don't know if they comply or not because no procedures are displayed so far so that to adhere.

> *"We don't know whether we comply or not on such implementation procedures of the guideline since we don't have a document" So we just provide temporary exemptions without even considering eligibility. Usually, circumstances determine". (Medical doctor in-charge of the surgical female ward).*

> *"If a patient who has been discharged from the hospital comes from outside Muheza district, the hospital staff cannot make any follow-ups on such client, therefore such revenues will be lost automatically". (Hospital Accountant).*

From the above respondent's views, the researcher revealed that there was no compliance with implementation procedures of the cost-sharing policy guideline. The procedures on how to grant temporary exemption are not known by the service providers.

4.5 Determine the extent to which exempted patients fulfil the guideline requirement in paying back the cost.

Respondents who interviewed about the extent to which exempted patients fulfil the guideline requirement in paying back the cost, they said that many people are not responding well on the issue.

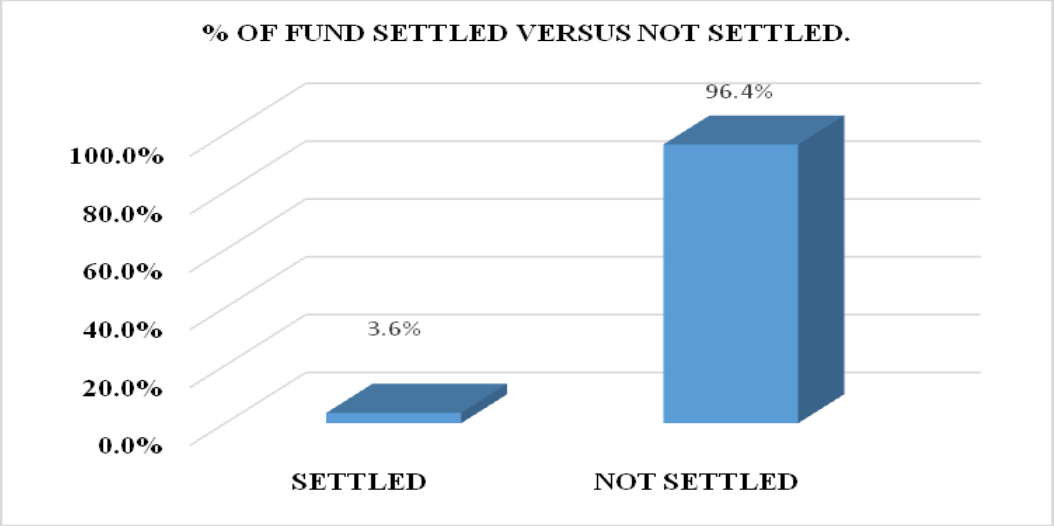
The following are some of the cases that responded after given temporary exemptions in different departments from 2015 to 2017 but after discharge, the patients responded as shown in the table below.

Figure 4.1: The table showing cases that responded after given Temporary Exemptions for 3 years.

NO.	*CONDITION*	*FREQUENCY*	*AMOUNT SETTLED*	*AMOUNT NOT SETTLED*	*TOTAL AMOUNT TEMPORARILY EXEMPTED*
1	Asthma	19	460,120.00	6,567,123.00	7,027,243.00
2	RTA (Fractures)	7	1,356,240.00	13,347,650.76	14,703,890.76
3	RTA (Internal hemorrhage)	5	415,700.00	15,705,660.55	16,121,360.55
4	Severe Burns	6	220,100.35	1,644,113.54	1,864,213.89
5	Snake bite	3	67,450.00	1,967,220.15	2,034,670.15
6	Severe Hypertension	36	180,370.80	5,880,113.07	6,060,483.87
7	Obstructed hernia	11	-	6,761,966.00	6,761,966.00
8	Myocardial Infarction	11	675,120.00	28,125,980.13	28,801,100.13
9	Urinary retention	4	-	2,450,330.17	2,450,330.17
10	Obstruction of airways	9	160,170.00	8,670,119.00	8,830,289.00
	Total	**111**	**3,535,271.15**	**91,120,276.37**	**94,655,547.52**

Source: Compiled by Researcher.

Figure 4.2: Column chart showing percentage of fund settled versus fund not settled from 2015 to 2017.



From the chart above it shows that the percentage of fund settled during post-payment at St. Augustine hospital for three years were very low (3.6%) compared to the percentage of fund not settled (96.4%). Therefore, it shows that patients are not fulfill the guideline enough in paying back the cost.

> *"Oooh, Take an example of the value of temporary exemption permits which were given under theatre department for various surgical procedures, for last year only, it was about Tsh. Ten million. This is very big amount of money, which the hospital has lost unnecessarily. If follow-ups could have done to such clients after their discharge, the hospital could have earned a lot of money to run many hospital activities, including procurement of drugs and other supplies". (Theatre in-charge).*

> *"Most of the patients who are admitted in Intensive Care Unit (ICU), because of the nature of their conditions, are usually given temporary exemptions, and I think it could rise up to Tanzanian shillings fifteen millions per year, but very few amount of money could be settled after their discharge. (In-charge of ICU).*

From the respondents' views of point, is shown that most of the patients who were temporarily exempted were not willing to pay back the treatment costs. The hospital loses a lot of money which could have used for running the hospital.

4.6 Examine factors facilitating or impinging payment of bills by temporary exempted patients.

The respondents who interviewed about factors facilitating or impinging payment of bills by temporary exempted patients, said that presence of the social welfare department and the guideline of cost-sharing policy could help to facilitate the payment of bills. On the other hand, absence of such items could limit the implementation process.

