IMPACT OF COST SHARING ON THE DELIVERY OF HEALTH CARE SERVICES IN TANZANIA: A CASE STUDY OF MOUNT MERU HOSPITAL IN ARUSHA REGION.

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Masters of Business Administration Dissertation

Institute of Accountancy Arusha.

November, 2020

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By

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A dissertation submitted in partial fulfilment of the requirements for the degree of Masters of Business Administration of Institute of Accountancy Arusha.

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November 2020.

AUTHOR'S DECLARATION

I, Fatuma Y. Msangi declare that this Dissertation is my own original work and that it has not been presented and will not be presented to any other Higher Education Institution for a similar or any other academic award.

Signature……

Date……

CERTIFICATION BY SUPERVISOR

I, the undersigned, certify that I have read and hereby recommend for acceptance by the Institute of Accountancy Arusha the dissertation entitled "Impact of Cost-Sharing on the Delivery of Health Care Services in Tanzania: A case study of Mount Meru Hospital in Arusha region" in fulfilment of the requirements for the Master's degree of business Administration offered by the Institute of Accountancy Arusha.

…….

Dr. Jonathan Shishiwa

(Supervisor)

Date ……

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DEDICATION

This Dissertation is dedicated to my beloved parents Mr. and Mrs Yassin Msangi, who laid the foundation of my education, God bless them.

ACKNOWLEDGEMENTS

I thank God for giving me strength and helping me throughout my lifetime. I would like also to acknowledge all who in one way or another, have given me support in accomplishing this dissertation. Special thanks should go to academic staff for their facilitation and my Supervisor Dr. Jonathan Shishiwa for his constructive feedbacks and contribution he provided throughout this Dissertation undertaking, despite of his heavy duties at the Institute of Accountancy Arusha.

Next, I would like to give my sincere gratitude to Mount Meru hospital. I would like to extend my appreciation for the positive cooperation I received from the management and staff particularly social welfare and quality improvement departments during my data collection period.

Special thanks go to my family members especially my beloved parents Mr. and Mrs. Yassin Msangi, my young brothers Mwidadi Msangi, Ibrahim Msangi and Madola Msangi. Last but not least, special acknowledgements go to my fellow colleagues and employer Hanns R Neumann Stiftung Africa for their support throughout my studies in IAA.

There are many others not mentioned who have assisted in different ways. To list them all would be impossible. I ask them to accept my heartily thanks to all of them.

ABSTRACT

This study focused in investigating the impact of cost-sharing on the delivery of health care services to vulnerable populations seeking and receiving health care services at Mount Meru hospital. So far Tanzanian society, the community of Arusha not being exceptional consist of people of varying economic status; therefore, cost sharing might influence differently the utilization of health services by different classes. The study objectives were to study implementation of cost sharing policy at Mount Meru Hospital in general giving special attention to the vulnerable population seeking and receiving health care services at Mount Meru Hospital, to determine the impact of cost sharing policy at Mount Meru Hospital and to identify opinion of health care workers, patients and clients towards cost sharing policy comparing to the previous policy of free health care service. 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 involved 66 participants working and getting service in different departments of Mt Meru Hospital. The research approach for this study were qualitative and quantitative data. The MS Excel spreadsheet programme was used in analysing data collected from questionnaires, qualitative data were collected from in-depth interviews with staff and patients, where narrations and quotes were taken directly from respondents. The study showed that Mount Meru hospital management has adopted cost sharing policy and uses national guidelines to implement the policy. The hospital management has put in place defined procedures to be followed by patients attending Mount Meru. Most of the patients are aware of the policy and have experienced procedures that are involved with payment of the charges. There is an improvement of overall quality of health service however there still some challenges that needs to be addressed. The study recommends to the government and hospital management to improve health services delivery to be able to achieve desired objectives which includes the review and amendment of health policy.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
CHF	Community Health Funds
FBO	Faith Based Organization
GOT	Government of Tanzania
HIV	Human Immunodeficiency Virus
MOH	Ministry of Health
NHIF	National Health Insurance Fund
SSA	Sub Saharan Africa
TMOH	Tanzania Ministry of Health
UNDP	United Nations Development Programme
UNESCO	United National Educational Scientific and Cultural
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children Emergency Fund
URT	United Republic of Tanzania
WHO	World Health Organization

CHAPTER ONE

PROBLEM SETTING

1.1. Introduction

This study has investigated the impact of cost sharing on the delivery of health care service. This chapter presents the introduction and back ground to the problem which led to the introduction of cost sharing on the delivery of health care service from worldwide up to the country level. In addition, the chapter covers the objectives of the study, research hypothesis, significance of the study, limitation and delimitation of the study, scope and layout of the study.

1.2. Background to the Problem

Health care financing is among the key components of a functional health system. After many years of commitment to free health care in many countries in sub Saharan Africa (SSA), cost-sharing policy in health care was proposed to be used in all public health facilities. The intention of introducing this policy was to provide supplements to government health spending as well as to address three aspects within the health care service sector which are; improvement of efficiency by moderating demand, containing cost, and mobilizing more funds for health care than what the existing sources provided. Having realized these benefits, many countries started engaging in cost sharing debate (Hunson and McPake 1993).

Before its introduction into public health facilities in Tanzania, cost-sharing was a common practice in private and Faith Based Organizations (FBO). In public health facilities i.e. dispensaries, health centres, district hospitals, regional and national or referral hospitals, health care was free of charge to all national citizens (MOH 1994, Abel-Smith and Rawal1992).

In Tanzania, the arguments against free public health services gained strength during 1990s. Several studies argued that free public health services suffered from misuse of resources and inefficiency; hence it was felt that the introduction of cost-sharing would eliminate or at least minimize these problems (Msambichaka et al2003). As pressure from western countries and big funding organizations increase, most of African countries were forced to formulate and introduce cost sharing policy.

In 1993 and1994 the government of Tanzania (GOT) introduced and implemented cost-sharing policy in the public health facilities in order to develop protection mechanisms, which would ensure access to health care for the poor and vulnerable populations. To ensure that the policy is appropriately implemented in order to

meet intended objectives, the GOT introduced waiver and exemption systems with the aim of enabling the poor majority of citizens and vulnerable population to access care.

Waiver and exemption are terms which have been used in Africa to describe targeting mechanisms. A waiver is related to the direct targeting and is used to reduce or eliminate fees for the poor based on an assessment of their inability to pay. Exemption is used to describe when services are automatically provided free because the patient and client have the characteristic being targeted. Vulnerable groups are characteristically targeted, and they include under-five children, pregnant women and elderly people (aged 60 years and above). These are exempted from official user fees under the cost-sharing policy in Tanzania (Ministry of Health Tanzania 1994).

The reason why the vulnerable groups get exemption it is because they are in greater chance of being affected by diseases, especially communicable diseases (Mubyazi 2004). In addition, the policy exempts people who are suffering from chronic diseases such as HIV/AIDS, leprosy, TB, and cancer (Mmbuji et al, 1996). However, the exemption applies only to level one (dispensaries) and two (health centres free if they attend) level three health facility (regional and referral hospital). At levels three health facilities, fees are waived or exempted for those assessed and found to be very poor or unable to pay due to any given justified reason (Ministry of Health Tanzania 1994).

Ensuring access to quality health care especially to the poorest and vulnerable groups is an essential element for promoting health, equity and subsequently reducing mortality and morbidity. In line with this, the Tanzania Ministry of Health (TMOH), developed a guideline for implementing the policy whereby a protection mechanism within cost sharing programme was introduced in order to;

a. Ensuring that the very poor and vulnerable groups are not to be denied the service because of their inability to pay,
b. Introducing the use of waivers and exemptions and
c. Setting user fees at very low levels. Such fees should be well below the actual costs of delivering services and the charging should vary by the type of health facility, higher at level three (Referral) hospitals and lower at regional and district hospitals (Ministry of Health Tanzania, 1994).

The guideline has also put in place a process for approval and granting of waivers and exemption in order to avoid bias and promote equity and justice in the process of assessment and granting. The assessment is done at the facility level usually at a hospital's social welfare unit where information from patient and client are gathered and assessed by health personnel before it is granted or denied. Beside all these efforts, several concerns have been raised on the possibility that the system is ineffective and therefore affecting poor and

vulnerable groups (Ministry of Health Tanzania, 1994; Mubyazi, 2004) especially at referral healthy facilities where unless fee is waived or exempted, all people are supposed to pay user fees (Ministry of Health Tanzania, 1994).

The aim of this study is to investigate the impact of cost sharing on the delivery of health care services to the vulnerable groups (under five children pregnant women and elderly people) who are seeking and receiving health care services at Mount Meru regional hospital in, Arusha.

1.3. Statement of the Problem

The cost sharing policy in Tanzania public health service system was introduced in July 1993 as a part of economic recovery and structural adjustment programmes aiming to improve efficiency and foster sustainability in the provision of health services through community participation. Such decision came after realizing that the quality of health care delivered was poor and that access to health care especially to the poor people and vulnerable populations was being compromised due to inadequate health financing. In line with this, the government introduced a system, which was to be used to implement the policy. This included payment (cost sharing or user fee), and exemptions and waivers granted to the poor, people with chronic diseases and vulnerable populations (i.e. children below five years of age, the elderly and pregnant women) who many not be able to pay hospital bills.

The expectations of the government from introduction of the policy were as follows;

a. Generate additional revenue to bridge the gap in government allocation to health care
b. Improve availability and quality of health services,
c. Strengthen the referral system,
d. Rationalize utilization of health care services,
e. Improve equity and access to health services by pooling financial risk and cross-subsidizing costs and
f. Strengthen community voices (users/prayers) towards improving services quality and provider's accountability.

However, nearly 26 years since its introduction, there is evidence that all intended expectations have not been met. In addition, there have been many complaints from the users about the systems used for implementation of the policy and the government is slow in working on the recommendations for improvement.

