

**EFFECTS OF EXEMPTIONS ON COST SHARING PRACTICES
IN GOVERNMENT HEALTH FACILITIES: A CASE STUDY
CHUNYA DISTRICT COUNCIL**

**EFFECTS OF EXEMPTIONS ON COST SHARING PRACTICES
IN GOVERNMENT HEALTH FACILITIES: A CASE STUDY
CHUNYA DISTRICT COUNCIL**

By

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**A Dissertation Submitted to the School of Public Administration and
Management (SOPAM) In Partial Fulfillment of the requirements for the
Degree of Masters In Health System Management (MHSM) Mzumbe
University, Tanzania**

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled “**A study of effects of exemptions on cost sharing practices in government health facilities**” at Chunya District Hospital in a partial fulfillment of the requirements for the award of the degree of Masters of health system management of the Mzumbe University.

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DEAN

DECLARATION

I, Chengula Veronica A. Declare that this research is my own work. It has not been submitted for any degree in any other institute of higher learning, and all the sources I have used or quoted have been indicated and acknowledge as complete references.

Signature

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DEDICATION

I would like to dedicate this work to my husband Richard M. Luzila and my children, Samuel Richard and Sarafina Richard, who missed my love while I was busy preparing this report. Lastly but not least for the important are my parents father A. P. Chengula and my beloved mother A. Mbilinyi, without them this work would not be successful. May God bless all of them.

LIST OF ABBREVIATIONS

ADDO	Accredited Drug Dispensing Outlet
AIDS	Acquired Immunity Deficiency Syndrome
AMO	Assistant Medical Officer
CCHP	Comprehensive Council Health Plan
CHMT	Council Health Management Team
CTC	Care and Treatment Clinic
FP	Family Planning
HIV	Human Immunodeficiency Virus
HNP	Health Nutrition and Population
IMF	International Monetary Fund
IPD	Inpatients Department
KCMC	Kilimanjaro Christian Medical Centre
MD	Medical Doctors
MoH	Ministry of Health
OED	Operational Evaluation Department
OPD	Outpatients Department
TB	Tuberculosis
UK	United Kingdom
VCT	Voluntary Counselling and Testing
VEO	Village Executive Officer
WEO	Ward Exertive Officer
WB	World Bank
WHO	World Health Organization

DEFINITION OF TERMS

Cost sharing: Are fees imposed for health care or education; often these services were previously provided for free or at normal cost (e.g. School fees, fees for textbooks, and fees for using clinics)

Clinician: Someone whose job is to treat people who are sick or injured. They include medical doctors (MDs), assistant medical doctors (AMOs), clinical officers (Cos) and Assistant Clinical Officers (ACOs).

Community Health Fund: Is the tool for mobilizing voluntary, community involvement and participation in supporting their health care.

Exemption: Is the term used to describe when services are automatically provided for free because of the ability to pay.

Health: In the constitution of 1948, the World Health Organization (WHO) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.

Health Care: Is a consumption of goods as well as an investment, good health care improves welfare, while as an investment commodity health care enhances the quality of human capital by improving and increasing the number of days available for productive activities.

Waivers: Is a voluntary relinquishment or surrender of some known right or opportunity.

ABSTRACT

The study looks into the effects of exemptions on cost sharing practices at Chunya district hospital. The research objectives were to determine the awareness of health service providers on exemption mechanisms, how exemptions are implemented and satisfy the eligible groups, what are the effects of exemptions and identifying appropriate mechanisms of improving the implementation of exemptions.

The study adopted a case study design by using questionnaires and interviews for primary data collection while secondary data were obtained from reviewed related documents. The study was completed by 60 respondents working in different departments of Chunya district hospital including CHMT. Moreover, the sampling techniques were both non-probability and probability sampling, which include purposive sampling and simple random sampling.

From the findings of the study, the majority 55 (91%) were aware with exemption mechanisms in their work place. Moreover, on the satisfaction of the groups who are exempted 35 (58%) the system is satisfying with some challenges. Furthermore, on the effects of exemptions on cost sharing the result showed that 56 (93%) of respondents agreed that exemptions has effects of cost sharing due to lower revenue collections, workforce crisis and inadequate medicine and medical supplies.

Tanzania should implement cost sharing and exemption mechanisms in situations that can maximize the revenue collection, compensate the revenue lost in exemption by using tax collected from natural resources i.e. gold mining, tourism, gas and mobilization of CHF.

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CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Overview

This chapter presents the background of study, statement of the problem, objectives of the study, significance of the study, limitation of the study and the scope of the study.

1.2 Background of the study

An exemption is a statutory entitlement to free health care services, granted to individuals who automatically fall under the categories specified in the cost sharing operationalization manual; MCH services, including immunization of children in all Grade III services; children of 5 years of age and below; patients suffering from TB, leprosy, paralysis, typhoid, cancer and HIV/AIDS; cholera, meningitis, plague, and long term mental disorders and elders of 60 years and above. A waiver is granted to those patients who do not automatically qualify for statutory exemptions, but are in need of the same, and classified as ‘unable to pay, in the operationalization manual (from CHF design manual)

In 1977, the government of Tanzania declared the principle of universal free medical services for all Tanzanians Ministry of Health (1996). In 1993 Tanzania faced difficulties, which necessitated the introduction of cost sharing. The difficult economic conditions which Tanzania suffered in the late 1980s made it difficult for the policy of free service for all. As a result Tanzania introduced cost sharing schemes in government health facilities to generate revenues in order to supplement the government budget. The moneys collected from cost sharing could be used to provide quality care, ensuring adequate supplies of drug and medical equipment as well as human resources.

A number of low and middle income countries have exempted sick people from user fees in certain categories of population of health services. These exemptions are effective in lifting part of financial barrier to access health services. One solution being considered to improve access to care is to make services free at the point of service. Many countries such as South Africa, Mali, Niger and Ghana have therefore

implemented exemption policies, sometimes targeted to population groups i.e. children under five or specific services e.g. caesareans. But they have been organized within unstable health systems where there is reduction of user fee/ cost sharing collections (Perkins and Mwakajunga, 2009).

Many other developing countries have also had a tradition of public provision of all health services. However, government resources have decreased in real terms while has increased in many of these countries in the last decades. This necessitated the need for traditional sources of revenue to operate the public sector health system and its services have become acute. The policy that introduced cost sharing in public health facilities was approved by the Tanzanians cabinet in June 1993. The initiative was one of the policy options being implemented to address the financing gap in the health sector. The decision was in response to falling standards of the services in many of health facilities in Tanzania (MoHSW, 1999)

With the introduction of cost sharing there also have been defining exemptions, especially for the poor people. The term exemption is not a new and described the targeting mechanisms to protect the poor who cannot afford the cost sharing are used to describe what services are to be automatically provided for free because the patient's inability to pay.

The section of providing an exemption for the poor and treatment of emergencies whether they are immediately paid or not, are hardly used and people are sometimes deprived of their care need. In part the non use of the clause exempting the poor is because the costs of exemption are to be borne by health facility out of surplus it generates. There is social work involved in verifying that a person is indeed unable to pay. Since it is just a statement of inability to pay is used, everyone will become too poor to pay (Agyepong, 1999). Exemption policies are aimed at increasing the access of marginalized groups to health services that do not seem to be working and further work is needed to determine how these groups can be assisted (Hunson and Pake 1993).

However, many studies shows that user fees contributes to catastrophic expenses and reduce people's access to health services, especially the poor and the most vulnerable groups of the society. Accompanying user fee, mechanisms was designed to protect and ensure equitable access to health care to poorer segments of the population. In Tanzania, the Ministry of Health introduced waivers and exemptions in 1994, to ensure access of health services by the poor and vulnerable members of the society. Exemptions are statutory entitlements that are automatically granted for all maternity services, children under five years and particular diseases such as TB/Leprosy, HIV/AIDS and some chronic diseases that would drain substantial income from the patients if such patients were asked to pay. Waivers on the other hand target the poor and vulnerable groups of the society on grounds of ability to pay (MoHSW 1999).

Exempting health delivery services was among the Millennium Development Goal four and five. This will not be achieved in many low- and middle-income countries with the weakest gains among the poor. Recognizing that there are large inequalities in reproductive health outcomes, the post-2015 agenda on universal health coverage will likely generate strategies that target resources where maternal and newborn deaths are the highest.

In 2012, the United States Agency for International Development convened an Evidence Summit to review the knowledge and gaps on the utilization of financial incentives to enhance the quality and uptake of maternal health care. The goal was to provide donors and governments of the low and middle income countries with evidence informed recommendations for practice, policy, and strategies regarding the use of financial incentives, including vouchers, to enhance the demand and supply of maternal health services. But in a real sense the system does not look on the side of supplies in health facilities that hinder the provision of quality health services (Agypong, 1999).

The health sector is seriously underfunded despite the fact that it is a priority sector in the Poverty Reduction Strategy, and despite the fact that a healthy population is a basic ingredient of economic growth. Lack of funds, however, is not the only cause

of the weak health system. Under skilled and demotivated personnel, deficiencies in quality of care, weak and confusing management systems, lack of information provided to health consumers, and lack of access by the very poor to treatment characterize much of the current situation (Whitehead et al, 2001).

Even though the aim of exemptions and waivers is to help the poor, but it benefit the better off more than those in need. The following are the limitations that are likely found out in government health facilities:

- i. Potential conflict between on generating revenue and protection of the vulnerable social groups
- ii. The exemption and waiver procedures have loopholes that allow the misuse and sometimes abuse of the system
- iii. Waived patients experience stigmatization and disadvantages while attending health services compared to those who pay for services and sometimes they are called '*Vibendera*' by the health service provider when they go to render services.
- iv. The poorest who are not able to pay often do not have access to waivers; either due to lack of information and/or denial of the waiver by service providers.
- v. With the introduction of user fees and CHF at primary level of care, there is the risk that access of the poor to essential health care is substantially decreasing
- vi. Identification procedures and screening criteria for waivers are unclear

1.2 Statement of the Problem

The implementation of cost sharing in Tanzania government health facilities was introduced in 1993 as a part of health reform. The system was implemented in four phases covering all levels of health care. The reform policies were introduced in the country as a donor's condition which required borrower countries to decentralize health services and introduce user fees.