> *"The hospital do not have Social Welfare Officers and therefore Social Welfare department. These officers are present at DMO's office, located about one and half kilometers apart, where they are busy with other businesses. Therefore it is not easy task for them to come every time when needed to deal with social welfare issues, especially in assessment of patients for temporary exemption purposes". (Clinician on duty from surgical female ward).*

> *"Absence of the cost sharing guideline hinders the implementation of provision of temporary exemptions to patients who are in needy, and therefore lowers the payment of bills by temporary exempted people. We usually provide temporary exemptions to patients without referring to any official document from the Ministry*. This is very bad". *(A nurse who was in night duty at surgical female ward).*

> *"Eeerm,....if the hospital cannot make some follow-ups to hospital loaners it can lead to many consequences such as inadequate funds for running various hospital activities. Therefore, making follow-ups is very important task for benefit of the organization, and I remember we put such suggestion in one of the management meeting conducted about four years ago". (NHIF/ User fee coordinator).*

"Some of the community members are not faithful enough to settle their bills, especially when are already discharged. So what is needed is the application of enforcement to those who was under temporary exemptions. My self I suggest even to involve the police force for searching those people, may be it can help". (Senior Hospital Accountant).

Hospital Matron commented that lack of sensitizations among health care givers on the importance of providing temporary exemptions for emergency services is another factor that contributing in impinging payment of bills by temporary exempted patients.

"Even if health staff provide temporary exemptions, but most of us are not aware that these are monies that we lend to our patients, and should be repaid on later. Therefore all documents which we use during such exercise should be considered as financial documents, and should be kept in safe place". (Hospital Accountant).

The doctor on duty from female ward mentioned that lack of inspiration from top hospital authority to their subordinates is another factor impinging the payment of bills by temporary exempted people.

"The hospital board and its management team have relaxed; they are not in position to insist on the issue, as a result we as subordinates are also relaxing. We don't see the importance of making follow-ups on un- paid bills". (Nurse on duty from theatre)

The casualty In-charge observed that, community members have not sensitized enough on the importance of temporary exemptions to patients `under emergency care, who do not have money on that time, but who can pay on later.

"Since the hospital always provide temporary exemptions without filling the temporary exemption forms, we might forget to make follow-ups to some of the patients who have been given such offer. There is no record keeping which can help in tracing their physical addresses, therefore lack of special

request forms is another factor that are impinging payment of bills by temporary exempted people". (In-charge of Casualty department).

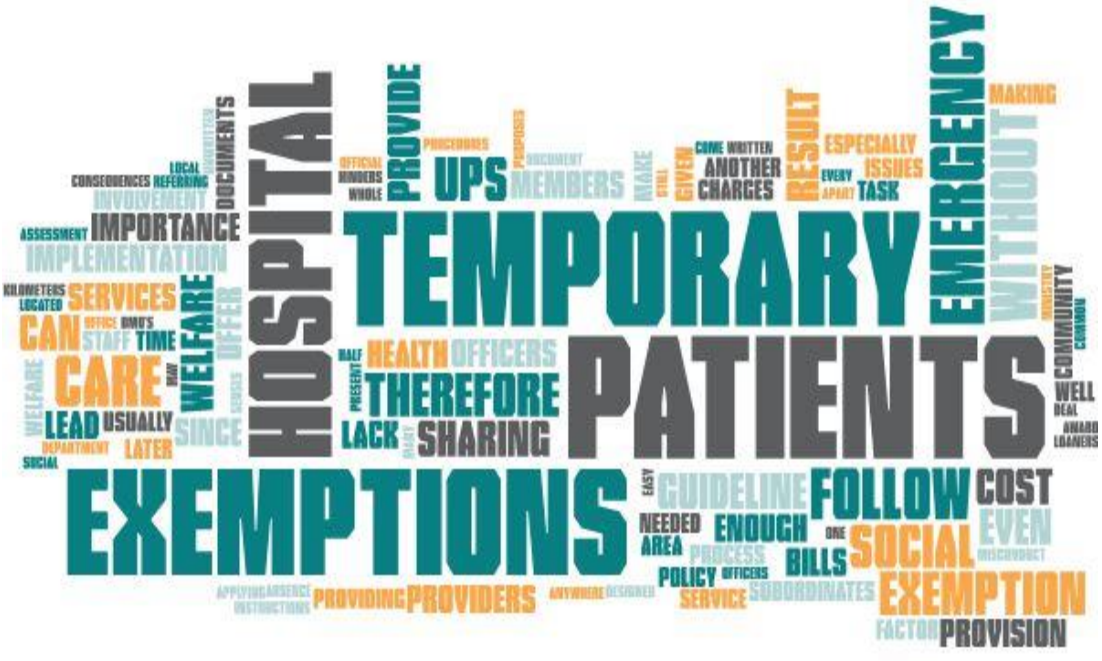
"Since most of the temporary exemptions are offered without involvement of Social welfare officers who are experts in this area, some of the patients who have given such offer could be financially not well to repay such charges after their discharges (i.e poor households). Therefore if such assessment could have done by Social welfare officers, such patents could have given permanent exemptions rather than temporary exemptions". (Medical Officer in-charge of the hospital).

"Lack of verification on payment responses is another factor that is impinging the payment of bills to the hospital. If the Accounts department could have done payment verification it could help in enhancing the payment of bills". (Nurse on duty from theatre).

"For unconscious in-patients, service providers after providing emergency first aid to their patients, and then condition improved in which patients become conscious, service providers are always not in position to conduct interview so as to know their insights, as a result we offer temporary exemptions without knowing them thoroughly, whether they are financially good or not". (Medical doctor on duty in ICU).

According to the respondents' views it was revealed that factors like absence of social welfare officers, absence of cost-sharing policy document, lack of follow-up mechanisms, unfaithfulness of community members, lack of effective communication between one department and another, lack of payment verification and lack of temporary exemption request forms are some of the factors that are impinging payment of bills.

Figure 4.3: Word cloud showing factors mainly highlighted by respondents that are impinging payment of bills to temporarily exempted patients.