Evidence from studies has shown that the system is ineffective, and the granting of exemptions and waivers is often misused (Euro Health Group 2004). Although the system is in place at all health facilities, the poor and vulnerable populations do not get exemptions and waivers easily. The system is being abused by both

health care workers and people who are not entitled to receiving them. This is creating a difficult environment for those who most need, who are pregnant women, children under five years of age, people older than 60 years, orphan and other affected groups like widows, people with disabilities and AIDSs patients.

Based on the information above, there are questions to be answered regarding the introduction of cost-sharing versus expected outcomes at different levels of health care facilities. The questions that form the basis of this research which were conducted at Mount Meru hospital are:

a. How is the cost sharing policy on the delivery of health implemented cost at Mount Meru referral hospital?
b. What is the impact of cost sharing policy on the delivery of health care services at Mount Meru referral Hospital?
c. What are the views of key stake holders on how the negative impact of cost sharing policy can be addressed?

Many previous studies on cost-sharing in health care have involved facilities at lower level of health care system and there is scarcity of data for higher level facilities such as referral hospitals. For this reason, this study was conducted at Mount Meru hospital, one of the few referral hospitals in the country. The findings of this study therefore, will increase further understanding on effects of cost sharing at higher level facility and will be used to provide recommendations to the government on how best the policy can be implemented and thus help to resolve or reduce the current existing negative effects.

1.4. Research Objectives.

1.4.1. General Objective of the Study

The general objective of the study was to investigate the impact of cost-sharing on the delivery of health care services on the vulnerable populations seeking and receiving health care services at Mount Meru hospital.

1.4.2. Specific Objectives of the Study

The specific objectives of the study were;

a. To examine implementation of cost sharing at Mount Meru Hospital in general giving special attention to the vulnerable population seeking and receiving health care services at Mount Meru Hospital.
b. To determine the impact of cost sharing policy at Mount Meru Hospital.
c. To explain the opinions of health care workers and patients on cost sharing policy.

1.5. Research Questions

This study was guided by the following specific research questions;

a. How is the cost sharing policy on the delivery of health care service implemented at Mount Meru Hospital?
b. Has cost sharing managed to have an impact on health care services at Mount Meru Hospital?
c. What are the opinions of key stake holders on cost sharing policy?

1.6. Scope of the Study

This study was about the impact of cost sharing on the delivery of health care services, it has focused on how cost sharing on the delivery of health care services is implemented and highlight the impacts of cost sharing in the delivery of health services especially the vulnerable population and also recommend on how to address the negative impacts. The study was conducted only in Arusha region. It was a case study of Mount Meru referral hospital which included the staff working at Mount Meru and the patients that attended the hospital.

1.7. Limitations of the Study

The study was limited by the following factors;

i. One of the major limitations of this study is the short duration it was conducted. The duration could not allow adequate time to obtain other information from the hospital registries such as data the revenue collection and patient/clients attendance before the introduction of cost sharing policy, such information could have allowed comparison with the available information.
ii. Some of the patients were scared to give true answers about the real situation scared that if the hospital finds out they won't get the service.

However, the above limitations were minimized by making it clear to the respondents the true aim of the research and to ensure the confidentiality of their identity. Also, by following the time schedule of the research.

1.8. Significance of the Study

Findings of this study provide empirical evidence on the impact of cost-sharing policy on the delivery of health care services to vulnerable populations seeking and receiving health care services at Mount Meru hospital. The findings benefit the policy makers, stakeholders and other actors by supplementing knowledge and creating awareness on the impacts of cost-sharing policy on the delivery of health care services to vulnerable populations seeking and receiving health care services at Mount Meru hospital. Findings also help the

researcher to be equipped with knowledge on the impact of cost-sharing on the delivery of health care services to vulnerable populations seeking and receiving health care services at Mount Meru hospital.

1.9. Organization of the dissertation

This dissertation is organized into five chapters. The first chapter covers the introductory part, background of the study, objectives of the study, research questions, significance of the study, limitation and delimitation of the study, scope and the layout of the proposal. The second chapter presents a review of existing literature on the impact of cost sharing policy implementation on health service which includes, theoretical literature review, empirical literature review, conceptional framework and research gap. The third chapter covers the methodology to be adopted in conducting the study which includes research design, research area, research population sample and sampling methods, data collection methods, data analysis methods, reliability and validity of the data. the research methodology, highlighting the location and characteristics of the study area, types and source of data, sampling techniques and data analysis methods. Chapter four presents the discussion on the results and findings emanating from primary data as collected from patients/clients and staff of Mt Meru hospital. Conclusion and recommendations drawn from the study are given in chapter five. A list of references cited in the text is presented at the end of this work.

1.10. Conclusion

This chapter revealed a research problem in its magnitude and indicated how important the study was to the number of groups. Therefore, the chapter built the foundation to achieve the main objective of the study.

CHAPTER TWO

LITERATURE REVIEW

2.1. Introduction

This purpose of this chapter is to review the literature relevant to the study. The review addresses theoretical and imperial review of the relevant literature to the study, conceptual framework which relates to cost sharing. This chapter will also discuss the research gap.

2.2. Conceptual definitions

a. Health Care

Health care as the maintenance or improvement of health via diagnosis, treatments, and prevention of disease, illness, injury, and other physical and mental impairments in human beings Zastraw (2008).

According to Mtei et al., (2012): health care: "refers to those resources society uses on people in ill health in an attempt to cure them or care for them". This can be prevention care, cure or rehabilitation. Every society requires adequate resources for its population but the financial ability of its people to cater for the most vulnerable in the society is imperative.

b. Health Cost Sharing

Cost sharing in health services is the portion of project or programme cost not borne by the sponsor. The "cost share" pledges may be either a fixed amount of money or a percentage of the project costs. The term "cost matching" often refers to cost sharing where the amount from the sponsor is equal to the amount from the cost-share partner. This is also known as a dollar for dollar cost sharing or cost matching (UW, 2007).

It is the community share of the cost of running any project. Cost sharing typically takes the form of in-kind resources includes contributed project personnel effort, manpower and cash. Tanzania Health Sector Strategic Plan (HSSP II) of July, 2003); aligns that, the money accrued to the fund shall be used for payment of health care services provided, procurements of drugs, medical supplies and equipment's based on health plans, health promotion and preventive measures, minor rehabilitation works in pre-selected government health care facilities in accordance with the approved plan and any other essential health purposes or activities as may deem relevant and approved by the Board.

2.3. Theoretical literature review

a. Implementation of cost sharing polices

The aim of introducing cost sharing in Tanzania aimed at improving quality of health services and reduces the government budget for the health sector, to improve equity and accessibility to health care services also to promote the efficient use of public health care facilities.

It was realized from many countries in sub Saharan Africa that, main factors associated with poor health care provision are physical and financial (Koblinsky, 2006). In the 80s' most health systems of sub Saharan countries were faced with decrease in both government financing and donor assistance. As a result, they were a faced with decrease in both government financing and donor assistance. As a result, they were advised to explore other options to raise funds to support health expenditures. In its "agenda for reform" policy initiated in 1987, the World Bank advised African and other developing countries to establish alternative payment mechanisms in order to increase accessibility, efficiency, equity, and effectiveness in their health care delivery systems (World Bank, 1993). Soon after such advice 37 African countries-imposed user fees and that 34 of them continued to provide health services without any problems.

Further evidence indicates that if cost sharing is successfully implemented, it can contribute up to 20% to government expenditure in health and therefore improve service. For example, in Cameroon user fees was reported to increase the use of health services by the poor as well as improve the quality of services (Litvack&Bodart, 1993). Such positive impact will be possible only if, cost sharing system is successfully implemented otherwise if poorly designed or poorly implemented, it discourages the use of health care services (Audibert and Mathonnat. 2000; Chawla and Ellis, 2000; Haet al, 2002). In trying to obtain general opinions about the experience of cost sharing from different stakeholders, some studies have interviewed health workers from public and private facilities.

In general, there was consensus among the interviewed stakeholders on the main reasons why user fees were introduced. In Tanzania majority of them pointed out that, it was aimed to raise revenue, to enhanced equity, reducing frivolous consumption, and improving quality of care.

Few interviewees associated user fees with poverty reduction as rationale for their introduction. However, some of their stakeholder indicated that they find it very difficult to correct, conclusive statement on the extent to which user fees has achieved their objectives. This is due to inadequate financial management systems,

there is likely to be a gross over-or understatement of the actual contribution from user charges. However, most respondents agreed that user fees have contributed significantly to quality improvements in some specific areas, such as the availability of drugs. However, this was more based on their personal impression than on reliable data (Laterveer, Munga and Schwerzel, 2004)

b. Impact of cost sharing

Constrain on the effective implementation of cost sharing include; poor design of the cost sharing system, inadequate capacity for implementation and financial management of the cost sharing system, weak supporting system like inadequate drug supply systems, poor management information systems, lack of supervision and the contextual constraints like public lack of experience in paying for services and political constraints (Shabani, 2008).

There are different opinions regarding the experience of cost sharing in Tanzania, some literature has reported negative experiences that, the revenue generated has not necessarily had a positive impact on health care quality because the collection is not at optimal levels expected to improve the quality of care (Mubyazi, 2004) as a result this has undermined population's willingness to pay and use services due to drug shortages and unfriendly staff. Other reasons included among others inadequate human resources, bureaucratic procedures, long queues and operational inefficiencies within the health care system that contribute to quality failures.

c. Experience of cost sharing and delivery of health care services in African countries.

Recently, there has been growing concern about declining health care standards, coupled with an equally growing demand from the general public for improvement in the services provided. Such concern is associated with introduction of cost sharing. A study conducted in Bukinafaso found that, introduction of user fees had resulted to poor utilization of health care services and suggested that incentives must be introduced in order to allow access to care for those who are unable to pay (Ridde, 2012).