The IMF had aggressively promoted user fees since the late 1980s and more recently has pressed the central government to give up responsibility to deliver basic health services such as health care. In 1998 internal review of world Banker Nutrition and Population (BNP) report showed that 40% of all projects in BNP portfolio and shocking 75% in sub Saharan Africa included the establishment or expansion of user fee. The WHO reported that user fees generally provide only a very small portion of health budgets rarely more than 5%. This led to poor provision of health services and discrimination of vulnerable groups basing on ability and willingness to pay. Later the exemption policy was introduced to promote equity to those in need of services and not able to pay.

The effort made by the government to exempt those who cannot pay for the services facing many bottlenecks. The system is not properly implemented largely because decision to exempt is often left to the discretion of local service provider, while the characteristics of the poor are generally not defined in a clear fashion and there is poor community participation. These may have effects on both revenue collection and on equity in health care provision. Thus, the study will intend to determine the effects of exemption policy on cost sharing in government health facilities, the ultimate goal being to improve both health revenue collections as well as to bring equity in health care.

Why user fee?

According to McIntyre (2007), out of pocket expenditures include direct payments made to public and private health providers. User fees are out of pocket payments made to public health care facilities. User fees were introduced in many African countries in the context of an economic recession experienced between the 1980s and 1990s. During the recession, many affected countries adopted economic structural adjustment programmes (SAP) policies which not only reduced the allocations to health and other social sectors, but also introduced fees for previously free public sector health care services (Russell *et al* 1995; World Bank, 1996; Whitehead *et al*, 2001).

The main purpose of introducing user fees was to generate additional revenue for various primary health care programmes, which were under-funded. Another objective of user fees was to strengthen the referral system, reduce the tendency among parties to by-pass lower level facilities and discourage frivolous use of health care services (Mmbuji et al, 1995; Newbrander et al, 2000). It has also been argued that user fees improve access to quality of health care services by ensuring the availability of drugs, medical supplies and other health care services. In addition, user fees promote a sense of ownership, efficient consumption patterns and the use of cost effective health services. For this reason, it was recommended that income generated from user fee revenue should be retained at the facility level and mainly used for purchasing drugs and medical supplies (Mamdani, 2005).

1.3 Objectives of the Study

1.3.1 General objective

The general objective of the study is to determine the effect of the exemptions on cost sharing practices in government health facilities.

1.3.2 Specific objectives

- i. To determine awareness of health service providers on exemption mechanisms.
- ii. To examine the implementation of the exemptions
- iii. To determine the effects of exemptions on cost sharing.
- iv. To identify appropriate mechanisms of improving the implementation of exemptions so as to improve both equity in health care as well as revenue collection

1.4 Research Questions

- i. Are the health service providers aware of the exemption mechanism?
- ii. Is the system implemented properly?
- iii. What are the effects of exemptions on cost sharing?
- iv. What are the ways of improving the implementation of exemptions?

1.5 Significance of the Study

The findings of the study will be of crucial significance for the following reasons:

- i. It will suggest the ways or means of improving services to the community who are exempted and promote the importance of cost sharing that will increase government revenue.
- ii. The study will help the service providers to know the better about the exemptions and whether it is working properly. Also will give some recommendations necessary for policy makers to improve the system.
- iii. It will stimulate further research on cost sharing and other related matters

1.6 Scope of the Study

The study was confined to CHMT, HMT members and other health service provider from different department of the Chunya District Hospital. The total numbers of respondents were sixty. I used such kind of respondents because they were the implementer of the policy and they are familiar with the effects which face exemptions as well as ways of dealing with the challenges

1.7 Limitation of the Study

- i. There was a poor response from some respondents due to the personal reasons. Some respondents thought that researches are not necessary, they do not help to solve the problems in the community, but they just have to fill the questionnaire and being interviewed for the benefit of the researcher for being awarded a degree. Some respondent wanted to be paid first so as to answer a questionnaire or being interviewed. Therefore the researcher had to use extra effort to convince them on the importance of this research as a result respond rate was greater than before.
- ii. The financial resource received from the council was not sufficient to meet the daily expenses while conducting the study as well as to meet transport, stationary and other necessary materials; due to these constraints the researcher was not able to complete the report on time.

CHAPTER TWO LITERATURE REVIEW

2.1 Overview

This chapter presents the literature and studies related to the topic. The chapter presents the theoretical and practical issues related to the subject it begins with theoretical reviews, empirical reviews, research gap and conceptual framework.

2.2 Theoretical reviews

User fees are fees imposed for health care or education (for example fees for using health care clinics, school fees, fee for text books) often these services were previously provided for free or at normal cost. In many cases, these user fees for services have been strongly promoted or even required by the World Bank and International Monetary Fund as a condition for new loans and debt relief.

User fees have been promoted as a needed source of health care and education. In reality, user fees generate only a portion of budgets while disproportionately excluding the poor. User fee (cost sharing) refers to the payment of out of pocket charges at the time of health care (Tenkorang 2000). In the study of the current method of financing health care sector have inefficiencies it concludes the government have not been successful in providing appropriate care to those who need it. The better off in most countries benefits more from free or subsidized services than the poor do. Individuals who need care do not obtain it because in most developing countries price at public medical care facilities is zero or very close to zero, the time price ratio the market and replace monetary price in determining the choice of medical care providers (Beaker, 1995).

User fee exemptions for health services have made it possible to address the needs that until now had not been met; an analysis of the literature shows the other side of the coin. In fact, in acting on the provision of services to make them accessible to more people, the exemption policies have at the same time interrupted other essential functions of the health systems of the countries involved, which were already, in any case, relatively unstable. If this very relevant user fee exemption policy is to be

effective and equitable, it is therefore essential that these interactions be taken into account when formulating exemption policies, in order to limit disruptions and to create the interaction needed for the system to perform optimally (Kusi et al, 2005).

Charging for health service is another way of finding more money to support the health sector, but some charges can be introduced which do not fall upon the poor. The introduction of charges depends on the actual position facing the particular public health services. If the health care system has decreased to such extent that is lacking essential supplies and even the poor have to report to the private sector to obtain it, is more equitable to charge a fee than not to charge a fee, even though they attempt to charge the poor are likely to be far from fully affective (Abel, 1994).

Health according to the constitution of 1948, the World Health Organization (WHO) defined health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, such definition is only too easy to agree with but difficult to operate in practice

Health Care is a basic human need, but in most developing countries the prospect of achieving even minimal adequacy of health care services is a distant goal. The basic health needs of a vast of numbers of people remain unmet and the pursuit of improved standards of health has been a primary concern over recent years (Abel, 1994). Moreover, health care is a consumption of goods as well as an investment, good health care improves welfare, while as an investment commodity health care enhances the quality of human capital by improving and increasing the number of days available for productive activities. The time cost in production because of ill health, thus indicates reduced output.

A health system is a collection of services, persons and actions whose interactions are complex and interrelated. As has been affirmed by WHO and others before, for a health system to be effective and equitable, its different functions must work in agreement, and any change will therefore have an effect on each function. Thus, exemption can modify a health system's equilibrium and disrupt its essential

functions.

Exemptions, and in particular waivers, are not systematically implemented and are not effective as a means of protecting vulnerable social groups and the poorest of the poor. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, small charges (e.g. Cards, materials), and bribes. The exemption scheme is poorly implemented partly because accountability mechanisms are not in place, and because health service providers are not following procedures that are often unclear to them to begin with. But an equally important factor is the low uptake and lack of insistence on free services by the poor, primarily because they are not aware of their rights. A lack of clear criteria and policy guidelines for identifying people who are eligible for waivers has resulted in ad hoc decisions, without clear records or follow up.

Health care charges

Are the charges which a person pays after receiving health services, include medical examination, drugs consultation fee, etc. Health care charges have placed an impossible financial burden on the poorest households who are often excluded from using health facilities when they most need them. The cost sharing revenue generated has not necessarily impacted positively on quality of health care, or access to health care by the poorest. User fees are not the only charges the poor have to pay; other costs include travel time, transport costs, other unofficial costs including bribes, and for drugs and supplies. The CHF may have improved the quality and range of available services, but the scheme has not necessarily benefited the very poor in a more equitable way.

The literature demonstrates a problem with the efficacy of the design and practices of waivers to protect the poor against user fee barriers. There are problems in the area of equity with user fees. The part providing the exemption for the poor and treatment of emergencies, whether they are immediately poor and treated in an emergency and whether they have to pay or not, hardly use and people are sometimes denied the care they need (Agyeping, 1999). Exemption policies aimed at increasing the access of the marginalized group to health services, but it has some challenges like inadequate

medicine, medical supply, fund and work force crisis. Further work is needed to determine how best these groups can be assisted (Hunson et al, 1993).

Based on several research studies, the Tanzanian Ministry of Health (MoH) developed several cost sharing guidelines regarding the implementation, e.g. waivers and exemption mechanisms in the health sector. Despite this, it was found that very few waivers and exemption were granted by health facilities. That letter from community leaders and the process of approval of waivers for the poor was done by the health personnel at the local facility level (Newbrander et al; 1996).

Cost sharing policy causes a drop in utilization rates and facility also a delay in seeking care. People do not show up at a health facility unless they are severely ill and when they are admitted to hospital, often turn up only after several days. Vulnerable groups need to ask money from their relatives when failed, they should be exempted hence reduction of revenue.

For user fees to be an effective policy tool, experience indicates that the government must support the aims of user fees systems with policies to promote equity (including exemption), and a broader reforms “Package” including administrative or organizational restructuring (e.g. Decentralization and greater local responsibility for revenue use) to improve managerial incentives and capacities. Without these reforms, unlikely that user fees revenue will be protected from burden of fees, or that efficiency gains will be realized (Bennett et al; 1995)

2.3 Empirical literature review

In many developing countries user fee in public health services has been an initiative of increasing revenue collection. Policy review emphasizes that user fee should be regarded as a means of contributing to better incentives and improved reform in government owned institutions in terms of equity, quality, efficiency, and sustainability and not as an isolated revenues raising devices (Bennet et al, 1995).