The above figure summarizes some of the issues which were highlighted more frequently by respondents during in-depth interviews as well as in FGD on factors that are impinging the payment of treatment bills. Most of the respondents revealed that absence of social welfare officers, absence of cost sharing guideline, lack of follow-ups and lack of exemption forms are impinging factors for payment of bills by temporarily exempted patients.

CHAPTER FIVE

DISCUSSION OF THE EVALUATION FINDINGS

5.1 Determine the level of emergency cases admitted at St. Augustine hospital and accessibility to health care.

5.2 The National health policy of 2007 under section 4 (dira, makusudio na madhumuni ya Sera) insisted on equity and fairness during health service delivery, in which all citizens have equal access to health care regardless of ability for payment. Patients who require temporary exemption should be considered equally like other ordinary patients who have paid for health services. Therefore the research findings revealed that under the accessibility factor, the hospital has adhered to the National health policy by providing health services to all patients regardless of their economic status.

5.3 Examine implementation procedures of the guideline for cost-sharing to emergency cases eligible for temporary exemptions.

According to the guideline, the following are temporary exemption procedures for in-patients under emergency care: The clinician or a nurse who took care of patients will request for temporary exemption. The request will be addressed to a Social welfare officer or any other officer who is responsible for temporary exemptions; If the patient deserves for temporary exemption, hospital management will provide a permit; A special form for temporary exemption will be used. The form is also considered as a financial document for revenue in the hospital and; When a patient who was admitted, after he/she discharged, his/her exemption number must be noted in the in-patient's debts register for follow-ups.

Therefore service providers should adhere to the above procedures during the management of patients under emergency care who deserves temporary exemptions.

According to the guideline, the section of temporary exemption (section 5.2) provides that, patients under emergency care who deserves for temporary exemptions should not be; under five, pregnant women, 60 years of age and above,

should not have chronic diseases such as Tuberculosis or Leprosy, and should not be poor.

The guideline provides a permit to some of the utilizers to receive health services without paying for, and without affecting the quality of services. The main purpose is to make sure that: Every citizen receive health services regardless of his/ her economic status; To reduce burden of medical treatment bills to citizens, especially on chronic diseases; To reduce under-five mortality; To protect vulnerable group; To reduce effects which can lead to maternal as well as infant mortality and; To protect marginalized group and elderly people (page 17 of the guideline).

Therefore procedures for requesting temporary exemptions should be well known to every stakeholder both service providers as well as community members, so in order to simplify implementation, the hospital administrator should display such procedures to the notice boards so that everybody can read and understand.

5.4 Examine compliance or overlap of implementation procedures of the guideline.

The cost-sharing policy guideline in the section of the temporary exemption has indicated the procedures for requesting the temporary exemption. Findings from the study have shown that the compliance of such procedures at St. Augustine hospital is low, hence the hospital operated under low budgets due to non-payment of treatment bills.

Also, the hospital has no social welfare department to deal with all social welfare issues of patients, particularly in a temporary exemption for eligible patients. Therefore the hospital must recruit the social welfare officers and establish some strategies on how to deal with all unpaid bills.

5.4 Determine the extent to which exempted patients fulfil the guideline requirement in paying back the cost.

The research findings revealed that most of the beneficiaries of temporary exemption were not willing to pay back the treatment costs, for example, repayment of loans in three years was 3.6% only compared to the percentage of a fund not settled (96.4%).

Therefore, it shows that the level of fulfillment of the guideline is not enough in paying back the cost.

This problem is a two-way traffic; on one side service providers were not responsible enough to manage the temporary exemption. Some of the patients under emergency care were given temporary exemption without consideration of other factors like verification of their economic status through oral interviews, exemptions were granted without filling the request forms, lack of internal communication between departments, lack of community sensitization and absence of follow-up strategies. On the other side, members of the community who are beneficiaries of the temporary exemption are not aware of the essence of a temporary exemption scheme to patients under emergency care. Some who benefited from this offer are not ready to pay back their bills believing that it was free of charge services. Others are not faithful enough to pay the bills when are already discharged. But generally, members of the community have not sensitized enough to understand the importance of temporary exemption for emergency health delivery.

5.5 Examine factors facilitating or impinging payment of bills by temporarily exempted people.

This study found out the number of factors that had contributed to the low payment of treatment bills after discharge. The following factors were acknowledged to be factors impinging the management of temporary exemption at St. Augustine Muheza designated hospital.

5.5.1 Absence of Social welfare department.

One of the critical roles of Social welfare officers is to deal with the management of all types of exemptions and waivers. The absence of these experts in the hospital could lead to poor management of such cases.

According to the National health policy of 2007, the social welfare department is a vital department that deals with all social welfare issues from ministerial level up to community level. Cases of cost-sharing, exemptions, availability of food for in-patients who cannot afford to get food during the hospital stay, management of all

special groups and other social welfares are very important activities in the health sector. Basing on such facts, St. Augustine hospital should recruit social welfare officers to deal with all social welfare activities in the hospital.

5.5.2 Absence of the guideline.

The cost-sharing policy guideline is an important document for routine activities in the hospital. It provides procedures on how to go about when dealing with temporary exemptions. Although the document has over 20 years in use since introduced in the health sector, and some of the interventions have changed, but to date, it is the only document that guides how to deal with cost-sharing for health services.

Absence of such document at a health facility can lead to poor management of cost-sharing activities such as low revenue collections, provision of temporary exemptions to patients who are not eligible and loss of hospital incomes. Therefore, service providers are responsible for using cost-sharing policy guidelines in order to improve revenue collections at the hospital.