Among other things, poor quality and access to care have led some African countries to abolish user fee in order to restore smooth operation of health care delivery. This was reported in 2011 by Ridde and Morestin in their review article that hospital attendance increased and returns to normal after abolition of user fee. However, such increase was not observed in other countries (Mwabu and Wang'ombe, 1997). In countries

where a difference was noted, increase in access ranged from 17% in Madagascar to over 80% in Uganda (Burnham et al, 2004; Yates et al, 2006).

Regarding the quality of care provided, a number of studies reported on the main reasons for poor quality of care provision after introduction of cost sharing. These were mentioned to be due to problems with drug supply and availability (Walker and Gilson, 2004). In some countries such services were reliably available during the start of the exercise, but this situation did not last long (Witter and Adjei, 2007). Poor quality of service was also associated with less time for each patient to be seen, lack of privacy during consultation (Walker and Gilson, 2004) and deterioration of cleanliness of facilities (Burnham et al, 2004). Long waiting times and unfriendly staff were also associated to this aspect (Kajula et al, 2004).

There are different opinions regarding the experience of cost sharing in Tanzania, some literature have reported negative experiences that, the revenue generated has not necessarily had a positive impact on health care quality because the collection is not at optimal levels expected to improve the quality of care (Mubyazi, 2004) as a results this has undermined population's willingness to pay and use services due to drug shortages and unfriendly staff. Other reasons included among others inadequate human resources, bureaucratic procedures, long queues and operational inefficiencies within the health care system that contribute to quality failures (Leusden, 2004). Some of the positive experiences reported included (1) improved of quality of health services, (2) increased availability of drugs, (3) increased maintenance of health facilities, and (4) increased contribution of user fees to the recurrent budget and non-wage budget for the health sector (Rwechungura, 2003; Msambichaka, 2003; MOH, 1999). While Mackintosh and Tibandebage, 2001 reported that some vulnerable people did experience inclusion and decent treatment from some health care facilities in Tanzania. In addition to this, they also found evidence of regressive outcomes of user fees with substantial exclusion and self-exclusion from government hospitals in Tanzania (Mackintosh and Tibandebage, 2001).

2.4. Empirical Literature Review

Ngugi (2000) in his study in Kenya which looked at the month-on-month attendance data for the service facilities, found that access at public facilities showed an overall drop in attendance rates after the fee was introduced. The drop was more significant in new family planning and child welfare attendance, while chronic cases increased their attendance especially at the dispensary level. Some of the reasons listed included bureaucratic procedures used at the hospital which has led to some of the patients many patients to use

over-the-centre medication instead of going to hospital especially when the condition was not perceived as serious but also for cost consideration.

Also, in Tanzania, according to the Poverty and Human Development Report 2007, numerous survey reports have highlighted serious public concern on the introduction and implementation of health user charges under the cost-sharing policy. The concerns are directed more on the cost of treatment and drug availability. Over 60% of the views were obtained from elderly people who declared that they did not know if they have to pay for health care (Human Development Report, 2007). The positive side mentioned in this report is that, parents reported that introduction of cost sharing has led to the reduction in under-five mortality, which is in line with the target set by 2010 by National Strategy for Poverty and MDG by 2015.

The Mbeya Region study reports several stories about children dying because of lack of funds for treatment, or of a mother who was refused MCH care because she was not able to pay a ‘‘fine’’ of Tsh 700 for not bringing the child back on time. The study also reports one woman who died in the maternity hospital because she was unable to pay for an emergency caesarean section, and of at least three other people that died because they did not have the required money and therefore were denied treatment (Tibandebage& Mackintosh 2002).

Milena (2002) documents that many consumers in Bulgaria commonly perceive cost-sharing to be more the problem than the solution to the health care crisis and that they are particularly worried about increased out of pocket expenses. A large percentage of Bulgarian questioned on health care cost sharing disagreed with charges related to actual service cost or service quality and nearly all respondents considered a ceiling on payments appropriate. The majority of the interviewed showed a strong support for an extensive system of exemptions from payments.

Because the revenue collected at the moment is not sufficient to improve and sustain the quality of care, it is unlikely that such collection will be adequate to address the large and growing demand and hence causing nationwide quality shortfalls that exist in many African countries. There is a need to complement a broader range of actions to enhance the sustainability of quality of health care.

Poor people's experiences of health services in Tanzania: a literature review reported that some various studies reported that cost sharing has even worsened the situation because the targeted poor people and vulnerable groups are still facing challenge to access care (Masuma, 2004).

In Kenya, the introduction of fees resulted in a decrease of outpatient attendance by 27% at provincial hospitals, 46% at district hospitals, and 33% at health centres (World Health Organization, 2006). And in Zambia, outpatient attendances dropped by 35% after fees were introduced, however, admissions to inpatient facilities remained fairly constant (Blas, 2001). While in Ghana, a 40% decrease in outpatient attendance was noted after fees were introduced (Birtwum, 2001). Few reports consider how removal of user fees affects use of services. In Kenya, outpatient attendances at three regional and four provincial hospitals rose to levels similar to those. Due to negative effects of cost sharing, abolition of cost sharing in Uganda was reported to improve access to health services for the poor by 46% (Uganda Bureau of Statics, 2001).

2.5. The Knowledge Gap

Tanzania faces serious challenges in improving the health and well-being of its people. Despite of cost sharing policy there are still a lot of unofficial health charges which have placed a particularly significant financial burden on the poorest or vulnerable groups that have very little income flexibility. Official charges are not always affordable and ‘‘unofficial’’ charges are still in place. At times, fees have been an impossible barrier for the poor to overcome denying them access to critical services. The proposed introduction of user fees at dispensaries and health centres ‘‘is likely to further raise the costs faced by users and may increase the incidence of informal charging.’’ (R&AWG 2003).

Between 1989 and 1991, Government conducted a comprehensive financing study of the potential of introducing user fees in public health facilities (MoH 1995). Findings indicated that, people incurred significant costs to purchase essential medicines and other small items that were often not in stock at the health facilities, to pay various ‘‘unauthorised’’ fees and emergency transport, and to sustain the costs of waiting time, opportunity costs away from income earning, etc.

‘You are nobody if you do not have money.’’ (SDC 2003) Access to services is viewed to be strongly dependent on ‘‘connections’’ and on ability to pay. Discrimination and lack of respect by health workers towards the very poor is a common theme emerging from several studies (SDC 2003, Tibandebage& Mackintosh2002, WDP 2003). Medical staff are often rude to the poor and dismissive.

Since cost sharing started in Tanzania in 1993, I have come across any documented study that has been undertaken to determine its impact on health service delivery in Arusha region. So far Tanzanian society, the community of Arusha not being exceptional consist of poor and rich people; therefore, cost sharing might influence differently the utilization of health services by different classes.

Now this study, aimed at exploring and put more knowledge on the implementation of cost sharing in Mount Meru hospital, giving attention on how the service truly impact the vulnerable population, and to determine the impact of cost sharing in general on the delivery of health care services by adopting methods that have not been used by previous researchers. The study will further give recommendations on how the negative impact experienced under cost sharing policy should be addressed.

2.6. Theoretical frame work

Microeconomic Theory

Microeconomic theory as founded by Andreu Mas-Colell (1995), generally views medical insurance as lowering the out-of-pocket price of curative inputs relative to the price of preventive inputs and thereby distorting the choice of inputs because preventive and curative services are typically substituting in the production of health. As a consequence of its relatively higher out of pocket price, prevention declines, the probability of sickness rises, and an increased consumption of medical care occurs (Pauly and Held, 1990). The medical costs of maintaining a given level of health rises and production inefficiency develops as a result. Because of "nine limiting conditions", however, some researchers note that medical insurance may not generate much ex post hazard (Kenkel, 2000).

First, health care providers may possess market power. The resulting restriction of output negates the typical export moral hazard effect of medical insurance towards overconsumption. Second, the ex post moral hazard effect may be small because medical insurance does not completely cover the utility loss associated with sickness (pain and suffering). Third, preventive inputs may remain attractive because the choice of health inputs involves completely preventing versus incompletely curing illness (Nyman, 2003). The attractiveness of preventive inputs, however, is limited by the fact that prevention can never reduce the probability of illness to zero. Fourth, medical insurance premiums may be risk-rated and thereby deter both ex ante and ex post moral hazard. Fifth, health insurers such as managed care organizations (MCOs) may invest directly in prevention to reduce the probability of a loss. Sixth, employers may offer subsidized worksite health promotion activities such as smoking cessation programs (Dave and Kaestner, 2009).

This subsidization of preventive activities may offset the distortional effect of medical insurance on the price of curative care. Seventh, people may tend to transition frequently between insured and uninsured status so insurance matters little when the decision to purchase medical care is made (Pauly and Held, 1990). Eighth,

medical insurance may promote efficient ex post moral hazard by providing low-income individuals with financial access to life-saving medical care they could not otherwise afford (Nyman, 2003).

Monitoring gives the health care provider the ability to prescribe unnecessary tests or surgery when a financial incentive exists to engage in opportunistic behaviour or supply inducement of this sort (Rawal, 1992). The consumer's out-of-pocket costs are largely unaffected by the unnecessary services, the consumer has little incentive to seek a second opinion.

The Relevance of Microeconomic Theory in this Study

Based on the potentialities of health qualities and health workers‟ responsibilities addressed in Microeconomic theory; most especially where it views medical insurance as lowering the out-of-pocket price of curative inputs relative to the price of preventive inputs.