Tanzania, like many other African countries, has been implementing a user fee policy

in its health sector since the early 1990s. User fees were seen as an efficient solution for funding improved health care. However, studies have shown that user fees contributes to catastrophic expenses and reduce people's access to health services, especially the poor and the most vulnerable groups of the society. Accompanying user fee, mechanisms was designed to protect and ensure equitable access to health care to poorer segments of the population.

In Tanzania, the Ministry of Health introduced waivers and exemptions in 1994, to ensure access of health services by the poor and vulnerable members of the society. Exemptions are statutory entitlements that are automatically granted for all maternity services, children under five years and particular diseases such as TB/Leprosy, HIV/AIDS and some chronic diseases that would drain substantial income from the patients if such patients were asked to pay. Waivers on the other hand target the poor and vulnerable groups of the society on grounds of ability to pay.

The exemption and waiver system was expanded with the introduction of the Community Health Fund (CHF) scheme which aimed at improving access to health care and to protecting people against financial cost of illness in an environment with shrinking budgets for the health sector.

Evidence indicates that exemption policies in Tanzania, while potentially effective in principle, are ineffective in implementation, Munyetti et al, (2006), reported that only 16% of patients who were unable to pay for health services were exempted from paying user fees. The remaining 84% either borrowed money to pay for health care; self treated or sought traditional health care.

Another study found that, out that exemption were given, a relatively large number of people (children under five years of age, pregnant women, the chronically ill and those considered being too poor), the most needy did not benefit such exemption. In addition, communities and health workers alike reported lack of information and understanding of the exemption scheme; thus the policy was interpreted differently by different facilities, and record keeping and transparency were poor. Similarly,

other studies have reported that most district managers do not provide exemptions, fearing to put at risk the Community Health Fund's financial viability (Munyetti et al, 2006).

As a study done by CHMT members (2005) in Morogoro Municipality, a broad objective of the study was to identify factors contributing to low health service user fee collection. Found that only 13.1% cost sharing were collected in health facilities and exemption was the factors for small collection. It was concluded that the system was not clear, some clients tend to over utilize the earnings which they have got during the harvesting period through different ceremony and when they fall sick no money to pay for services therefore they should be exempted because they have to get the services.

Msamanga et al, (1995) covered out patients in Kilimanjaro and Mara regions. The main objective of the study was to identify quality and effects of exemptions in a health facility. The study found that 255 (45%) of patients felt as qualifying for exemption, patients attending private health facilities were less likely to ask for exemptions than those who contacted public and voluntary agency (mission) health facilities, only 70% were aware of the government policy guidelines that patients under vertical programs like TB/Leprosy were supposed to be exempted from health care user charges

Exemption mechanisms in most developing countries face challenges in providing equitable access to health care for poor and marginalized groups simply because no collection of user fee that may reduce some difficulties in the organizations, Ndyomugenyi et al, (1998). These studies compete that implementation often varies from policy intent. Gilson (1997) points out that the implementation of exemptions does not protect the poor in many places and rather benefits more wealthy groups such as civil servants and soldiers who are exempted from fee payment. However, the difference here is that the problem has more to do with a lack of political will to implement safety nets than a problem of identifying the needy.

Newbrander et al (2005) covered health administrator and other health staff exit hospital patients and members households living closer to health facilities. The study was to review official documents concerning waivers and exemptions in the government cost sharing policy. The main objective was to look the response on deciding the group of people who are eligible for being waived or exempted. The team visited Muhimbili National Hospital, one regional hospital, 4 district hospitals, 2 mission hospitals and one parastatal organization. Only 2 hospitals were found with the records on waivers and exemptions, although they did not show any calculation of their actual costs

In 1994, another study was undertaken with three officers in the cost sharing implementation unit at the ministry of health to assess, among other things, the implementation of the waivers and exemptions, availability of information to patients and the general public and the cost of exemptions granted. The study was conducted at Bugando, KCMC in Kilimanjaro and six district hospitals. It was found that, all hospitals have established an exemption mechanism, and there were personnel responsible for administering waivers to patients in need. The study report reviewed does not, however, indicate any evidence for difficulties or drawbacks faced cost sharing (Kruk et al, 2003)

A research done by Witter et al (2006) in Ghana whose main objective was to look at how exemption has increased service deliveries, it was found that health workers may have worked above their capacity to contain the increased workload. Many health workers in the two regions averred a motivation to ensure successful delivery outcomes despite the increased work demands following the exemption. This accounted motivation contrast with the situation in Uganda following the abolition of maternal user fees where staff morale suffered as a result of a 47% increase in average workload and the loss of the fee revenue that had been used to supplement staff salaries. Similarly, in South Africa, health workers perceived little value in their raised levels of workload and stress resulting from a 'fee-free' policy for maternal and child care as they were largely due to increased attendance by persons with self-limiting illness.

A research done by Kusi et al, (2006), where the main objective was to find out the positive effect of exemption in government health service deliveries found that a number of institutional deliveries in the Central Region of Ghana increased by 33.6% from 9,439 in the pre-exemption period to 12,615 in the post-exemption. At the same time, the institutional MMR declined from 953 deaths per 100,000 births in the pre-exemption period to 856 per 100,000 births in the post-exemption period. In the VR, the number of institutional deliveries increased by 10.6% from 5,558 in the 11 months before implementation of the exemption policy to 6,146 in the same period following implementation. Such success faced some challenges which are insufficient supply of emergency medical supply (i.e. Delivery kits, delivery beds) and medicine.

UNICEF cites a study which found that exemption schemes for health in sub-Saharan Africa are not only rare, but are also implemented in informal and ad hoc ways. This survey showed that the exemptions based on the ability to pay are extremely uncommon in practices. UNICEF further points out that if financial incentives or staff performance are linked the successful collection of fees as they have been in many countries, then there can be a direct trade off between the goal of revenue collection and that reducing the negative impact of the poor (UNICEF, 2004).

Although World Bank has acknowledged that these exemption systems seldom work in practices. The WB Operation Evaluation Department (OED) reported in 1998 that few health project loan documents include details about how the poor will be exempted. The OED commissioned a set country a case study. In Zimbabwe it was found less than 20% of the eligible poor ended up receiving individual waivers for health user fees (WHO, 2005).

Jubilee 2000 UK, in Mozambique in advance of the debt relief agreement, the Government was required by WB to increase revenues for health care from private sources and as a result the parliament of Mozambique passed a law that will raise

charges for health care services yet even before the recent floods, only 40% of the population had access to health care services.

A study done by Limbambala et al (2001), found that many health workers opt for non-exemptions of needy and other marginalized groups to keep their units operating. This scenario demonstrates that exemption schemes seem to have failed in Uganda because they lacked adequate financing mechanisms such as direct central and/or local government subsidies for exemptions and waivers. The schemes were developed without putting in place the capacity and logistics required for their implementation both at the national and service delivery level. Guidelines to regulate exemptions are non-existent or ignored, or selectively applied at the lower unit level.

Lack of political will and commitment to the implementation of safety nets means that lower level units have little incentive or guidance to implement them. Thus very few indigenous receive exemptions and waivers. On the other hand, many non-poor exempt by virtue of their connections to local leaders and health workers.

User fee removal has been put forward as an approach to increasing priority health service utilization, reducing impoverishment, and ultimately reducing maternal and neonatal mortality. However, user fees are a source of facility revenue in many low-income countries, often used for purchasing drugs and supplies and paying incentives to health workers. Evidence shows that the effects of user fee exemptions research done in Uganda on maternal health service utilization, service provision, and outcomes, including both supply-side and demand-side effects. The introduction of user fee exemptions appears to have resulted in increased rates of facility-based deliveries and caesarean sections in some contexts. Impacts on maternal and neonatal mortality have not been conclusively demonstrated; exemptions for delivering care may contribute to modest reductions in institutional maternal mortality but the evidence is very weak (Okunzi, 2000).

User fee exemptions were found to have negative, neutral, or inconclusive effects on availability of inputs, provider motivation, and quality of services. The extent to which user fee revenue lost by facilities is replaced can directly affect service provision and may have unintended consequences for providing motivation. Governments should link user fee exemption policies with the replacement of lost revenue for facilities as well as broader health system improvements, including facility upgrades, ensured supply of needed inputs, and improved human resources for health. Removing user fees may increase uptake, but will not reduce mortality proportionally if the quality of facility-based care is poor, (Okunzi, 2003)

A study done by George et al, (2002), in Uganda 3 district health facilities it shows that exemptions and waivers leaves the Ugandan health worker with a dual challenge working without adequate supplies at the facility, and exempting ill individuals in need of assistance. In most cases, health workers opt for non-exemptions of indigenous and other marginalized groups to keep their units operating. This scenario demonstrates that exemption schemes seem to have failed in Uganda because they lacked adequate financing mechanisms such as direct central and/or local government subsidies for exemptions and waivers. The schemes were developed without putting in place the capacity and logistics required for their implementation both at the national and service delivery level.

While users advocate for free health services, district officials and health workers want cost recovery with minimum exemptions. This is not surprising because the users, who are mainly peasant farmers with unstable income, want to access health services even when they have no money at hand. On the other hand, district officials and health workers want user fees to run the health units. Resolving the conflict between revenue collection at health units and providing services to users who have no money is a dilemma faced by public health planners in developing countries (Okunzi, 2000)

The implementation of exemptions depends on the interests, positions and actions of the various stakeholders that have kept changing over time depending on the pressure from the population. For example, in Uganda exemptions were in the heat of political campaigns for the presidential elections in March 2001, the central government opted to scrap cost sharing in order to ease political pressure. The Ministry of Health was supposed to implement central government plans, therefore, its interests changed with the political position of the executive of the central government. These were done without looking on the effects that will affect health system, especially medical supplies and medicine, human resources and funds for running different activities in the organization specifically health facilities.