5.5.3 Lack of follow- up strategies

Patients under emergency care who are eligible for temporary exemption, usually are the ones who are economically well off (that means, they can pay for health charges), the only problem is that they might fail to pay for health service at the point of service delivery due to many reasons, therefore such patients must be granted temporary exemptions. But after discharge or a few days later before discharge, they supposed to settle their bills. What is required is the hospital to establish some mechanisms on how to make follow-ups to those loaners.

The research findings in chapter four, has shown that the hospital do not have mechanisms to deal with clients who treated under post-payment agreements. Therefore the hospital must have follow- up strategies to insurance organizations and owners of vehicles involved in accidents when dealing with road traffic accident casualties, follow-up strategies to health insurance organizations when dealing with patients who are members of health insurance organizations and follow-up strategies when dealing with individual clients who are already discharged and they are at their

far homes. By doing this, the hospital could collect many revenues from a temporary exemption scheme, and therefore improve the overall hospital revenues.

5.5.4 Lack of involvement and sensitization among community members.

Community involvement and sensitization on the temporary exemption as part of cost-sharing is an important strategy to deal with. When members of the community understand the essence of cost-sharing in health facilities they could improve the payment of bills than before.

The research findings in chapter four, indicating that members of the community are not involved as well as sensitized in the issue of temporary exemptions, as a result most of them have a negative attitude towards such strategy. It is high time for the hospital to sensitize communities around so that to join hands together when dealing with temporary exemptions. Health workers, also need refresher training to build their capacity on how to manage temporary exemptions. By doing this, it can help in increasing revenue collections at the hospital.

5.5.5 Absence of request forms.

Request forms can be used as a legal document signed between the patient and the hospital. Therefore filling of temporary exemption request forms is an important stage in the management of temporary exemptions. Research findings in chapter four above have shown that St. Augustine Muheza designated district hospital does not use request forms when granting temporary exemptions to eligible patients. This mistake might be among other factors that could lead patients under the temporary exemption, before or after discharge to escape from paying the bills, believing that no agreement has entered to pay the bills.

Therefore, the use of temporary exemption request forms is very important, as they can show the physical addresses, phone numbers, close relatives and other contacts of the client. Through these addresses, the hospital can trace those loaners to pay back the bills.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS.

6.1 Introduction

This chapter presents the research conclusion, suggestions and recommendations by which different stakeholders should work upon, which can give chances for more improvement.

6.2 Summary

The study examined the process evaluation of temporary exemption implementation for emergency cases, a case study of St. Augustine Muheza DDH. The specific objectives was to determine the level of emergency cases admitted at St. Augustine Muheza DDH, examine implementation procedures of the guideline for cost-sharing policy to emergency cases eligible for temporary exemption, to examine compliances or overlap of implementation procedures of the guideline for cost-sharing policy to emergency cases eligible for temporary exemption, to determine the extent to which exempted patients fulfil the guideline requirement in paying back the cost and to examine factors facilitating or impinging payment of bills by temporary exempted people.

The study used a cross sectional evaluation design which was applied to evaluate the implementation of temporary exemption. The sample consisted of twenty five participants who provided detailed and comprehensive information for the study. These participants were distributed into two groups namely, fifteen health care givers as well as ten community members who were close relatives to in-patients under emergency care. Primary data was collected through interviews and focus group discussion, and secondary data were collected through documentary reviews. Atlas.Ti content analysis method was used to analyze the in-depth interviews.

The study found that the level of temporary exemption implementation for emergency cases at St. Augustine Muheza DDH was not very satisfactory due to: Unavailability of the social welfare department in which social welfare officers could deal with assessment of patients under emergency care who offered temporary

exemptions, the hospital has no special temporary exemption request forms necessary for filling-in the personal particulars which on later might be used for making follow-ups of un-paid bills, most of the health staff are not knowledgeable enough to provide temporary exemptions, no sensitization and involvement with community members concerning the temporary exemption concept, and the hospital has no mechanisms of follow-ups to the insurance companies for payment of patients' treatment bills before or after their discharge. Other reasons are: The hospital has no a culture of making cross-checking of the payments made by loaned clients through bank statements, which could help in making follow-ups to those who have not responded, the hospital does not have cost sharing guideline necessary for provision of temporary exemption to patients, and lack of inspiration from top hospital management that has caused the subordinates to become irresponsible during the temporary exemption processes.

6.3 Conclusions.

From this study, it has been realized that St. Augustine Muheza DDH have not adhered to the procedures for granting temporary exemptions to eligible patients under emergency care, which has led to low payment of treatment bills.

More important is that, the guideline for cost-sharing policy document was developed in 1993 by the Ministry of Health and reviewed in 1997, since then, there was no review which have done to improve the document. Most interventions have changed and improved in comparison with the guideline. Therefore it is high time for the Ministry to review such a document so that to cope with the current environment. During the review, it is better for including all emergency services and accidents into a permanent exemption category so that to relieve patients under emergency care from treatment bills catastrophe. Then such bills should be refunded by high authority to enhance sustainability of services.

6.4 Recommendations.

The evaluator appreciate and appraise for surgical department (casualty, theater, male & female surgical wards) and ICU for good services that are provided to all emergency cases that are brought to St. Augustine Muheza DDH. All emergency

cases were attended accordingly, and no patient was left unattended due to lack of money. However the following recommendations should be considered as important areas for improvements:

Since the guideline for cost sharing policy document has over 20 years in operation without review, it is obvious that the document is no longer serves the same purpose, many changes has taken place, therefore it is better to be reviewed so that the Ministry of Health come out with a new version which can serve the current purposes. But more important amendment should be the provision of fully exemption to all emergency cases as well as accidents, and the costs encountered to be paid by high authorities and other stakeholders such as NHIF.

Meanwhile, the following recommendations are important for Muheza Local government authority, particularly to the St. Augustine Muheza DDH staff.