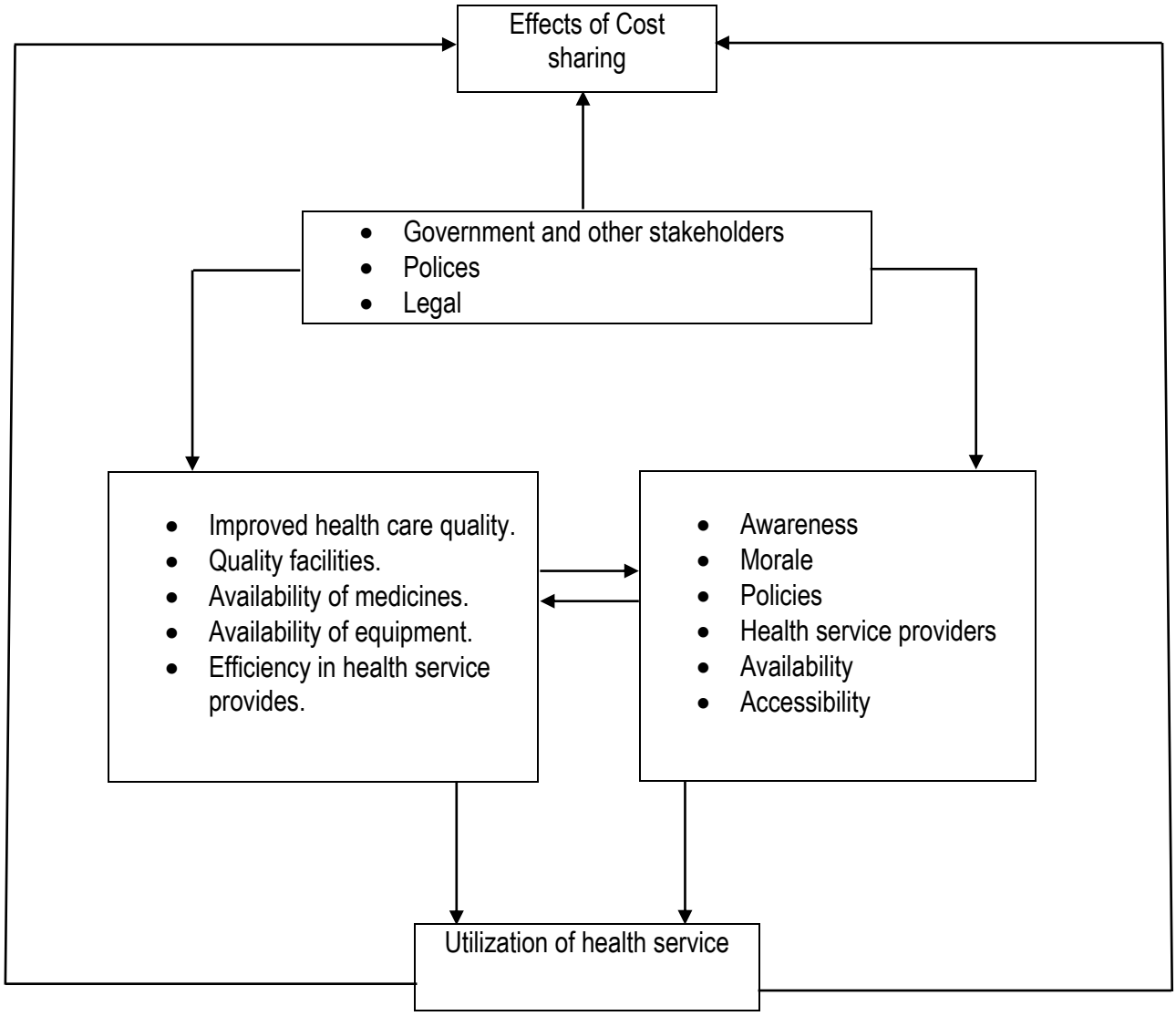
The theory further establishes that; the medical costs of maintaining a given level of health rises and production inefficiency develops as a result because of "nine limiting conditions" mentioned above. In the current study the theory helps to inform what must be done and the way it has to be done through a study on community perception regarding cost sharing, effects of cost sharing on health services and the challenges of cost sharing on health services to the vulnerable groups

The study aims at investigating the impact of cost sharing is generating the anticipated impacts in terms of quality improvement and universal access to basic and quality health care at the primary level, particularly by those deemed vulnerable to such fees.

2.7. Conceptual framework

Before cost sharing, all medical services delivered right from government were free of charge (Mubyazi, 2004). Cost sharing started in 1991, it intended to reduce government spending and encourage self-reliance (Rawal et al., 1992). The model for this research study assumes that, the impact of cost sharing being a dependent variable are examined by (independent) variables such as government and other stakeholders, awareness on cost sharing policy, groups of people to be exempted, challenges facing service delivery, during implementation, quality of the health service and ways of improving service delivery.

Figure 2.1: Conceptual framework



Source: Compiled by researcher (2020)

2.8. Conclusion

This chapter reviewed various literatures about cost sharing that linked this study with others previous studies worldwide. Through this chapter the researcher was equipped with understanding about the challenges faced various health institution with the implementation of cost sharing.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Introduction

This chapter discusses the research methodology that was used in conducting the study. It addresses research design, research area, research population sample and sampling methods, data collection methods, data analysis methods, reliability and validity of the data. The research methodology, highlights the location and characteristics of the study area, types and source of data, sampling techniques and data analysis methods. In addition, it also includes, ethical consideration, budget and work schedule.

3.2. Study Area

The study has been conducted at Mount Meru hospital which is a referral hospital located in Arusha. The hospitals offer both inpatient and outpatient services. Mount Meru Regional Hospital in the city centre of Arusha is the main public hospital for the Mount Meru, Arusha and Lake Manyara regions. All smaller district hospitals and many private hospitals refer patients to this large hospital, which is located opposite of the Arusha International Conference Centre. Mount Meru has adopted cost sharing policy since the introduction; the policy applies to all patients who seek medical care following stipulated guidelines.

3.3. Research Design

A research design is the logical sequence that connects the empirical data of the research questions to its conclusions (Yin, 2003). This study is a case study approach. A case study analysis involves careful and complete observation of social unit, be that unity a person, a family, an institution, a cultural group or even the entire community. A case study is the research design that entails the detailed and intensive analysis of a single case (Bryman, 2004). This design is chosen because of its flexibility in terms of data collection, data analysis as well as its depth of studied variables.

3.4. Research Approach

This study used mixed research type which is an approach to inquiry involving collecting both quantitative and qualitative data, integrating the two forms of data, and using distinct designs that may involve philosophical assumptions and theoretical frameworks. Qualitative research relies on categorical data as described by Charles and (Mertler2002). The study also dealt with subjective assessment of attitudes, opinions, and behaviours which will be helpful in portraying intangible aspects in the community such as social norms, socio-economic status, gender roles, and ethnicity (Denzin and Lincoln, 2000).Quantitative

research relays on numerical data (Charles and Mertler2002; Kothari 2004) quantitative research was measuring quantity. Quantitative approach was used because some of the data was in terms of numbers, figures, decimals and percentage. Moreover, the core assumption of this form of inquiry is that the combination of qualitative and quantitative approaches provides a more complete understanding of a research problem than either approach.

3.5. Research population, sample size, sampling techniques

The population of the study included staff working at Mount Meru and patients. Staff include those working at different departments and those from social welfare unit. Patients/ clients included parents who bring their children at Mount Meru, pregnant women and elderly patients seeking medical care at different health care departments/units. According to Bailey (1994) minimum of 30 respondents is the bare minimum for studies in which statistical data analysis can be done. The sample size of the study was 66 respondents, whereby, 21 were staff and 45 were patients. The sample size of the study was chosen due to time available and scope of the study. Sampling technique is a definite plan for obtaining sample from a given population. Kothari, (2004) referred to sampling technique as a procedure that the researcher would adopt to select items for the sample. The study used both simple random and purposive sampling; simple random sampling was employed to sample patients and it's because it is easy to use and its accurate representation of the larger population while purposive sampling was used to select staff from the hospital in order to focus on particular characteristics of the departments which were of interest of this study.

3.6. Data Collection methods

a. Interview

Interview involving presentation of oral-verbal stimuli and reply in terms of oral-verbal responses. According to Kothari (2004), interviews are interpretive research methods aimed at understanding and interpreting subjective views. In this context, semi structured interview was conducted guided by already interview guide questions set with respondents. Respondents were purposively selected based on their knowledge of the subject matter and the relevant position they hold who in this case were 2 staff from quality improvement department and one staff from social welfare department. The information obtained from the key informants were used to complement the information from the respondents. Staff were interviewed because it is believed that interviews are to provide a 'deeper' understanding of social phenomena than would be obtained from purely quantitative methods, such as questionnaires

b. Questionnaires

This involved a series of questions for the purpose of gathering information from respondents. A questionnaire is simply a 'tool' for collecting and recording information about a particular issue of interest, mainly made up of a list of questions, but should also include clear instructions and space for answers, it consists of a number of questions printed or typed in a definite order on a form or set of forms(Kothari, 2004). Questionnaires were developed in open and closed- ended questions to capture the response. This study has used questionnaires to all the patients and some of the staff because large sample of the given population can be contacted at relatively low cost, they are simple to administer, the format is familiar to most respondents, they should be simple and quick for the respondent to complete.

c. Documentary review

Secondary data consists of information that has undergone formal statistical process and is nationally and internationally recognized (Kothari, 2004). This involved reviewing documents from the hospital which includes cost sharing. This type of data collection constituted important source of data which were collected through, journals, books, articles, newspaper, reports and electronically stored materials.

3.7. Data Analysis methods

Landau, S., & Everitt, B. (2003). Data analysis is the process of gathering, sorting, organizing, and structuring data. The process involves the ordering and structuring of data to produce knowledge. The study collected both quantitative and qualitative data. The collected data was organized in order to remove errors that were present. Quantitative data was coded, processed and converted into tables for calculation of frequencies and percentages by using the MS Excel spreadsheet programme. Analysis method used for quantitative data was descriptive analysis.