The operation of exemptions and waivers is guided by a set of policy principles and guidelines the effectiveness and success of its implementation largely depends on the interpretation of the guidelines and level of understanding by the staff at the facility level. The granting of a waiver at the facility level, for example, is supposed to be done by trained personnel (social workers) but due to a lack of skilled personnel this is not the case (Mamdani et al, 2004). In practice, the granting of waivers at the facility level is often carried out by a health care provider, resulting in leakages and under-coverage (Mamdani & Bangser 2004). Unlike other studies, this one has to determine the effects of exemptions on cost sharing practices in government health facilities.

2.4 Research gap

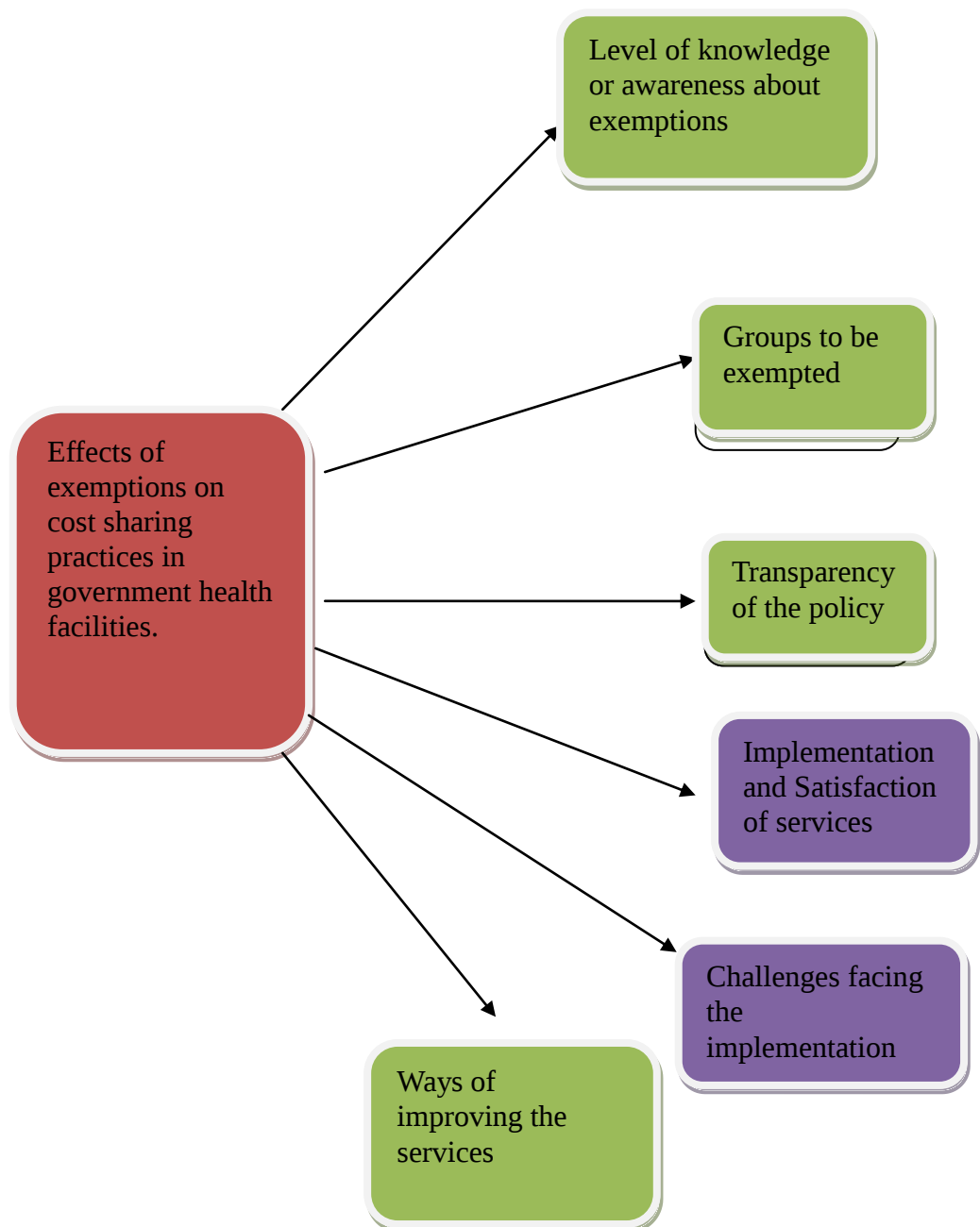
For the purpose of this study, according to theoretical and empirical literature review didn't come up with ways on how to address the effects of exemptions on cost sharing in Government health facilities. Therefore on my research I have provided some recommendations and way forward to reduce those effects of exemptions.

2.5 Conceptual framework

The model for this research study assumes that, the effects of exemptions on cost sharing being a dependent variable are examined by (independent) variables such as awareness about exemptions, groups of people to be exempted, accessibility of health

services, challenges facing service delivery, during implementation, transparency of the policy and ways of improving service delivery. From the hypothesis it is observed that, exemptions may be achieved when the taxes which are collected from natural resources are allocated to health services provision, clear mechanisms of reimbursement for services that are exempted, reviewing the guideline of exemptions, improving the way of mobilizing people to contribute for CHF, identifying the people who are real being exempted, improving model of identifying vulnerable groups and providing identity cards which will be usable any place of government health facility.

Figure 2.1: Conceptual framework



Source: Compiled by the researcher

CHAPTER THREE RESEARCH METHODOLOGY

3.1 Introduction

This chapter is concerned with the design and methodology of the study. It describes the data collection methods, study design, study area, sampling techniques, sample frame and sample size.

3.2 Study design

The research had a qualitative and quantitative in nature whereby a descriptive case study design was employed in this study, as it allowed in-depth information to be gathered at one point in time and it was explorative. The researcher has to examine the effects of exemptions on cost sharing practices in government health facilities in relation to awareness, implementation or satisfaction, challenges and ways to rectify the situation. A case study is the means by which a researcher explores individuals or organizations, through simple or complex interventions, relationships, communities, or programs

3.3 Study area

The study was conducted at Chunya district council. The scope of the study area covered one hospital (Chunya district hospital). The choice of the study area was due to the following reasons.

- i. The researcher was familiar with the area, therefore, was expecting to get enough cooperation in searching various sources she will need for the study.
- ii. The Chunya district hospital is only hospital with a good number of health service providers from the level CHMT to lower level / health service provider.
- iii. The researcher had health problems which hindered her to conduct research away from her working environment.

3.4 Study population

A population in research refers to those elements that make up the focus of the study that fit a fixed criteria (Wood and Haber, 2010). It is therefore a collection of elements about which a researcher wishes to get information from. The study confined to public health service provider in Chunya district hospital, there are 120 health service providers working in different departments.

3.5 Sample size

For this case study sampling frame includes CHMT core member and co-opted members, health service providers working in different department including Doctor's (i.e. Medical doctors, Assistant Medical doctors), clinician, nurses, and laboratory technician from Chunya District Hospital.

Table 3.1: Sample size

S.No	Types respondents	Number	% of respondents
1	CHMT	16	27%
2	MD	2	3%
3	AMO	5	8%
4	Clinical officers	10	17%
5	Nurses	22	37%
6	Laboratory technician	5	8%
Total		60	100%

Source: Compiled by the researcher

3.6 Sample size and sampling techniques.

For CHMT members all core members and co opted members were included in the study, but for service providers a simple random sampling method was employed, whereby respondents were counted and those falling in odd numbers starting with one were included in the study.

3.6.1 Purposive sampling

According to Omary (2011), purposive sampling techniques involve picking units most relevant or knowledgeable in the subject matter and study them. The techniques targeted to reach a total of 16 CHMT and 44 service providers working in different

department and a simple random sampling techniques was employed to select 60 respondent

3.7 Data collection techniques

Self administered questionnaires, interview and other documentary review were the methods to be used during data collection. The table below illustrates the methods applied.

Table 3.2: Data collection techniques

No	Objective	Variable	Instrument
1	To determine awareness	Awareness	Questionnaire
2	To examine implementation	Implementation	Questionnaire/ documentary review
3	To determine the effects	Effects	Questionnaire/ documentary review
4	To identify the appropriate mechanism	Mechanisms	Questionnaire

Source: Compiled by the researcher

3.6 Data collection methods

Questionnaires were administered to all sampled units and were requested to answer by filling or by the help of the interviewee. Also interviews (only structured) were carried out as an explorative method to squeeze more information from the respondents. Additional to the data collected through those mention tools, secondary data were being gathered from pre-existing records to enable precise information. All relevant sources of data were being considered to allow for triangulation.

3.6.1 Interview

The interview is one of the prominent methods of primary data collection. It refers to as a two way systematic conversation between investigator and an informant, intended for obtaining information relevant to a specific study (Krishnaswami and Ranganatham, 1983). This method helped to collect data from clinicians and nurses, 2 AMOs and 6 nurses were interviewed because they were busy to fill the questionnaire provided to them. Main purposes were to get some additional information in order to complement what the questionnaire has not been able to

fulfil.

3.6.2 Questionnaire

Questionnaires were prepared and administered to gather information from health workers a number of questions consisting of open ended questions, with clear instructions were prepared and distributed to CHMT members, clinicians, laboratory technician and nurses. Sixty questionnaires were distributed and 52 were collected in respectively from respondents. Questionnaires were used to health service providers because of their nature of their work which make them very busy to be interviewed.

3.6.3 Secondary data/documentary review

Information was obtained by reviewing relevant documents relating to this study. The document included files, OPD attendance registers, finance reports and other relevant materials. The aim of using the documents was to cross check the number of people who are exempted and the collection of user fee. The observation was that the total number of people attending on OPD services is different to the amount collected. For example, in the third quarter of 2013/2014 that is January –March total cost sharing collection were 2,300,000/= while the expenses utilized by the exempted groups were 5,600,000/=.

3.7 Data entry, cleaning, management analysis

According to Singh (2006), data analysis is all about the process of evaluating collected data in research using analytical and logical reasoning to examine each component of the data provided. The author adds that data analysis is the process of inspecting, cleaning, transforming and modelling data with the aim of understanding useful information, suggesting solutions and eventually supporting decision making. However, both qualitative and quantitative data were gathered. Descriptive, frequency and cross tabulation analysis procedures were commanded, and quantitative data were applicable.