1. CHMT, RHMT and other supervisory teams should adhere to the supervision checklist that insist on various areas/ departments to be supervised, in which the implementation of cost sharing guideline is among of the important areas.
2. For unconscious in-patients, service providers must first provide emergency services regardless of the ability to pay. Then when the condition improved the Social welfare officer should now start interviewing the patient, making as many probes as possible to know the financial status of the patient. This process can help to place the patient in the right group.
3. St. Augustine Muheza DDH should conduct refresher trainings to the staff on the management of temporary exemption for emergency cases. By doing so, it can help staff members to be more active than before.
4. St. Augustine Muheza DDH should conduct community sensitization on management of temporary exemption for emergency cases.
5. St. Augustine Muheza DDH should make sure that policy documents and guideline for cost sharing is available at every department in order to enhance management of temporary exemptions.

6. St. Augustine Muheza DDH should make follow-ups to all health insurance companies (public and private) so that all treatment charges from clients who are members of such organizations are paid.
7. In case of casualties of road traffic accident, the hospital should make follow-ups to the owners of vehicles which involved in accidents or to the insurance companies in which such vehicles are members so that all treatment charges from clients who were involved in such accidents are paid.
8. The hospital must establish the special temporary exemption request forms, so that all eligible clients fill such forms before exemptions are granted.
9. Muheza district council should allocate one or more Social welfare officers to work at St. Augustine Muheza DDH, or else the hospital should make recruitment in order to fill the vacancy.

6.5 Limitation

Being the study carried out at St. Augustine Muheza DDH, still there is low implementation of cost sharing policy for emergency cases in the area of temporary exemption. So the evaluation findings cannot be used to the public health facilities in which social welfare departments are well established, and are frequently supervised by higher levels compared to faith based organizations.

6.6 Areas for Further Research/ Evaluation

Further research should be carried out to make comparison between the implementation of cost sharing policy for emergency cases, focusing at temporary exemption in public health facilities and faith based health facilities in Tanzania.

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APPENDIX

WORK PLAN.

The development of this proposal is a stepwise process starting from November 2018 to July 2019. The development process will include consultations and collection of program documents from the institutions to be evaluated. The summary of the work are summarised in table 4 below.

Table 4: Summary of activities to be done with timelines

SN	Activities	Responsible person	N	D	J	F	M	A	M	J	J
			2018					2019			
1.	Development of instruments	PI									
2.	Protocol and ethical consideration approval	PI									
3.	Meeting with facility in-charge and other health workers on the utilization of judgment matrix	PI									
4.	Translation of questionnaires to local language	PI									
5.	Select data collectors, supervisors and training assistants	PI									
6.	Pretesting of tools and data collection, checking and editing										
7.	Data summarizing and entry										
8.	Analysis										
9.	Write up										
10.	Presentation to Mzumbe University										

APPENDIX I

INTERVIEW QUESTIONS FOR CLINICIANS, NURSES, & INCHARGES OF THEATER, SURGICAL WARD AND CASUALTY DEPARTMENT.

Dear informant, my name is Rasmo Msabaha a student of Mzumbe University pursuing a MSc in Health Monitoring and Evaluation. I'm conducting an evaluation study on **"**THE COST SHARING POLICY FOR EMERGENCY CASES, FOCUS AT TEMPORARY EXEMPTION IN FBOs, A CASE STUDY OF ST. AUGUSTINE MUHEZA DDH", as a requirement for the completion of my studies. This study is for academic purposes and not otherwise. I humbly request your voluntary participation in responding to the following questions which intend to collect information that will be used as findings of the study. Your answers will be kept confidential. Nevertheless your identity will be kept anonymous.

1. What is your professional title?
2. How long have you been in your professional practice?
3. Here at your ward/ department what kind of cases are considered as emergency?
4. How many cases which are treated under emergency care in your department per one year?
5. What do you understand about temporary exemption concept? Do you offer temporary exemptions to patients?
6. What are the procedures for requesting temporary exemption at St. Augustine Muheza DDH?
7. Suggest ways that can improve the current situation regarding procedures for requesting temporary exemption at St. Augustine Muheza DDH.

APPENDIX II

INTERVIEW QUESTIONS FOR CLOSE RELATIVES OF IN-PATIENTS UNDER EMERGENCY CARE.

1. What is your name? Where do you come from, and why are you here?
2. What is your relationship with the patient you are taking care?
3. Have you heard before about temporary exemption concept?
4. It seems that service providers are always complaining about community members to be unresponsive in repayment of treatment charges which was loaned for patients under emergency care. What is your opinion?

APPENDIX III

INTERVIEW QUESTIONS FOR SOCIAL WELFARE OFFICERS, HEALTH SECRETARIES, NHIF/ USER FEE COORDINATOR, ACCOUNTANTS & HMIS COORDINATOR.

1. What is your professional title?
2. How long have you been in your professional practice?
3. What do you understand by term temporary exemption? Do you offer temporary exemptions at your hospital?
4. What are the criteria for offering temporary exemption at St. Augustine Muheza DDH?
5. What do you understand about the guideline for implementation of cost sharing policy at health facilities? Do you have such document at your hospital?
6. How is the guideline of cost sharing policy in the area of temporary exemption for emergency cases being implemented at St. Augustine Muheza DDH?
7. To which extent are patients under emergency care who were given temporary exemption willingly to pay for their bills?
8. How the follow ups of unpaid bills from patients under emergency care who were given temporary exemptions is being conducted at St. Augustine Muheza DDH?
9. How follow ups to motor vehicles' owners as well as to health insurance companies on unpaid treatment bills for patients who involved in accidents is being conducted at St. Augustine Muheza DDH?
10. What obstacles if any, do you face during follow ups of unpaid treatment bills from clients who already discharged?
11. What obstacles if any, do you face during follow ups of unpaid treatment bills from insurance companies in which vehicles that involved in accident follow under their membership?
12. What obstacles if any, do you face during follow ups of unpaid treatment bills from health insurance companies in which patients are members?