Qualitative data was divided into themes and then analyzed by content and narrative analysis which focuses on the experience shared by people to answer research question. In some cases, the respondent's actual words were reported exactly so as to provide live experience.

3.8. Reliability and Validity of data

Validity refers to the extent to which a test measures what we actually wish to measure. Reliability has to do with the accuracy and precision of a measurement procedure. Sound measurement must meet the tests of validity and reliability. In fact, these are the two major considerations among three one should use in evaluating a measurement tool (Kothari 1990)

3.8.1. Reliability of the data

A measuring instrument is reliable if it provides consistent results. If the quality of reliability is satisfied by an instrument, then while using it we can be confident that the transient and situational factors are not interfering (Kothari 1990). In this case reliability was ensured by conducting the pilot study to identify the weaknesses in data generation process.

3.8.2. Validity of the data

Validity is the most critical criterion and indicates the degree to which an instrument measures what it is supposed to measure. In other words, validity is the extent to which differences found with a measuring instrument reflect true differences among those being tested. But the question arises: how can one determine validity without direct confirming knowledge? The answer may be that we seek other relevant evidence that confirms the answers we have found with our measuring tool (Kothari 1990). In this study validity was achieved through involving the supervisor throughout all stages.

3.9. Ethical consideration

World Health Organization (2019) the aim of establishing ethical principles for health research is first and foremost to protect the liberty and welfare interests of individual participants. The ethical principle of respect for persons is grounded in the general requirements of informed consent for autonomous people and protection for those who cannot make their own decisions. The ethical principle of beneficence requires that the potential benefits and risks of a study are in reasonable relation to one another. Thus, patients participating in research must be protected from interventions known to be inferior and benefit from interventions (when possible), and the risk to participants must be generally minimized and reasonable in relation to the potential benefits. The ethical principle of justice requires that the potential benefits and burdens of study participation be distributed equitably.

Vulnerable participants – understood to be those who cannot protect their own interests through the informed consent process or who are at "identifiably increased likelihood of incurring additional or greater wrong" for other reasons – are entitled to additional protection, including a surrogate decision-maker, and limits to the risks to which they may be exposed. An exception to the largely individualistic focus of ethical principles is the requirements that the research have social value and that researchers protect and promote the interests of communities in research. World Health Organization (2019). This research has considered and follow all ethical principles for health researches like protecting confidentiality of the respondents and seeking their consents before starting the interviews.

3.10. Conclusion

Chapter three presented the whole procedures on how the study was conducted. It articulated how the sample was selected and how data was collected and analysed. Through this articulation it was evident that the study achieved its main objective

CHAPTER FOUR

PRESENTATION AND DISCUSSION OF FINDINGS

4.1. Introduction

This chapter dwells on describing results and discussion. The chapter discusses the implementation of cost sharing at Mount Meru Hospital, opinions of health care workers, patients and clients on cost sharing policy comparing to the previous policy of free health care service and the effect of cost sharing on the delivery of health care and possibility of improving the system.

4.2. Social characteristics of the Respondents

Overall, a total of sixty-six candidates were interviewed and answered the questionnaires. Of these, 45 (68%) were patients/clients and 21(32%) were hospital staffs. Among the patients/clients, females constituted the majority 84 % (39/45) while male were 14% (6/45). 27% of the respondents had primary education level, 45% had secondary education level, 26% had university level and only 2% had not attained any education level. About marital status the majority of the respondents (79%) were married and only 21% were single.

Table 4.1 Baseline Characteristics N=66

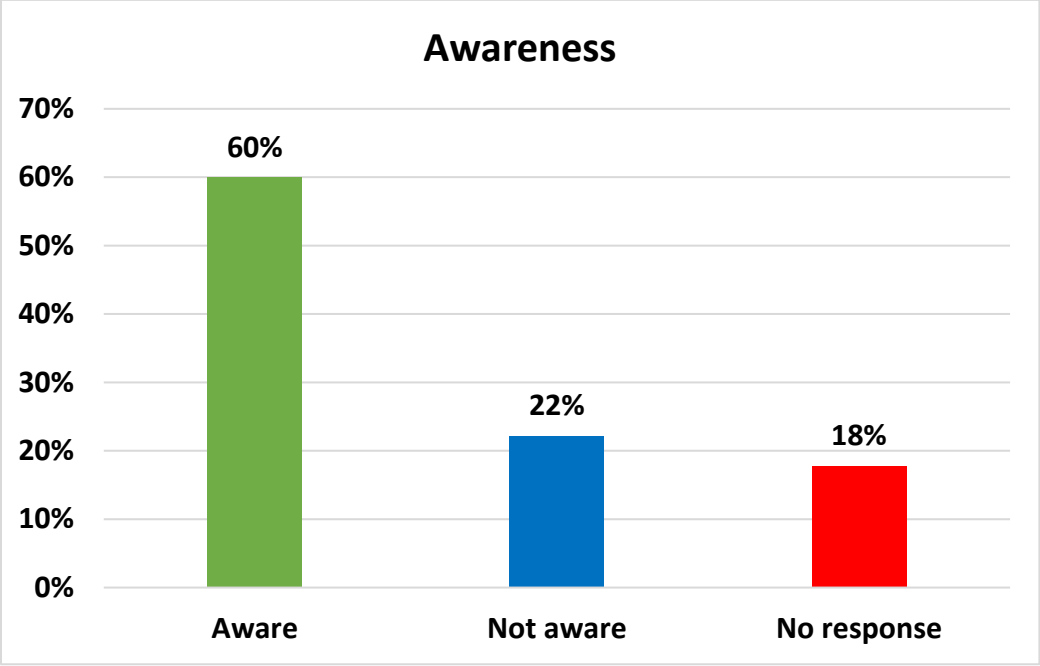
Particulars	Patient	staff	interview	Total	Percentage%
People seeking care					
Pregnant Women	29			29	64%
Children under 5	10			10	22%
Elderly people	6			6	13%
Total	**45**			**45**	**100%**
Level of education					
Primary	17	1	0	18	27%
Secondary	22	6	2	30	45%
University	5	11	1	17	26%
None	1	0	0	1	2%
Total	**45**	**18**	**3**	**66**	**100%**
Marital status					
Married	38	11	3	52	79%
Single	7	7	0	14	21%
Total	**45**	**18**	**3**	**66**	**100%**
Sex					
Female	39	16	2	57	86%
Male	6	2	1	9	14%
Total	**45**	**18**	**3**	**66**	**100%**

Source: Research data (2020)

4.3. Awareness of cost sharing policy concept

To ensure the general objective of this subject was achieved, specific objectives were analysed and relevant information was obtained. The awareness on the concept of cost sharing was first tested to both patients/and clients. 60% of the patients were aware of cost sharing, while 22% were not aware and 18% didn't respond to the question. On the other hand, all the staff who were interviewed seemed to be aware of what cost sharing is. The response to patient's awareness to cost sharing concept is summarized below in figure 4.1

Figure 4.1 Patients awareness of cost sharing concept



Source: Research data (2020)

4.4. Presentation of the findings

4.4.1. Implementation of cost sharing policy at Mount Meru

a. Implementation approach of cost sharing policy at Mount Meru

Information about introduction and implementation of cost sharing was obtained from hospital administration. It was reported that; cost-sharing policy at Mount Meru was introduced immediately when the policy was approved and is implemented by using guideline provided by the government of Tanzania (GOT) through the ministry of health and social welfare (MOHSW). Although each level of health facility has a different guideline, all guidelines contain basic information. Mount Meru being at a referral level, the guideline currently used requires that all patients regardless of their social economic status must pay user fee. However, the guideline

states that, waiver or exemption should be granted to some patients and clients who are unable to pay and fulfil eligibility. The guideline has also set standard fee to be paid for each service provided, usually is set at low level than what would have been supposed to be paid for that service.

b. Procedures of implementation of cost sharing at Mount Meru

The three staff who were interviewed from social welfare and quality improvement department shared the following procedures. Procedures used to implement cost sharing guideline at Mount Meru are embedded within daily routine clinical care. In order to make this as smooth as possible hospital administration has put in place steps/procedures that must be followed by all patients and clients attending Mount Meru from the time they arrive at the hospital for any intended visit until they leave. The steps/procedures are described below for each specific visit.

I. Procedure for outpatient visit.

All those attending as outpatient for the first time must first see a clinician for permission to open a file and then go to the medical record unit to be registered for file and at account unit to make payment both for the file and consultation. There after they consult a doctor, depending on the nature of problem, the doctor will either prescribe drugs or order further diagnostics and treatment. If investigations have been ordered, patient must go back to the accounts section to pay for investigations before are done and bring the results back to the doctor for interpretation and treatment which must be bought at the pharmacy section. In case, no investigations ordered, patient goes straight to the pharmacy to purchase medicines and there after goes home until next appointment.

II. Procedures for inpatient visit

Those who attend as inpatient or require admission as decided by doctor and in addition to the charges for the file and consultation, pay a deposit of between 20,000/ and 40,000/- which is used to cover the charges for investigations and medications prescribed while in the ward. A deposit also covers cost for number of days he/she stays in the ward. On discharge, patients will either be reimbursed any remaining money from the deposit or pay extra if charges exceed the deposit.

III. Procedures for emergency situation

In case of emergency, for example a woman coming for delivery, or an accident or any other similar situation. Patient bypasses all the procedures described for outpatient and inpatient visits. Such patient receives

immediate care and other procedures are retrospectively done when patients is stable or during the time of discharge.