3.8 Ethical considerations

Ethics refers to the systematic thinking about the moral consequences of decisions (John & Sack, 2001). The following ethical considerations were observed by the researcher: obtaining permission to conduct the study and collect data, respecting the respondents' rights to self-determination and all information were confidential.

3.9 Reliability and validity

Validity: Means that your scientific observation actually measures what they intend to measure. On the side of my study the main objective was to examine the effects of exemptions on cost sharing in government health facilities.

Reliability: Someone else using the same method in the same circumstances should be able to obtain the same findings. The study was reliable simply because there other studies which has done in other developing countries and they found that the revenue collection is low due to exemption. For example the research conducted at the Morogoro Municipal in 2005 shows that only 13.1% of cost sharing was collected and exemptions was the factor for low collection.

CHAPTER FOUR

PRESENTATION OF FINDINGS AND DISCUSSION

4.1 Introduction

This chapter presents findings of the study. It gives answers to study questions which were raised before the research was conducted. This study is based on the effects of exemptions on cost sharing.

To ensure the general objective of this was achieved, specific objectives were analyzed and relevant information was obtained. The analyzed specific objective of the study was as follows;

First, to determine awareness of health service providers on exemption mechanisms.

Second, to examine the implementation of the exemptions

Third, to determine the effects of exemptions on cost sharing.

Fourth, to identify appropriate mechanisms of improving the implementation of exemptions so as to improve both equity in health care as well as revenue collection

The investigator analysis and presentation of the findings was guided by the objective of the study above as well as the study questions as originating from the specific objectives. The study was set to answer the following questions;

- i. Are the health service providers aware of the exemption mechanism?
- ii. Is the system implemented properly?
- iii. What are the effects of exemptions on cost sharing?
- iv. What are the ways of improving the implementation of exemptions?

The study consisted sixty respondents (16 CHMT, 8 HMT, 6 AMOs, 8 Clinical Officers, 22 nurses, 2 social welfare officers) working in different departments at the Chunya District Hospital. Purposive and simple random sampling was the sampling techniques used.

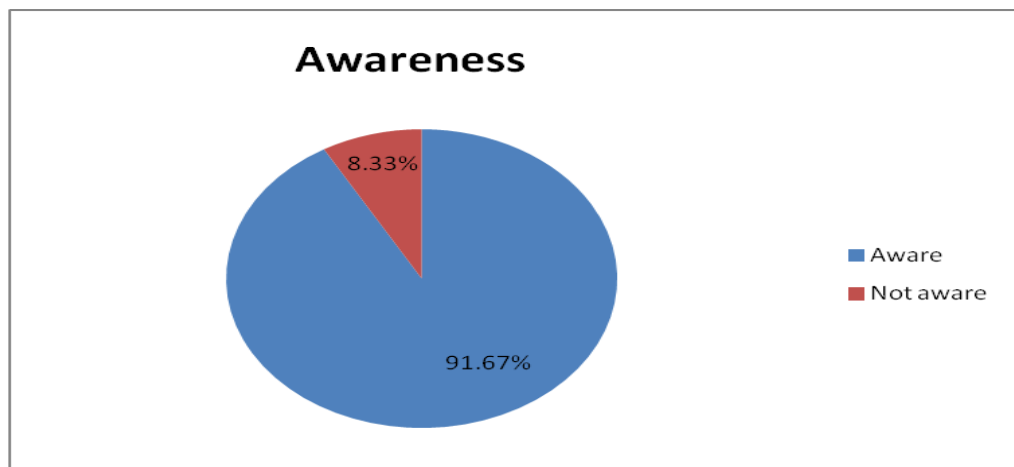
4.2 Findings

In identifying effects of exemptions on cost sharing in government health facilities the following areas were tested to identify if exemptions affect cost sharing and the following are the findings.

4.2.1 Awareness of health providers on exemption mechanism

In seeking to determine the awareness of health service providers on exemption mechanisms which are employed at Chunya district hospital at different departments, respondents, the findings of the study revealed that 55 respondents were aware with exemption mechanisms; only 5 respondents were aware but failed to identify exemption mechanisms in their working place, The response to awareness of exemption mechanisms is summarized in **Figure 4.1** below:

Figure 4.1: Awareness on exemption mechanisms



Source: Compiled by a researcher

From the Figure 4.1 above, it is clear that 91.8% of respondents are aware of the exemption mechanisms whereas 8.3 % of respondents are not aware with the system. This indicates that the majority of respondents were aware about exemption mechanisms in their working departments. However the providers reported that the system does not satisfy the needs of the exempted groups due to lack of drugs and other medical equipments like x-ray reagents, laboratory reagents and a few numbers of skilled medical personnel.

4.2.1.1 The exempted groups

Moreover, most of the respondents were able to mention at least four groups qualified to be exempted; these are vulnerable groups, including pregnant women, children under five years, people with chronic diseases like HIV/AIDS, TB and elders of 60 years and above. The rest of respondents, 8.33% were able to mention at least 1 to 2 groups which are pregnant women and under fives. Respondent especially CHMT were able to clarify services that are to be exempted as including reproductive health services i.e. all vaccinations for the under one year, family planning and delivery services; treatment of chronic diseases, for example, ARVs and TB drugs, medicine for venereal diseases such as syphilis, gonorrhoea; medicine and medical equipment which are consumed by the under fives.

4.2.1.2 Transparency of exemptions mechanisms

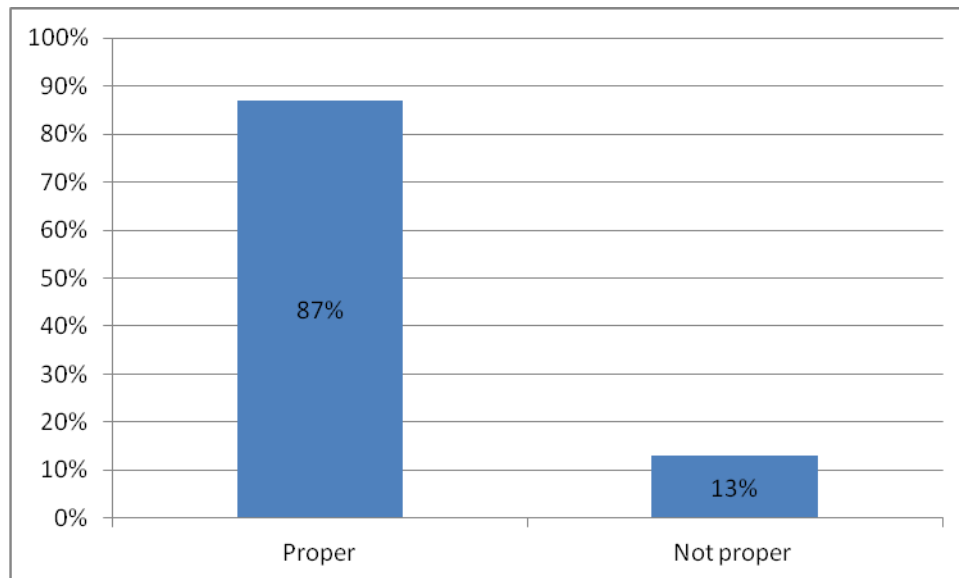
The policy is transparent to service provider and some of the community people they understand what is about the exemptions. In Chunya district hospital there are some billboards which show the groups of people and services which are exempt. But what is needed is education to the community on the importance of joining CHF whereby the six members in one family can contribute only Tshs. 10,000/= per annum and they can get all health services throughout the year, even medicine and medical supplies will be available to all because the government pay such money on time when has been claimed by the DMO

4.2.2 Implementation and satisfaction on exemptions

a) Implementation of exemptions

When respondents were asked for their opinions the implementation of the system 52 (86.67%) of them reported that the system is not properly implemented where as 8 (13.33%) of respondents did not know. The response is summarized in the Figure 4.2 below:

Figure 4.2: Implementation of exemptions



Source: Compiled by the researcher

The above Figure 4.2, indicates none of respondents believe that the system is properly implemented. 8 (13.33%) said that the system is implemented because services to be exempted are known and groups are identified i.e. elders 60 years and above, pregnant women, children under five, people living with HIV, TB clients etc; the remains agreed that the system is not transparent to the community, hence it need more education to the community either by having identity cards as that of National Health insurance Fund (NHIF) or community health fund (CHF), others suggests that if possible they have to pay at least a half of charges for services utilized. The above findings indicate that the exemption system has got many challenges in its implementation. Therefore, there is a need for the system to be revised and reorganized so that can be implemented properly and the expected group can receive health services without obstacles.

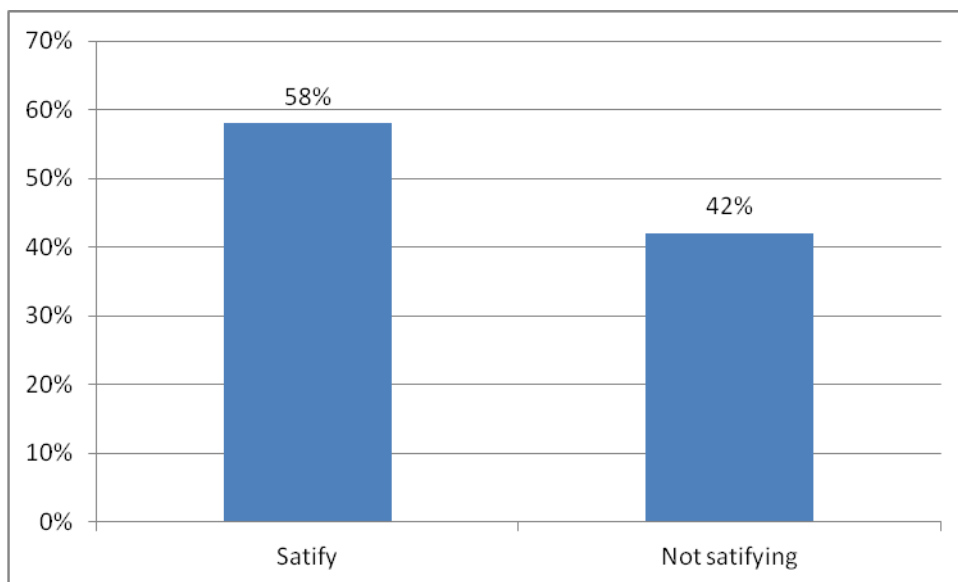
(b) Satisfaction on exemptions

Exemptions are implemented at Chunya district hospital as government health facilities, but the system does not satisfy the exempted groups because the service is of low quality and when vulnerable groups seek such services they are told to buy medicine or medical equipment for example Implanon for family planning has been

out of stock for 3 months the department of reproductive and child health. Therefore, clients have to buy the village pharmacy known as *accredited drug dispensing (ADDO)*. Moreover, other medicine for other groups like for under fives and elders always when clients go to the hospital there is no medicine hence they have to buy from ADDO.