13. What are the factors facilitating the implementation of the guideline for cost sharing policy in the area of temporary exemption to patients under emergency care at St. Augustine Muheza DDH?
14. What are the factors impinging the implementation of the guideline for cost sharing policy in the area of temporary exemption to patients under emergency care at St. Augustine Muheza DDH?
15. How payments of the treatment charges from patients under emergency care who were discharged from the hospital are being conducted at St. Augustine Muheza DDH?
16. How verification of payments done by clients who were given temporary exemptions and are already at their homes are conducted at St. Augustine Muheza DDH?
17. Suggest ways that can improve the current situation regarding the implementation of the guideline for cost sharing policy in the area of temporary exemption.

APPENDIX IV

INTERVIEW QUESTIONS FOR MEDICAL OFFICER INCHARGE OF THE HOSPITAL

1. How long have you been in your professional practice?
2. How many emergency cases are admitted at St. Augustine DDH per one year?
3. What do you understand about the guideline for implementation of cost sharing policy at health facilities? Have you ever seen such document?
4. How is the guideline for cost sharing policy in the area of temporary exemption to patients under emergency care is being implemented at St. Augustine Muheza DDH?
5. How the follow up of unpaid bills from patients under emergency care who were given temporary exemptions is being conducted at St. Augustine Muheza DDH?
6. How the follow ups to motor vehicles' owners as well as to health insurance companies on unpaid treatment bills for patients who involved in accidents is being conducted at St. Augustine Muheza DDH?
7. What obstacles if any, do you face during follow ups of unpaid treatment bills from clients who already discharged?
8. What obstacles if any, do you face during follow ups of unpaid treatment bills from insurance companies in which vehicles that involved in accidents follow under their membership?
9. What obstacles if any, do you face during follow ups of unpaid treatment bills from insurance companies in which casualties follow under their membership?
10. What are the factors facilitating the implementation of guideline for cost sharing policy in the area of temporary exemption to patients under emergency care at St. Augustine Muheza DDH?
11. What are the factors impinging the implementation of guideline for cost sharing policy in the area of temporary exemption topatients under emergency care at St. Augustine Muheza DDH?

12. Suggest ways that can improve the current situation regarding the implementation of the guideline for cost sharing policy in the area of temporary exemption.

MADODOSO YA KISWAHILI.

Ndugu mshiriki, kwa majina naitwa **Rasmo Msabaha,** mwanafunzi wa shahada ya pili, chuo kikuu Mzumbe nikisomea Ufuatiliaji na Usimamizi wa shughuli za Afya. Nafanya TATHMINI YA SERA YA UCHANGJIAJI WA HUDUMA ZA AFYA KWA WAGONJWA WA DHARURA, HASA KATIKA KIPENGELE CHA UTOAJI WA MISAMAHA YA MUDA KATIKA HOSPITALI ZA MASHIRIKA YA DINI, MATHALANI HOSPITALI YA MISHENI MUHEZA, ikiwa ni mojawapo ya matakwa ya kuhitimu masomo yangu.

Utafiti huu ni kwa ajili ya masuala ya kitaaaluma na si vinginevyo. Hivyo kwa unyenyekevu mkubwa naomba ushiriki wako kwa kujibu maswali yafuatayo yenye lengo la kukusanya taarifa ambazo zitatumika kama matokeo ya utafiti. Majibu yako yatakuwa ni siri, na pia ushiriki wako hautawekwa wazi.

Naomba kuwasilisha.

DODOSO KWA MADAKTARI/ TABIBU, WAUGUZI NA WAUGUZI VIONGOZI WA IDARA YA UPASUAJI (THEATRE & SURGICAL WARD) NA MAPOKEZI.

1. Una utalaam wa nini/ Una cheo gani?
2. Umekuwa katika nafasi uliyonayo kwa muda gani sasa?
3. Hapa Hospitalini huwa mna kawaida ya kupokea wagonjwa wa dharura?
4. Ni aina gani ya wagonjwa huchukuliwa kama wagonjwa wa dharura hapa hospitalini?
5. Ni wagonjwa wangapi wa dharura hupokelewa katika idara/ wodi yako kwa mwaka?
6. Wagonjwa wa dharura wanapofikishwa hospitalini huwa wanaanzia wapi?

7. Je, wagonjwa wa dharura huwa wanapaswa kulipia gharama za matibabu? NDIYO/ HAPANA.
8. Kama jibu ni NDIYO, huwa wanalipaje gharama hizo?
9. Wewe/ ninyi kama watoa huduma wajibu wenu ni upi wakati wa kuwahudumia wagonjwa wa dharura kuhusiana na uchangiaji wa huduma za matibabu?
10. Kama jibu ni HAPANA, kwanini hawatakiwi kulipia?
11. Iwapo ikitokea baadhi ya wagonjwa wa dharura kutokuwa na ndugu wa karibu na pia kutokuwa na fedha za kuchangia gharama za matibabu, Hospitali inakuwa na utaratibu gani ili kuhakikisha wanapata matibabu?
12. Je, imewahi kutokea mgonjwa wa dharura aliyekosa fedha za uchangiaji wa huduma kunyimwa matibabu?
13. Unafahamu chochote kuhusu msamaha wa muda kwa wagonjwa dharura?
14. Ni utaratibu gani unaotumika katika kuomba msamaha wa muda kwa wagonjwa wa dharura hapa hospitalini?
15. Je, wagonjwa wa dharura ambao hawana fedha za uchangiaji wa huduma za afya huwa wanapata fursa ya kupewa msamaha wa muda?
16. Kwa mtazamo wako, unadhani ni kitu gani kifanyike kuhusiana na namna ya kuomba msamaha wa muda kwa wagonjwa wa dharura ili kuboresha hali ya sasa hapa hospitalini?