IV. Mode of payment for hospital charges

Mode of payment for the charges at Mount Meru is either by cash or by any form of health insurance funds (HIF). The most commonly used form of HIF is the national health insurance funds (NHIF). Patients, who are unable to pay either by NHIF or by cash, undergoes an assessment for waiver or exemption.

V. Waiver and exemption procedures

Patients failing to pay either outpatient or inpatient charges are subjected to the assessment for the eligibility of waiver or exemption. The assessment is done by heath care workers at social welfare unit and is based on some set criteria, among them include; (1) occupation (2) area of residence (3) living status (4) marital status (5) type of disease (6) social status and many others. For a child and pregnant woman to qualify for exemption they have to show their clinic cards, any other group have to show, referral letter and introduction letter from their local chairman. Having provided assessment score and recommendation, the file is sent to the director of hospital services for approval of exemption or waiver. Those who do not qualify for exemption or waiver, are allowed to go home and required to pay either full or half of the entire charges either through bank or bring cash in person.

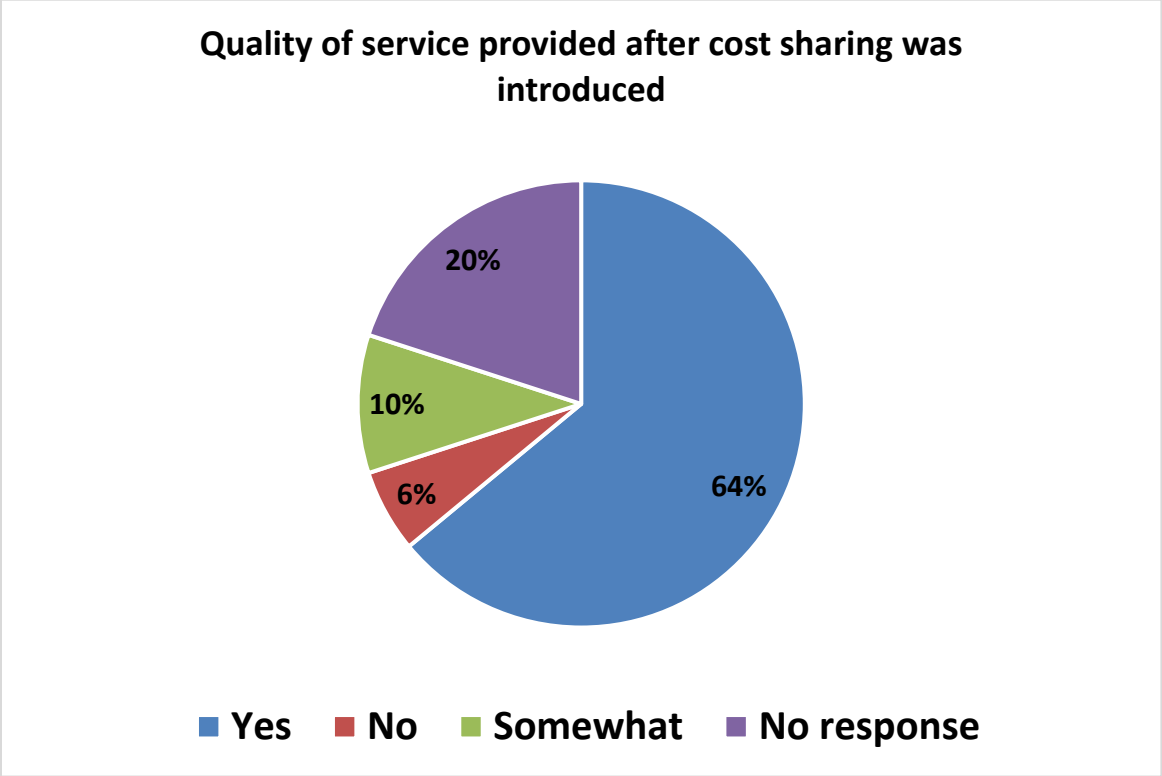
4.4.2. Impact of cost sharing on the delivery of health care at Mount Meru Hospital

It is expected that, if cost sharing policy is successfully implemented it results in to the increase in the revenue collected from it and as a result the revenue is used to improve the quality of care and access to the care especially by the vulnerable populations and many other advantages. I used questionnaires to interview patients/clients and healthcare workers. The interview intended to determine the quality of health care delivered in terms of availability of medicines and investigations, consultation and surgery waiting time, and attitude of staffs.

Impact of cost sharing on the quality of health care delivered:

To all the patients who answered the questionnaire, 64% of them responded that the overall quality of the health service offered has improved and its now better, 20% did not respond to the question while 10% said the service has somehow improved while only 6% said the service has not been improved. The following figure presents the opinion of the patient as to whether the service has been improved or not.

Figure 4.2 Response of the patient as to whether the service has been improved or not

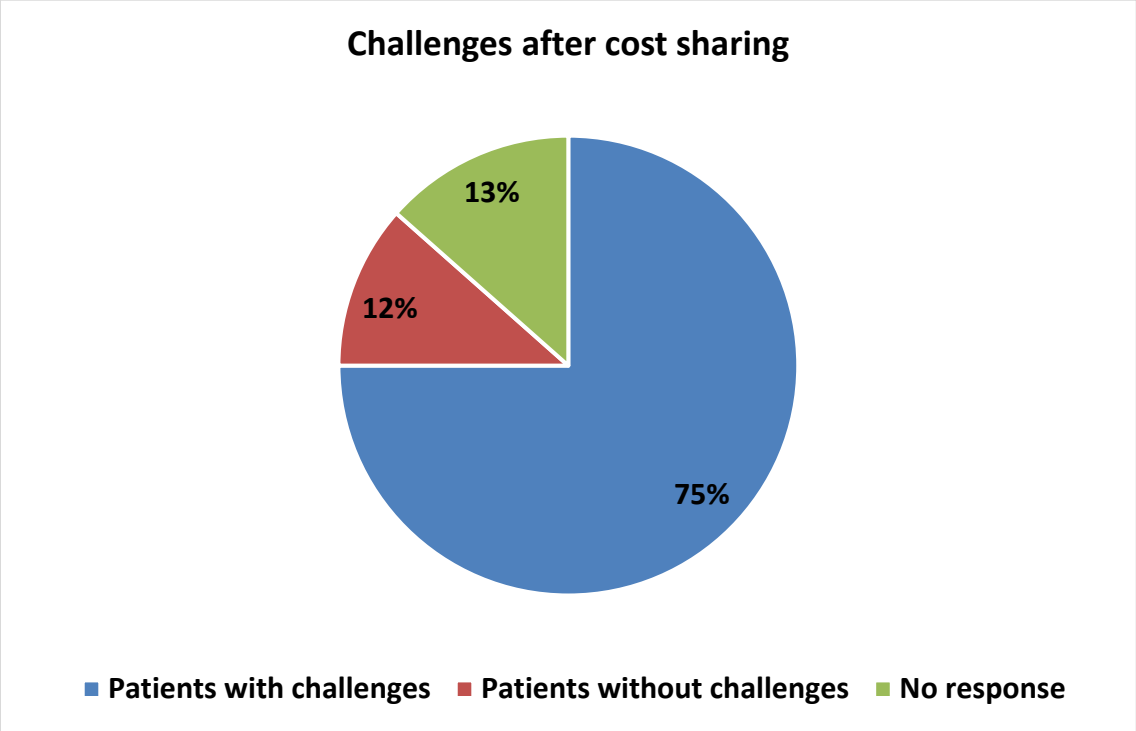


Source: Research data (2020)

However, despite the improvement on quality of service, patients also addressed the challenges that they are still facing. 75% of the patient's respondents reported the following challenges that they are still facing under cost sharing policy: there is still long waiting period for surgery appointment which was also the case before introduction of cost sharing. They also reported that expensive medicines are often not available at the hospital or covered by NHIF; they have been ending up getting prescription to buy at private pharmacies where prices are not subsidized. Some of the investigations are done by appointment even after making full payment; this is causing inconveniences and more costs when one has to come two or three time for same investigation. They also mentioned there are few specialists for women and children, while some of the staff aren't polite and they use harsh words while attending the patients. Some of the patients mentioned it takes too long for them to get tests results and sometimes hospital staffs ask for bribes.

Bellow figure summarizes patient's response with above challenges and those who responded that they are not getting any challenges accessing health service in Mt Meru.

Figure 4.3 Response on Challenges faced after of Cost Sharing



Source: Research data (2020)

On the other hand, healthcare workers had opinion that cost sharing had improved the quality of health care, they listed number of things that have changed or implemented including hospital renovations, introduction of fast track system where by a patient can be attended fast only that he/she must pay more than what is prescribed for cost sharing.

4.4.3. Opinions of key stake holders on cost sharing policy

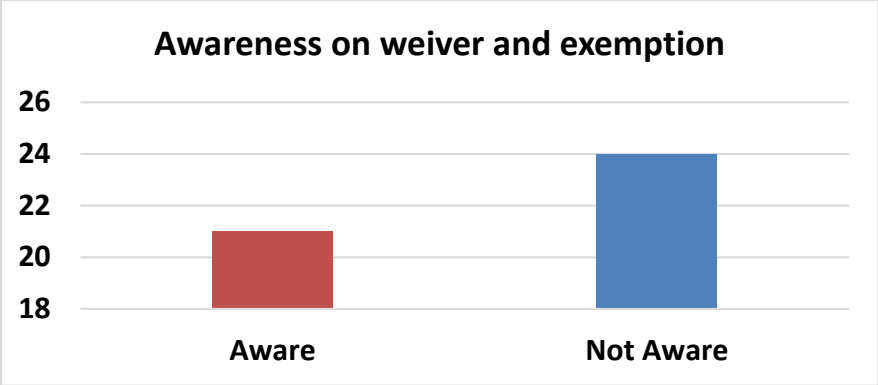
Opinions of patients and hospital workers about introduction and implementation of cost sharing comparing to the previous policy of free health care service at Mt Meru hospital are presented below:

4.4.3.1. Patient's opinions

In general, most of the patients reported to be aware of introduction of policy at Mount Meru and they support the idea. However, they were concerned about the way the policy is implemented at Mount Meru especially the steps/procedures used which is reported to be too complicated, bureaucratic and often associated with very long queues which cause a lot more delays.