The department of Care and Treatment Clinic (CTC) the respondent said that medicine are present even though sometimes during the time of CD4 check-up were for seeking such service to a different hospital, which is far away from the district hospital which is about 45 km from Chunya district hospital, they should go to Mwambani Catholic hospital for CD4 services. And on the side of result return to the clients there are some delays because it takes some days due to the high population of being tested.

Figure 4.2: (b) Satisfaction on exemptions



Source: Compiled by the researcher

From the above figure shows that, 35 (58.33%) respondents to the question about satisfaction of exemptions they replied that can satisfy with some challenges. 25 (41.66%) they said that exemptions does not satisfy because there are many missing items like drugs, medical supplies, long waiting time, especially for the clients of

CTC, some bad language from service providers. 80% percent of medicine and other medical supplies clients should to buy out of the health facility.

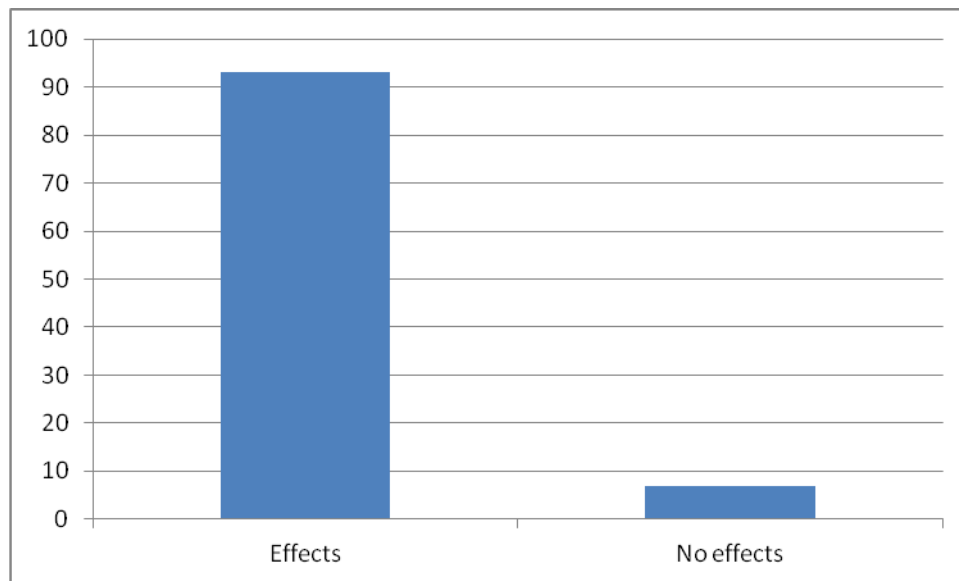
4.2.3 Effects of exemptions on cost sharing

The effects of exemptions on cost sharing were determined through interviews and questionnaires whereby respondents were asked about how the exemptions affects cost sharing 93.33% agreed that exemptions affects cost sharing through reduction of health facility income because some people are able even though are old or pregnant, some are over utilizing health services simply because they are exempted from paying. Therefore, government incurs costs for services which lead to shortage of drugs, medical equipments and service providers.

It was also revealed that exemptions reduce income for the revolving drug fund (RDF) and medical equipments. However, it is agreed that the government has responsibility to help vulnerable groups; therefore it should increase subsidies in health facilities in order to compensate the revenue loss.

Furthermore, respondents suggested that exempted groups should pay at least 20 percent for the services utilized by them and those payments will cover some discrepancy of medicine and medical equipments.

Figure 4.3: Response on effects of exemptions on cost sharing



Source: Compiled by the researcher

The *Figure 4.3* above shows that 56 of respondents said yes, whereas 6 of the respondents say no. Therefore, the figure 4.3 indicates that 93.33% of the respondents agreed that exemptions affects cost sharing in government health facilities. 6.67% of respondents denied. Moreover, waiver and exemption are perceived as lost revenue for health facility this is in fact largely a true effect of the exemptions in terms of protecting vulnerable social groups and its negative impact on the revenue collection process. The opinion of hospital management teams thought that cost sharing does not generate significant funds; however, there was a general agreement that hospitals can afford more with cost sharing revenue. Laboratory services were said to have improved both in quality and utilization.

The exemption policy states that loss of revenue from exemptions should be compensated through budgetary provision. However, there is a gap between policy and practice. Compensation is not transparent and takes time. Meanwhile the quality of care at facilities declines through lack of resources. The more exemptions a facility has, the inevitably the less revenue it generates. A lack of funding to health facilities to compensate for the loss in revenue due to exemption and waivers has a negative impact on the facility performance and discourages facilities from granting

of the exempted.

4.2.4 Challenges facing implementation of the system

Regarding the challenges facing the system respondents reported the following challenges; some people are able to pay for services, but they are exempted this reduces the revenue, for example elders who have retired, they do business, some pregnant women have ability to afford expenses and some under fives their parents have the ability to pay because when they go to private hospital they do pay for rendered services.

Some respondents suggest that according to the big challenge of out of stock of medicine and medical equipments, there should be another mechanism for payments because in government health facilities always medicine and medical equipment are not there and the normal procurement of such needs goes quarterly from MSD. Therefore if there is some money from cost sharing they can cover the gap from out of stock from supplies instead of telling patients to go to buy from local pharmacy where they take under dose then diseases become resistance in their bodies hence weaken the productivity in the community.

This necessitates the policy makers to recheck the policy and if possible to regulate. As well to educate the community on the importance of cost sharing and if possible the importance of the Community Health Fund (CHF) these will reduce the absences of medicine and medical equipments. Poor quality of care, health care charges (official and unofficial), long distances coupled with poor roads and inadequate and unaffordable transport facilities, and poor governance and accountability mechanisms all limit poor people access to health care. Lack of essential drugs and supplies, of skilled providers, discrimination against clients who are not able to pay, and poor referral systems result in poor quality of care.

Exemptions and waivers in particular, are not effective as a means of protecting vulnerable social groups and the poorest of the poor. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs,

transport, some small charges (e.g. Cards, materials), and bribes. Many of these costs are beyond the reach of the very poor.

Lack of funding to the health facilities to compensate for the loss in revenue due to exemptions and waivers has a negative impact on facilities performance and discourages facilities from granting of exemptions/waivers.

Many people living in poverty opt to go to traditional healers because they can afford its expenses, they opt for government health facilities, since they are cheaper compared to private and religious facilities and they tend to be nearby because of limited and insufficient financial resources and severely constrained human and material resources.

4.2.5 Ways of improving exemptions in order to reduce the effects

In trying to establish the ways of improving the implementation of exemptions in order to reduce its effects on cost sharing practices respondents proposed the following:

First; there must be identity cards for the exempted groups, special health facilities, separate fund for bearing the costs and others suggested that they should pay at least a half of the expenses for the services rendered.

Second; Costs which are being incurred from the exempted vulnerable groups should be recorded and present to the ministry of health (MoHSW) so as to be included in an estimate of the fiscal year budget.

Third; Counter check of vulnerable group in the community is necessary for reducing the number of cheaters. This can be done by ward executive officers (WEO) with the support of social welfare officers because they know whom one is a real need to be exempted. As well policy should be transparent to the community through health promotion or education because when they know well whom are to be exempted when, where and for what service, these will be easier for them to join on

CHF which will help the hospital to have a large stock with relevant medicine and medical equipment which will help the community at large.

Fourth; It was suggested that NGOs available and other sponsors should be mobilized to help the government by providing enough medicine and medical equipments which will be used to the exempted groups. Such equipments are X-ray, ultra sounds and different training programs for staffs in order to get updates because demand for health service is higher than supply.

Fifth; There should be adequate management and information systems that ensure appropriate collection and utilization of fees. Communities are generally not involved in planning and financial management of health services to ensure that health services focus on meeting their priority needs.

Sixth; Ordinary people at the community level through village committee should have access to information about budgets, incomes, expenditures, use of medical supplies, for effective monitoring their use.

Seventh; Any reform proposed by the government should start at the community level so as to participate fully during implementation. By the time Community participation is limited in part due to a general lack of knowledge about recent reforms, but also because poor people do not know their rights or feel they can exercise them. Reliable mechanism for rising concerns and for channelling these to the district level for action should start at the community level.

As one hospital administrator in Uganda typically observed that the guidelines on exemptions are not a government policy on exemptions from cost sharing, but are someone else's ideas. We may choose to follow them or ignore them. In our cases here, we do not follow them, but have instead guidelines set by our own management committee.

4.7 Discussion of research findings

The objective of the study was to determine the effects of exemptions on cost sharing practices in government health facilities. Based on the findings that have been established in the course of the study, it was found that the implementation and management of exemption system were particularly are not satisfying the groups whom are in need of health services.

4.7.1 Awareness on exemption

Concerning awareness on the exemptions to the health service provider and other stakeholders, most of the countries appeared to have provided clear orientations regarding which services or which populations were the targets of exemptions. However, these orientations did not always appear to have been expressed in clear directives as was seen in South Africa. In Ghana, Kenya, and Senegal where it seemed that various actors in the system had been inadequately informed. This is contrary to my study whereby only 8.33% respondents were not aware and failed to identify exemption mechanisms in their working place, but 91.67% of them were aware about exemptions and exemption mechanisms.