DODOSO KWA NDUGU WA WAGONJWA WA DHARURA WALIOLAZWA HOSPITALINI.

1. Kwa majina unaitwa nani?
2. Kwanini upo hapa hospitalini?
3. Je una uhusiano gani na mgonjwa wako? Je, ni ndugu au rafiki tu?
4. Je, umewahi kusikia kuhusu suala la msamaha wa muda kwa wagonjwa wa dharura?
5. Kwa maoni yako, unadhani msamaha wa muda una faida yoyote kwa wagonjwa au kwa hospitali?

6. Je, mgonjwa wako aliyelazwa amepewa msamaha wa muda? Au wewe mwenyewe umewahi kupata msamaha wa muda?
7. Unaweza kueleza jinsi msamaha wa muda unavyotolewa hapa hospitalini?
8. Kwa mtazamo wa watoa huduma wetu wa afya, inaonekana jamii hamko tayari kulipia gharama za matibabu kwa wagonjwa wa dharura waliokopeshwa. Je, mtazamo huo una ukweli wowote? Nini maoni yako juu ya mtazamo huo?

DODOSO KWA AFISA USTAWI WA JAMII, KATIBU WA AFYA, MRATIBU WA NHIF/ UCHANGIAJI NA WAHASIBU.

1. Una utalaam wa nini/ Una cheo gani?
2. Umekuwa katika nafasi uliyonayo kwa muda gani sasa?
3. Je, hospitali hii ina kawaida ya kupokea wagonjwa wa dharura?
4. Je, wagonjwa wa dharura huwa wanapaswa kulipia gharama za matibabu? NDIYO/ HAPANA.
5. Kama jibu ni NDIYO, huwa wanalipaje gharama hizo?
6. Kama jibu ni HAPANA, kwanini hawatakiwi kulipia?
7. Iwapo ikitokea baadhi ya wagonjwa wa dharura kutokuwa na ndugu wa karibu na pia kutokuwa na fedha za kuchangia gharama za matibabu, Hospitali inakuwa na utaratibu gani ili kuhakikisha wagonjwa hao wanapata matibabu?
8. Je, imewahi kutokea mgonjwa wa dharura aliyekosa fedha za uchangiaji wa huduma kunyimwa matibabu?
9. Umewahi kuona/ kutumia *Mwongozo wa Utekelezaji wa Sera ya Wananchi kuchangia huduma za Afya katika Vituo vya Huduma ya Afya?*
10. Unafahamu nini kuhusu *Mwongozo wa Utekelezaji wa Sera ya Wananchi kuchangia gharama za huduma za afya katika Hospitali?*
11. Kuna matokeo chanya yoyote yaliyopatikana kutokana na utekelezaji wa *Mwongozo wa Utekelezaji wa Sera ya Wananchi kuchangia gharama za matibabu*, hasa katika kipengele cha msamaha wa muda kwa wagonjwa wa dharura hapa hospitalini?

12. Unafahamu chochote kuhusu msamaha wa muda kwa wagonjwa wa dharura?
13. Hospitali huwa inachukuliaje kimapato kuhusu nyaraka za misamaha ya muda kwa wagonjwa wa dharura, kwa mfano Majeruhi wa ajali za barabarani?
14. Ni vigezo gani hutumika ili mgonjwa wa dharura aweze kupata msamaha wa muda hapa hospitalini?
15. Kwa namna gani wagonjwa dharura waliopata msamaha wa muda wako tayari kulipa bili zao? Hulipa bila matatizo yoyote, au kuna changamoto ya ulipaji?
16. Ni namna gani ufuatiliaji wa malipo ya bili za matibabu hufanyika kwa wagonjwa wa dharura waliotibiwa kwa kibali cha msamaha wa muda na baadae kuruhusiwa kwenda nyumbani?
17. Ikiwa mgonjwa wa dharura ni mwanachama wa bima yoyote ya afya (mfano NHIF, STRATEGIS, AAR au JUBILEE) lakini kwa wakati huo hajafika na kadi yake ya uanachama, je anaweza kupata huduma ya matibabu kama mwanachama wa bima ya afya husika? Kama jibu ni ndiyo, ni hatua gani ya ufuatiliaji wa bili yake ya matibabu katika Mfuko husika?
18. Ni vikwazo gani huwa mnakutana navyo wakati wa ufuatiliaji wa malipo ya gharama za matibabu kutoka kwenye Ofisi za bima ya Afya ambazo wagonjwa wa dharura ni wanachama wake?
19. Ni namna gani ufatiliaji hufanyika kwa wamiliki wa magari yaliyopata ajali pamoja na Kampuni za bima ambazo magari hayo hulipia kuhusiana na madai ya gharama za matibabu kwa majeruhi hapa hospitalini?
20. Ni vikwazo gani huwa mnakutana navyo wakati wa ufuatiliaji wa malipo ya gharama za matibabu kwa wagonjwa wa dharura waliopata ruhusa?
21. Ni vikwazo gani huwa mnakutana navyo wakati wa ufuatiliaji wa malipo ya gharama za matibabu kutoka kwenye Kampuni za bima ambazo magari yaliyosababisha ajali ni wanachama wake?
22. Ni mambo gani yaliyosaidia utekelezaji wa Sera ya Wananchi kuchangia huduma za afya katika kipengele cha msamaha wa muda kwa wagonjwa wa dharura hapa hospitalini?