Opinions were also given in the way waiver and exemptions are granted, they pointed out that, currently many people are not aware that waiver and exemption exist at Mount Meru 24 (53%) patients out of 45 respondents were not aware. Some patients realized only when they were sent to social welfare unit after they were found unable to pay for charges. In addition, there is bias involving the assessment for eligibility by healthcare workers. Some of the people who are not eligible are granted and those who are eligible are refused.

Figure 4.4 Awareness on waiver and exemption



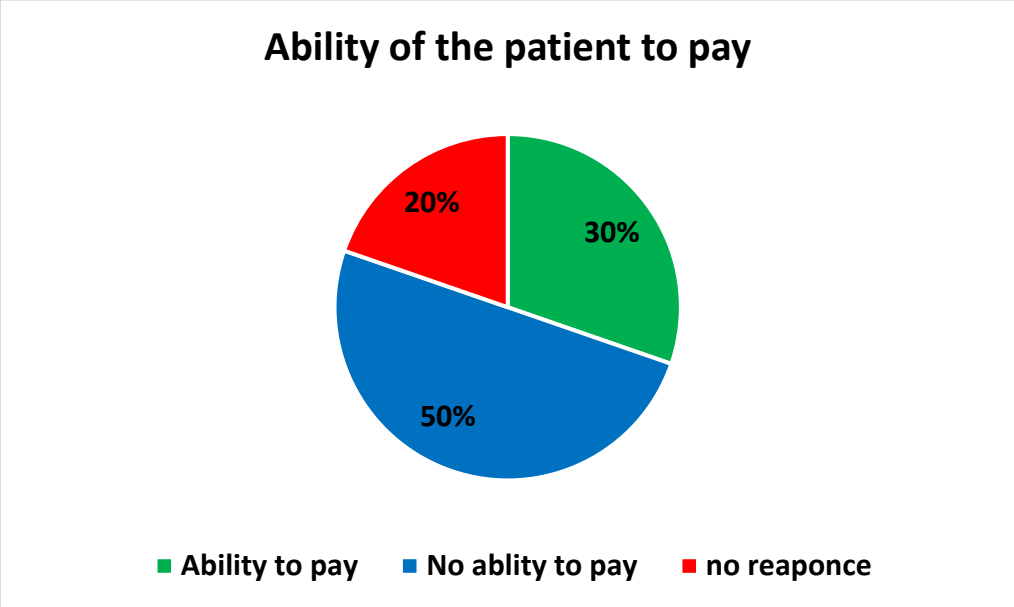
Source: Research data (2020)

There was a concern on system of payment for fees. Although, most of them acknowledged not to have been denied care when they were not able to pay, they argued that the system of paying fees for the file and consultation before seeing a doctor is not appropriate and suggested to be revisited because it can cause more serious problem especially to the pregnant women and very sick children who need immediate care. Some of the individual opinion responses to this objective are presented in quotes (1) and (2) as follows: (1) "I had to remain in the ward for few more days after allowed to go home because I was not able to pay the bill". (2) "Family members had to go back home to take more cash before their relative is allowed to go home". The following table summarizes the ability of the patients to pay for health treatment.

Table 4.2 Opinion of patients and staff on patient's ability to pay

Opinion	Patient	Staff	Total	Percentage
Ability to pay	18	2	20	30%
No ability to pay	15	18	33	50%
no response	12	1	13	20%
Total	45	21	66	100%

Figure 4.5 Summary of patients and staff opinion on ability to pay



Source: Research data (2020)

When asked what do they do for treatment when failing to pay 4% the patients responded they uses health insurance, 53% uses other means like selling a piece of land, asking money from relatives and borrowing while only 4% again say they go to social welfare to ask for waiver and exemption, 38% did not respond to this question

4.4.3.2. Health worker's opinions

Health care workers opinion on the introduction of cost sharing was positive, because, apart from the fact that some of the funds are used to motivate staff, significant amount of the revenue is used to improve the quality of health care. The quality of care here was referred to number of things, which among them included hospital renovations, introduction of fast track system whereby patients can be attended fast only that they must pay more than what is prescribed for such service.

Below are individual opinion responses (in quotes (1), (2) and (3)) from staffs regarding introduction of cost sharing policy: "…..One of the critical issues in implementation of cost sharing policy is how to determine or develop appropriate criteria for identifying people eligible for exclusion (Waiver or exemption) from health care charges on the basis of their inability to pay……" staff one

"…...In ability to judge this immediately may results to deaths or more serious medical problem especially in emergencies situation. Some people seem to be able to pay, but they don't want so if you denied them care they need it will result to more problem…..." staff two

"……The other issue is that, the waiver and exemption does need a lot of extra social work which lot of clinician don't have and may not be able to go through all these at busy time……." Staff three

The opinions of health care workers on the sufficiency of the subsidies received from government is as follow: 72% of staff agreed that they receive subsidies for the vulnerable group 28% didn't agree, now on a matter of whether the subsidies receive are sufficiency enough to cater the needs of the targeted group only 6% had an opinion that the funds received are enough, 33% said they weren't enough, 22% didn't know and 39% didn't respond to the question.

Lastly both staff and patients shared their opinion on the ability of the hospital management to address the challenges that they both had mentioned. 63% had an agreeing opinion that hospital management is in position to address some of the challenges, 29% didn't think hospital management has the ability to address them and 8% did not respond to the question. The following table summarizes the findings.

Table 4.3 Ability of the hospital management to address the challenges

Opinion	Patients	Staff	Total	Percentage%
Ability	29	11	40	63%
No Ability	11	7	18	29%
No response	5	0	5	8%
Total	45	18	63	100%

Source: Research data (2020)

4.5. Discussion of the findings

This research aimed at determining the effect of cost sharing policy on the delivery of health care services on the vulnerable populations seeking and receiving care at Mount Meru hospital. More specifically, it aimed at examining how cost sharing policy is implemented at Mount Meru, determining the impact of cost sharing policy in Mt Meru hospital and, documenting opinions of patients/clients and health care workers about cost sharing policy at Mount Meru Hospital. Results from each of these specific objectives are discussed and thereafter conclusion of the study and recommendations are provided.

4.5.1. Implementation of cost sharing policy:

Mount Meru hospital administration adheres to the government direction by using national guideline to implement the policy. The guideline was introduced along with the policy in order to harmonize operations and standardize care and procedures to all health facilities, so that access and provision of quality service is assured (Ministry of Health, 1994). Although the guideline used at Mount Meru is slightly different from those used in low level facilities, they contain same basic information, the only major difference being that some patients/clients do not pay charges at low level health facilities while at Mount Meru the guideline requires that all people pay the charges using different mechanisms of payment regardless of their social economic status (Ministry of Health, 1994).

Targeting and characteristics mechanisms are recommended to be used at referral hospitals like Mount Meru. The mechanisms give opportunity to poor people and vulnerable population who could not pay the charges to get exemption or waiver. And those who can pay can do so using different modes of payment which include payment by cash or payment through health insurance funds (New brander and Sacca, 1996).

4.5.2. Impact of cost sharing on the delivery of health care services at Mount Meru hospital

Cost sharing was introduced in order to have impact on the delivery of health care system. It was expected to increase revenue collection which in turn was expected to improve access to health care by the poor and the quality of care provided. Although the majority of the patients have rooted for the overall improvement of health services findings of this study have also reported a lot of challenges that the patients seeking healthcare at Mount Meru Hospital are still facing. Some studies have reported that cost sharing has even worsened the situation because the targeted poor people and vulnerable groups are still facing challenge to access care (Masuma, 2004). Patients interviewed, reported that there is still long waiting time for surgery appointment, some investigations are not done because equipment's are broken and, in some occasion, patients sleep two to three because of over admission or inadequate beds.

Payment system has also affected access, delivery of care and quality. The stipulated costs do not cover for out of pocket costs such as transport and food especially in cases of referrals. These costs are crucial factors that may hider access to care especially to the poor people from rural population and as a result some people decide not to take up referrals even in emergencies, hence risking their lives (Masuma, 2004).

The quality of health care provided is being compromised by un-availability of drugs, shortage of qualified personnel and health facility infrastructure. It is interesting that, while Mt Meru has observed a slight increase in the revenue collection from cost sharing, drugs and reagents have frequently been short of supply due to

inefficiencies in the Medical Stores Department (MSD). These and the shortage of qualified personnel affect provision of timely and appropriate treatment at hospital level and accessibility to quality service.

As previously mentioned above, another contrast in the opinions on effect on quality of care between health care workers and patients is that healthcare workers had opinion that cost-sharing improved quality while patients mentioned a lot of challenges that contradict the response on improvement quality. In general, introduction of cost sharing in Tanzania, present more advantages than disadvantages. What is required is to readily improve the procedures on how the guidelines are implemented.

4.5.3. Opinions of patients/clients and health care workers about experience they had with costs sharing implementation.

In general, all patients interviewed had experienced cost sharing at Mount Meru. Of these, pregnant women and parents/guardians of children were more likely to experience because of their frequency attendance. Similar observation was also reported in other studies (Mubyazi, 2004; Ridde, 2009). Same as it was reasoned, we think high attendance of women and children is attributed to be due to the fact that under-five children and pregnant women frequently seek medical care because are likely to become ill and additionally pregnant women attend antenatal clinic (ANC) regularly for assessment (Ridde, 2009).