The exemption policies appeared sometimes to interfere with other health policies and programs such as community based insurance. In Ghana the difficult of obtaining accounting reports from managers was an important element for actors in the system. However the complexity of reimbursement process and the multiplicity of actors were also factors impeded a real transparency in the process and made it difficult to assign clear responsibility to actors at different levels in the system (Kruk 2008).

At Chunya district hospital 92% of the respondents were aware of how to handle exempted groups when they come to hospital for service, this is different to Uganda as reported by George, (2002) that in many health facilities, service providers and members of management committees had not received any training on handling exemptions. The guidelines on exemptions stipulated the use of exemptions and waiver books for every patient treated without paying. But they found that the

exemption and debtors' books were not used in many health units. The books were usually not available in most health facilities; especially in the rural areas and most health facilities did not have specific staff in charge of cost recovery as stipulated by the Uganda guidelines. This is different on my research area whereby a social welfare officer with the assistance of ward executive officer or VEO has to identify the exempted group in the community and to provide identity card for receiving health services.

Cost sharing in the Chunya District Hospital is used to cover costs like payment for different bills, for example, electricity bill, water bill and paying temporally labor. The study done by Msamanga et al (2000), the lower level health units, which are heavily dependent on cost sharing, particularly dislike the type of equity pursued by the central government. The matter is complicated due lack of a formal national policy on cost sharing that is clearly enforced and monitored centrally. Local government further gave wide discretion to lower level health units to determine exemptions and waivers as they see fit. However, lower units are being asked to explore means of sustaining their operations and they necessarily rely heavily on cost sharing. This leaves the Ugandan health worker with a dual challenge: working without adequate supplies at the facility, and exempting ill individuals in need of assistance.

Problems of implementing waiver systems were also observed at the local community level. Some community leaders grant waivers to their friends and relatives, who did not necessarily deserve it, leaving out the intended beneficiaries, thereby affecting utilization and access for vulnerable groups. However, according to (Russell, 2004) using communities to identify individuals eligible for waiver has worked well in Ghana, the poor perceive that the existing poor relationship between clients and health care workers, particularly in public health facilities is reserved for those who are unable to pay (REPOA 2007). They may qualify to be waived for free health care, but the public health care facility is far from their home of the needy person. How would they get there when since poor people have no fare for transport? This was also reported by (Save the Children 2005 and Mamdani & Bangser, 2004).

The majority of respondents agreed that exemptions have many effects on cost sharing practices. They reduce health facility income because some people are able to pay even though are old or pregnant, some are over utilizing health services simply because they are exempted.

4.7.2 Effects of Exemptions

a) Service delivery

Many studies mentioned increased service utilization after the implementation of exemption policies, particularly in Madagascar, in Uganda for primary health care visits and in Ghana and Senegal for institutional deliveries. In Uganda it appeared that the free service could not satisfy the increased service demand, prompting patients who were better off to use services that were not free. This increases in demand therefore pressure on the health system. This pressure alleviated by additional reforms implemented on the supply side, i.e. increased budget for drugs, improvement in stocking system as well salary increase. However raise in demand had a negative effect on service quality for example out of stock of medicine and medical equipments, longer waiting time decreased motivation among health workers (Wilkinson et al 1997). From the document available, i.e. OPD registration and financial reports shows that in Chunya district hospital 75% patients per day who come to seek services are those groups of exemptions who cannot pay for any service they rendered.

b) Workforce crisis

Workforce crisis has been the problem because the government has announced that every district hospital has separate place known as elders' window "*Dirisha la Wazee*" they had to separate clinician and special nurse for caring such people. The crisis was seen in the decline of health service providers' morale and in their attitude towards their work. In Uganda the 2001/2002 administrative data showed that additional salaries were eliminated for auxiliary and technical staff. The absence of these stuffs that were originally paid by user fees contributed to the human resources crisis. Therefore, this crisis translated into a heavier workload experienced by health service provider, inadequacy of medical personnel lead to be overworked and exploited in the face of increasing work demands. Negative effects on practices were

reported in South Africa, the loss of income for service providers caused by eliminating user fees lead doctors to devote themselves more in private practices, especially if the problem of discontinuity in drugs persists, (Kruk et al. 2008).

c) Health information systems

Health information systems about exemptions, the study that was done in Ghana reported that little information was available at the central level on the number and type of deliveries carried out in health centers and on the amount of reimbursements was narrated, (Mbaruku, 2008). But in my study there is no clear information on returning funds that have been utilized by the exempted groups, even though some CHMT members they told that funds are returned through (OC- other charges) which is not enough to cover costs. Respondent was asked whether there is a clear way of reimbursing the fund for those whom are exempted, 90% they don't know, where the rest they said that there is a mechanism of being reimbursed, but the funds are being reallocated to by the council in order to implement other local government activities.

d) Medicine, equipment and other medical supplies

On the side of medicine and medical products, vaccines and technologies, the experiences indicated an overall shortage of drugs, 54% this highlighted in South Africa, Kenya and Madagascar, Galea, (2008). Similarly, in Uganda, the stock forms showed an increase in quantity of drugs received after fees were abolished simply because exempted people were free of charge to utilize services, therefore study population said that problems of availability of medicine particularly anti malaria's, delivery kits delays caused by administrative excessive bureaucracy at the district level.

Due to the shortage of medicine and medical equipments patients responded to the shortage by turning to private services to purchase medicines because were able and willing to pay for health services utilized. Some researcher reported that health workers perceived severe decline in service utilization after seven months of exemption to be a consequence of the shortages of additional drugs. This is obvious in our country, especially public health facility including Chunya District hospital

only 50 percent whom are exempted they can get medicine such as vaccines for under five and pregnant mothers, family planning services are available and ARVs for people living with HIV.

e) Health Financial system

Health systems financing, is a major problem because of underfunding the exemptions. In Uganda, despite an increase in the budget allocated, the health centers lost income and were unable to cover recurring expenses. In Ghana and Kenya, some health centres had resumed charging for services and drugs in order to deal with funding shortfalls. Governments sometimes had to gradually reintroduce user fee after they had been abolished. In Senegal health centres increased the fees for certain acts that could still be charged in order to compensate for lost income from those acts that had become free, (Trop Med Int. Health 2008). In my study shows that there is a shortage of funds for buying medicine and medical equipment so as to provide quality health services to all.

f) Leadership and governance

There is some positive effect on the introduction of exemptions for deliveries increased up to 111% between 2002 and 2004 in Ghana. It was found that the central regions increases from 51.6% to 63.6%, while in village regions increases 45.6% to 50.6% after the implementation of fee exemption. In Uganda 28% increased deliveries in health facilities following abolition of user fee, hence reduces MMR Accra MOH (2005). Likewise to Chunya there is a decrease in MMR but there are negative effects of the policy since there are missing items for saving those groups whom are in need of such services so they are told by the health service provider to come with medical equipment like gloves, Mackintosh, washing basin during the day of giving birth.

In Uganda the study reported that motivation contrast with the situation following the abolition of maternal user fees where staff morale suffered as a result of a 47% increase in average workload and the loss of the fee revenue that had been used to supplement staff salaries. Similarly, in South Africa, health workers perceived little value in their raised levels of workload and stress resulting from a ‘fee-free’ policy for maternal and child care as they were largely due to increased attendance by persons with self-limiting illness.

4.3.5 Challenges in exemptions implementation

1. Even if official fees are exempted or waived, the poor and vulnerable still end up having to pay for drugs, transport, some small charges (e.g. Cards, materials), and bribes. Many of these costs are beyond the reach of the very poor.
2. A lack of clear criteria and policy guidelines for establishing people who are eligible for waivers results in individual formed decisions, with no clear records or follow-up by management. Poor people themselves are not routinely informed of the procedures for getting exemptions and/or waivers.
3. Lack of funding for health facilities to compensate for the loss in revenue due to exemptions and waivers has a negative impact on the facility performance and discourages facilities from granting of exemptions/waivers
4. Poor people’s incomes are typically sufficient for subsistence only; many people living in poverty opt not to seek treatment at all, or resort to traditional healers whereby their payments almost are in kind. If they can afford it, they opt for government health facilities, because they are cheaper compared to private and religious facilities and they tend to be nearby.
5. The dilemma, then, is how to make quality care available to all including the poor in an environment of limited and insufficient financial resources and severely constrained human and material resources.

4.3.6 Way forward

- i. The health service provider should provide health service equally and not taking away medicine, which is allocated to the vulnerable groups. Because sometimes drugs for exempted groups are present, but health workers they take and sell in their pharmacy. The health care system does not need only massive investments of funds, but also commitment and accountability among all actors, government, policymakers, donors, nongovernmental organizations, faith based organizations, health workers themselves and others generate funds that will cover costs for services.
- ii. Availability of funds can make quality care available to all including the poor because the environment of limited and insufficient financial resources and severely constrained human and material resources.
- iii. Reduce the excessive bureaucracy for poor people. Waivers should come to the poor rather than the poor having to seek for waiver; granting of waivers should not be left to health workers.
- iv. Exemptions mechanism should be put in place to enforce transparency and accountability as well as to monitor and evaluate implementation of the system.
- v. Exemptions and waiver policies should be refined, clarification of the eligible poor; specification of free services for each group; targets at ward level for the number of poor people who should be given waivers based on local poverty rates; examine whether the exemption and waivers categories chosen exclude any specific vulnerable group, such as HIV affected households or households with a high dependency ratio.
- vi. Design incentive mechanisms for management of cost sharing that will reinforce an effective implementation of the policy for waivers and exemptions

- vii. A special identity card for the poor with photo attached for a longer period of time; at present, the letter from the community leader is only valid in one specific area

4.7 Conclusion

Based on the findings, it is concluded that the current system of the exemptions affects cost sharing practices. So there is a need for the government to review and revise the system so as to be able to promote equity in health care and improve health revenue collection. While this and other studies have provided useful information showing that the poor and other marginalized groups lack equitable access to health care in many developing countries, not much has been done to address this dilemma. Tanzania should implement cost sharing and an exemption mechanism in situations such as decentralization where local governments' major interest is to maximize revenue to meet the costs of decentralized services, rather than promotes equity in service utilization.