23. Kuna vikwazo vyovyote vinavyokwamisha utekelezaji wa Sera ya Wananchi kuchangia huduma za afya katika kipengele cha msamaha wa muda kwa wagonjwa wa dharura hapa hospitalini?
24. Ni namna gani/ ni njia ipi hutumiwa na wagonjwa wa dharura waliotibiwa na kuruhusiwa hufanya malipo ya bili za matibabu waliyokuwa wakidaiwa hapa hospitalini?
25. Ni kwa namna gani Uongozi wa hospitali hufanya uthibitisho wa malipo kutoka kwa wagonjwa wa dharura waliokuwa wamepewa msamaha wa muda kwa ajili ya matibabu na kuruhusiwa?
26. Naweza kuona idadi ya wagonjwa wa dharura waliowahi kutibiwa hapa hospitalini katika miaka 3 iliyopita? Kati ya hao ni wagonjwa wangapi walipewa misamaha ya muda, na kati ya hao ni wangapi waliweza kulipa bili zao baada au kabla ya kuruhusiwa?
27. Kwa maoni yako, unadhani kutokulipwa kwa bili za misamaha ya muda iliyotolea kwa ajili ya matibabu ya majeruhi wa ajali, huathiri mapato ya hospitali?
28. Kwa maoni yako, unaweza kushauri namna ya kuboresha utekelezaji wa Sera ya Wananchi kuchangia huduma za afya katika kipengele cha msamaha wa muda kwa wagonjwa wa dharura?

DODOSO KWA MGANGA MFAWIDHI WA HOSPITALI.

1. Umekuwa katika nafasi uliyonayo kwa muda gani sasa?
2. Ni wagonjwa wangapi wa dharura hupokelewa hapa hospitalini kwa mwaka?
3. Unafahamu nini kuhusu Mwongozo wa Utekelezaji wa Sera ya Wananchi kuchangia gharama za huduma za afya katika Hospitali?
4. Ni namna gani Mwongozo wa Sera ya Uchangiaji huduma za afya katika kipengele cha Msamaha wa muda kwa wagonjwa wa dharura hutekelezwa hapa hospitalini?
5. Ni namna gani ufatiliaji wa malipo ya bili za matibabu kwa wagonjwa wa dharura waliopata msamaha wa muda hufanyika hapa hospitalini?

6. Ni namna gani ufatiliaji hufanyika kwa wamiliki wa magari yaliyopata ajali pamoja na Kampuni za bima ambazo magari hayo hulipia kuhusiana na madai ya gharama za matibabu kwa majeruhi hapa hospitalini?
7. Ni vikwazo gani huwa mnakutana navyo wakati wa ufuatiliaji wa malipo ya gharama za matibabu kutoka kwenye Kampuni za bima ambazo magari yaliyosababisha ajali ni wanachama wake?
8. Ni vikwazo gani huwa mnakutana navyo wakati wa ufuatiliaji wa malipo ya gharama za matibabu kutoka kwenye Ofisi za bima ya Afya ambazo wagonjwa waliopata ajali ni wanachama wake?
9. Kuna matokeo chanya yoyote yaliyopatikana kutokana na uwepo wa *Mwongozo wa Utekelezaji wa Sera ya Wananchi kuchangia gharama za matibabu,* hasa katika kipengele cha msamaha wa muda kwa majeruhi wa ajali hapa hospitalini?
10. Ni mambo gani yaliyosaidia utekelezaji wa Sera ya Wananchi kuchangia huduma za afya katika kipengele cha msamaha wa muda kwa majeruhi wa ajali za barabarani hapa hospitalini?
11. Kuna vikwazo vyovyote vinavyosababisha utekelezaji wa Sera ya Wananchi kuchangia huduma za afya katika kipengele cha msamaha wa muda kwa majeruhi wa ajali za barabarani hapa hospitalini?
12. Ni namna gani majeruhi wa ajali za barabarani waliotibiwa na kuruhusiwa hufanya malipo ya bili za matibabu waliyokuwa wakidaiwa hapa hospitalini?
13. Ni kwa namna gani Uongozi wa hospitali hufanya uthibitisho wa malipo kutoka kwa majeruhi waliokuwa wamepewa msamaha wa muda kwa ajili ya matibabu na kuruhusiwa?
14. Kwa maoni yako, unaweza kushauri namna ya kuboresha utekelezaji wa *Sera ya Wananchi kuchangia huduma za afya* katika kipengele cha msamaha wa muda kwa wagonjwa wa dharura?

MAJADILIANO (FGD) KWA MADAKTARI/ TABIBU, WAUGUZI VIONGOZI WA IDARA YA UPASUAJI (THEATRE & SURGICAL WARD), MRATIBU WA MTUHA, WAHASIBU NA MRATIBU WA MFUKO WA TAIFA WA BIMA YA AFYA HUHUSU UTEKELEZAJ WA MWONGOZO WA UCHANGIAJI KWA WAGONJWA WA DHARURA.

1. Naomba tujitambulishe kila mmoja, na kutaja tumekuwa katika nafasi tulizonazo kwa muda gani sasa?
2. Ni aina gani ya wagonjwa huchukuliwa kama wagonjwa wa dharura hapa hospitalini?
3. Je, wagonjwa wa dharura huwa wanapaswa kulipia gharama za matibabu?
4. Ninyi kama watoa huduma wajibu wenu ni upi wakati wa kuwahudumia wagonjwa wa dharura kuhusiana na uchangiaji wa huduma za matibabu?
5. Je, imewahi kutokea mgonjwa wa dharura aliyekosa fedha za uchangiaji wa huduma kunyimwa matibabu?
6. Ni utaratibu gani unaotumika katika kuomba msamaha wa muda kwa wagonjwa wa dharura hapa hospitalini?
7. Je mnadhani uwepo wa mwongozo wa uchangiaji huduma za afya unatosheleza mahitaji kwa wahusika, hasa wa misamaha ya muda?
8. Kwa mtazamo wanu, mnadhani ni kitu gani kifanyike kuhusiana na namna ya kuomba msamaha wa muda kwa wagonjwa wa dharura ili kuboresha hali ya sasa hapa hospitalini?