In circumstance where exemptions exist in theory, but are in operational in practice, even district revenue collection goals are compromised as the exemption scheme is misused to exempt the rich among the poor at the cost of service quality improvement. There is a need to formalize the user fee policy, so as to protect the poor in this form of health financing mechanism.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study, conclusion and recommendations based on the findings presented and discussed in chapter four. The study aimed to determine the effects of exemptions on cost sharing practices in government health facilities, Chunya District hospital was focused on the study. Specifically the study was centred on specific objectives which include; to determine awareness of health service providers on exemption mechanisms, to examine the implementation and satisfaction of the exemptions, to determine the effects of exemptions on cost sharing, and to identify appropriate mechanisms of improving the implementation of exemptions so as to improve both equity in health care as well as revenue collection.

5.2 Summary

The summary of the findings is organised based on the study objectives. Generally findings indicated that Chunya district hospital has experienced the effect of exemptions on cost sharing. The study aimed to find out the awareness of health service provider on exemptions mechanisms. The study revealed that 92% of the respondents are aware on it. The 86% of the respondents reported that exemptions are implemented with challenge of missing items whereby exempted people should buy from ADDO. Moreover, the study was finding out the effects of exemptions whereby 93% of the respondent agreed that there effects on cost sharing. Furthermore, respondents suggest that those who are exempted should pay at least 20% of the services utilized.

5.3 Conclusion

Removing user fees could improve service coverage and access, in particular among the poorest socioeconomic groups, but quick action without prior preparation could lead to unintended effects, including quality deterioration and excessive demands on health workers. The government need to make a realistic forecast of the possible resource implications of a well-implemented user fee removal programme also can apply six steps for a successful policy change: (1) Analysis of a country's initial position (including user fee level, effectiveness of exemption systems and impact of

fee revenues at facility level); (2) Estimation of the impact of user fee removal on service utilization; (3) estimation of the additional requirements for human resources, drugs and other inputs, and corresponding financial requirements; (4) mobilization of additional resources (both domestic and external) and development of locally-tailored strategies to compensate for the revenue gap and costs associated with increased utilization; (5) building political commitment for the policy reform; (6) communicating the policy change to all stakeholders

5.4.0 Recommendations

Basing on the findings of the study, the researcher is proposing the following recommendations for the MoHSW, CHMT and Health service Provider working from different departments in Chunya district hospital

5.4.1 Recommendation to the Government

It is important to the MoH to establish the programme for rising awareness of the community on the importance of cost sharing with the aim of improving revenue collection for effective health service provision. Government should provide medicine and medical equipment that will help public health service providers to have enough stock. Planners should plan a relevant budget concerning health issues because in health system there are many emergencies which need more money to overcome the gaps.

Ministry of Health and social welfare should ensure that all government health facilities offer affordable and quality health services to the exempted groups. This requires health systems to have an adequate trained staff, regular supply of medicine and medical supplies. The functioning referral system is also necessary to ensure that exempted can get services at all levels. Besides the ministry of health should enforce standard protocols for service delivery, management and supervision and use them along with feedback from clients to monitor and evaluate service quality (e.g. Elders Window) as has been started in some district hospital in the country.

There is a need for the Government through MoH to provide an extra stock of medicine and medical equipment because sometimes patients whom are exempted they do not get prescribed drugs and other services on time. For example ultra sounds; X-ray CT Scan is present in regional and district hospital and some private hospitals where the patients have to pay in order to get such Health services.

5.4.2 Recommendation to CHMT

CHMT should plan and implement educational programmes for vulnerable groups about exemptions. Appropriate identity cards should be prepared and provided to convey information about some groups who are exempted. These can be done through TV and Radio programmes as well as newspapers and for rural areas drama shows can be used to mobilize people.

District officials and health workers want user fees to run the health units in resolving the conflict between revenue collection at health units and providing services to users who have no money is a dilemma faced by public health facilities therefore CHF should be sensitized to the community that will cover the gap. These will help the users of health services, who are mainly peasant farmers with unstable income (seasonal income), want to access health services even when they have no money at hand, and it will cover the deficit supply of medicine and medical equipments. Or the exempted client may contribute at a minimal percent so as to cover at least 20% of the utilized services because others are able and are willing to pay that's why they can get services in private health facilities in higher costs.

Administrators of government health facilities must consider establishment of approach in the management of vulnerable groups because it has different channels of receiving fund e.g. income from different health sources like CHF, NHIF, income from natural resource like mining, national parks etc.

Since most of the respondents have reported that the exemptions affects cost sharing in government health facilities. There is a need for the ministry to recheck the effectiveness of the system and its limitations so as to improve health services to the people to ensure equity in health care and improve health care revenue collection.

5.4.3 Recommendation to health service provider

The service providers, especially social welfare officers should identify the real vulnerable groups who need health service. And when they reach the hospital, they should be listened to by service providers and they should create a supportive environment in which clients are sufficiently informed. Service providers also should educate such groups on the importance of joining CHF whereby they can contribute a small amount of money that will cover at least four to six people in the family and make the availability of medicine and medical supplies because the government for the claimed CHF has to top up the same amount.

Likewise to the community, especially the vulnerable groups should be an individual bases. Beneficial and similar practices could be incorporated into formal health services. In doing so, will enhance the quality of health services from the users' perspective.

My findings are reliable with the experience from many other researchers, which shows that health care is poor and marginalized groups simply because no collection of user fee that may reduce some difficulties in the organizations. Therefore, the government should provide education to the community on the importance of cost sharing because can provide financial support for buying missing items on time.

5.4.4 General recommendation

1. Further research is needed in other places in Tanzania so that the exemptions could be researched throughout the country.
2. The government through the ministry of health should redefine and readdress the exemptions in the community. For example in order to achieve the best impact of fee free on maternal outcomes, supplementary measures such as strengthening other components of the health system (e.g. logistics, personnel, funding), assuring equity, improving monitoring systems and improving geographical access are needed.
3. Both central and local governments should explore other means of sustaining the

operations of lower level health units that rely heavily on cost sharing.

4. Central governments have an option of either pointing out the weaknesses of the policy, or doing away with the policy and seeking alternative, equitable ways of delivering equity and quality services to the population.

5.4.5 Further research

Further research is recommended in the areas of exemptions utilization in Tanzania, because many of the studies reviewed for the purpose of building this study, were conducted in developing countries. Research should cover rural and urban areas or various social setups.

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**QUESTIONNAIRE ON THE RESEARCH CONCERNING THE EFFECTS
OF EXEMPTIONS ON COST SHARING PRACTICES IN GOVERNMENT
HEALTH FACILITIES**

Dear Sir/Madam,

I'm Veronica A. Chengula; a student from Mzumbe University pursuing masters-degree of Health System Management. I am conducting a research on the effects of exemption policy on cost sharing in government health facilities. Please take your time to answer the following question, according to your experience and skills. The information collected will be kept confidentially.

Background Variable

Name.....

Title

Age.....

.

Level of Education

Degree

Diploma

Certificate

Answer all questions clearly

1. Have you recently heard about exemptions in your workplace?

Yes

No

If yes, what is it?

.....

.....

2. What groups of people are exempted on receiving health services? List at least 4 groups

i).....

ii).....

iii).....

iv).....

3. What exemptions mechanisms are you aware of? Mention at least three

i).....

ii).....

iii).....

4. Do you think exemption policy satisfies health care needs of the vulnerable groups/clients?

Yes

No

If no; Give reasons why?

.....

.....

.....

.....

5. Do you think exemption policy is properly implemented?

Yes

No

I do not know

If yes or no, why do you think so?

.....

.....

.....

.....

6. In your opinion do you think exemption policy is transparency to the clients?

Yes

No

If no, give 2 reasons

7. Do you think exemptions affect cost sharing?

Yes

No

If yes, mention them (at least four)

i).....

ii).....

iii).....

iv).....

8. Are there any challenge on the implementation of the exemption policy

Yes

No

If yes, mention them

i).....

ii).....

iii).....

iv).....

9. What are the ways of improving the exemption policy so as to reduce its effects on cost sharing practices in government health facilities?

.....

.....

.....

.....

Thanks for your cooperation

V.A. Chengula

Guided Interview Questions

INTERVIEW GUIDE

Guiding interview questions for 2 AMOs, and 6 Nurses

1. Are you aware of exemptions mechanisms?
2. Do you implement exemptions mechanisms at your work place?
3. Who are the groups are to be exempted?
4. Does an exemption satisfy the vulnerable groups?
5. What are the effects of exemptions facing cost sharing in government health facilities?
6. What are the challenges facing the exemptions mechanisms?
7. What should be done to improve exemptions?

Appendix C

Work plan

Work plan											
A task to be performed	2014				2015						
	Sept	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July
Proposal writing											
Proposal presentation and approval											
Preparation of units of study											
Pilot testing of data collection tools											
Revision of study methodology											
Hiring and training of personnel data											
Actual field work											
Data collection											
Transformation of data into software											
Preparation for analysis											
Data cleaning											
Data recoding											
Processing and analysis											
Report writing											
Report submission											
Report presentation											

Appendix D

Budget

NO	ACTIVITY	MONTH/TIME	AMOUNT
1	Pilot testing of data collection tools	December- January	50,000/=
2	Hiring and training of personnel data	February	150,000/=
3	Actual field work	February-March	250,000/=
4	Data collection	February-March	200,000/=
5	Transformation of data into software	February-March	50,000/=
6	Preparation for analysis		
	Data cleaning	April	30,000/=
	Data recoding	April	20,000/=
	Processing and analysis	April- May	50,000/=
7	Report writing	April, May and June	100,000/=
8	Report submission	July	50,000/=
9	Report presentation	July	50,000/=
TOTAL BUDGET			1,000,000/=