Although, majority of patients preferred to pay hospital charges by NHIF; this type was not favoured most because it involves a lot of paper work and therefore, payment by cash was insisted because the money obtained could directly be sued for other purpose. Due to this, those who use NHIF felt underprivileged and disadvantaged considering also the fact NHIF did not cover costs for some of the health care services including CT scan. This is against the intended outcome for introduction of NHIF and cost sharing and therefore necessitates urgent intervention to review the process.

Among people who were granted waiver or exemption they reported to have experienced very long process of assessment for eligibility which made them feel embarrassed when they had to disclose their personal details. Same experience was reported in a similar study in Tanzania, whereby poor people felt embarrassed when they were going through assessment procedures (Masuma, 2004).

The fact that patients are not much aware of the existence of waiver and exemption at the hospital, as well as the process involved to obtain one could be one of the factors contributing to this. This argument is supported by findings from a recent hospital survey in Tanzania which revealed that little information has

been disseminated about the waivers and exemptions. Some of the facilities have not advertised them because of the fear that they will be abused (Newbrander and Sacca, 1996).

Opinions by health care workers were that, introduction of cost sharing is a good idea and has helped to reduce unnecessary use of the health services by patients who are not serious and could be attended at lower level facilities where they don't have to pay. The procedures set by Mount Meru hospital for implementing cost sharing was good and that there are people who are readily available to assist patients who attend Mount Meru for first time. However, they were concerned that some patients in collaboration with some staffs intentionally don't want to adhere to the procedures established for implementing cost sharing; instead they skip procedures and try to avoid some charges including helping them to get waiver or exemption. Clearly here, we observe contradicting opinions between patients and health care workers. The opinion that procedures established are good versus bad, can be explained by the reason that, health care workers view the procedures more in the advantage that revenue is collected in advance to prevent those who do not pay after treatment and not necessarily looking into the best medical practice that care comes first and money later. Researcher concur with patients that payment should come later after treatment.

Results in Table 4.4 show that 50 percent disagreed that cost sharing for health service provision is affordable, while 20 percent could not decide and 30 percent agreed. This explains that, most people in the study area do not afford cost sharing for health service. Informal discussions with the respondents revealed that cost sharing for health service is for everybody, whether you are poor or rich. This is because government has decided, if they could be asked first before starting the implementation of cost sharing for health service programme, they could reject the idea, may be if the policy could put a clear exception for the poor people who are the majority in Tanzania.

4.6. Conclusion

The chapter has discussed the implementation of cost sharing at Mount Meru Hospital, opinions of health care workers, patients and clients on cost sharing policy comparing to the previous policy of free health care service and the effect of cost sharing on the delivery of health care and possibility of improving the system.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This chapter presents a summary of the study findings, conclusion and recommendations based on the findings presented and discussed in chapter four. The study aimed to determine the impact of cost sharing policy in government health facilities, Mt Meru hospital was focused on the study. Specifically, the study was centred on specific objectives which include; To examine implementation of cost sharing at Mount Meru Hospital, to determine the impact of cost sharing policy at Mount Meru Hospital and to explain the opinions of key stake holders on cost sharing policy.

5.2. Summary of the key findings

This section summarizes the key findings of the study which are based on objectives:

Mount Meru hospital management has adopted cost sharing policy and uses national guidelines to implement the policy. In addition, hospital administration has put in place defined procedures to be followed by patients attending Mount Meru in order to ensure that the policy is successfully implemented and that poor people and vulnerable groups have access and receive better care. There is quality improvement after cost sharing policy, however patients still face challenges in accessing health care services. Opinions of patients/clients and health care workers who experienced implementation of cost sharing are as follows, they are aware of the policy and have experienced procedures that are involved with payment of the charges. And those who were not able to pay the charges were granted waiver or exemption after they have been assessed for eligibility. Also, many of people do not have an ability to pay cost sharing for health service. This is due to an adverse poverty situation which is dominating the majority of Tanzanians.

Although at some point patients/clients and health care workers had different opinions on the effect of cost sharing policy and its implementation, in general all of them have common feeling that the idea of introducing the policy is good, however there is need to improve the system and procedures.

5.3. Conclusions

This study has revealed that in a general term there is an improvement of health care service in Mt Meru hospital. However, there are still a lot of challenges under the system. Though the policy for cost sharing clearly stipulated the procedures and which groups are targeted in health care, there is a need to review the policy. As the study findings reveals, the government should revise new mechanisms on improving health

care for vulnerable or targeted groups including introducing health insurance scheme for this groups since it provides more coverage even in private hospitals.

5.4. Recommendations

Based on the results and discussion it is recommended that the following to be revised in order to improve efficiency in the implementation of the policy at Mount Meru and other levels. It is also important to note that one of the recommendations provided here, suggest major changes to existing policy, but it is suggested that the system should be improved, mechanisms and procedures to ensure that the policy is fully operational and effective, thereby improving access to health care and delivery of quality care especially to the poor and vulnerable group.

a) Procedures and steps to be used by patients/clients when attending Mount Meru

Procedures used at Mount Meru to establish the policy should be reviewed. This should also mean at minimizing delay of patients to get care, improve access to quality of care by ensuring drugs and investigations are readily available. If possible, files of patients coming for appointment visits should be available at the specific clinic so that the patient/client are first seen by doctor and that payment for consultation are other charges can be made later. This will give opportunity to the patients/clients to be seen early and there reduce long waiting time and queues.

Alternatively, because the major reason for long queues is due to the fact that all patients attending various departments obtain files and pay charges at one place, hospital management should consider introducing departmental medical record and account offices so that payment can be made at different department and therefore reduce the queues.

b) System and procedures of issuing waiver and exemption

Policies for exemption and waivers should be refined, clarification of the eligible poor, specification of free services for each group; targets are ward level for the number of poor people who should be given waivers based on local property rates; examine whether the exemption and waivers categories chosen exclude any specific vulnerable group.

Review the exemption and waivers with the objective of making them more applicants friendly and operational efficient and more focusing on targeting the poorest and vulnerable groups. Revision should as well aim at improving the system in order to maximize efficient and minimize exclusion of poor and vulnerable persons from accessing health care at the same time preventing rich people and health worker abusing the system.

c) Cost sharing fees and charges

It is recommended that Mount Meru hospital management should put a system of informing and updating the public well in advance about existing and new charges. The recommendation to the government is that charges for different services should be reviewed by level of facility and by location, to recognize that ability to pay will differ by catchment area. So that charges/fees are lower in poorer areas and districts than in richer ones.

d) Training of health staffs

Adequate training for health staff on the guideline and procedures involved with implementation of policy and assessment for waiver and exemption is also required. Collected revenues should be used to provide improvements in quality and services such as improved drug supply, new sheets for wards, and repaired diagnostic equipment.

e) Other general recommendations

There is also need for care workers to have good and positive attitude when attending patients as well as positive attitude towards NHIF card holders. Another issue to consider is that, revenue collected from cost sharing and other sources of funds, can be used by GOT to bringing health facilities closer to the people. This will increase the geographical equity of access to health care facilities among the residents and reduce some extra cost people incur by paying for transport to and from seeking health care from health facilities located very far from their homes.

5.5. Areas for further research

Since this study was conducted as a case study of Mount Meru hospital, there is a need for another study to cover large area for comparative purposes. Research should cover rural and urban areas or various social setups.

5.6. Critical evaluation of the study

During Data collection the researcher faced some difficulties because some of the patient where afraid to share some of the information thinking that they might look bad in the eyes of the of healthcare workers who were attending to them, however after noticing the situation the healthcare workers intervened and made it clear to them that it's okay to answer all the question that were in the questionnaires, there after the process was easier and all the distributed questionnaire were filled.

5.7. Conclusion

This chapter has presented a summary of the study findings, conclusion and recommendations based on the findings presented and discussed in chapter four, it recommended for areas for further studies and made a critical evaluation of the stud

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APPENDICES

Appendix I: Interview guide for the staff

1. What is cost sharing in the provision of health care service?
2. How did you perceive the idea of cost sharing when it was introduced?
3. How is cost sharing implemented in this hospital?
4. What has been the impact of cost sharing to service delivery to the old, children and disabled? Please tell me the advantages of health cost sharing systems to public health employees?
5. What are the main shortcomings of the cost sharing policy?
6. How does the cost sharing system affect your work performance?
7. How do you rate the cost sharing programme here at Mt Meru Hospital?
    a. Successful, why?
    b. Unsuccessful, why?
8. Is the service provided now better than the one provided before cost sharing policy was introduced?
9. Is there efficiency in the health service provided now as comparing to before cost sharing was introduced?
10. What problems do you face in provision of health service?
11. How do you address the problem identified above?
12. Have you ever attended any seminar/workshop/trainings on cost sharing management or any other related to health care? Why?

Appendix II: Research Questionnaire for the patients

Topic: Impact of Cost Sharing on the Delivery of Health Care Services: A Case Study of Mount Meru Hospital

I am interested in investigating the impact of cost-sharing on the delivery of health care services on the vulnerable populations seeking and receiving health care services.

A researcher is a student of Master of Business Administration at the Institute of Accountancy Arusha. So, a study is carried out as a partial fulfilment of the requirements of the degree mentioned above. Findings of this study will lead to clear understanding of the Impact of Cost Sharing on the Delivery of Health Care Services and provide the government and other interested parties as a basis for charting out remedial programmes

Please assist by answering the following questions as honesty as possible. The information given will be treated confidently and used solely for the purpose of this study. There is no need for you to disclose your name otherwise you specifically wish to do so.

Respondents' details

Department……

Age……

Sex……

Marital status……...

Level of education……

Please fill the empty space and put a tick on your answer for the multiple-choice questions.

1. What do you understand to be the concept “cost – sharing policy”?

.....

2. Are you aware of the waivers and exemptions?

.....

3. Do you access free health care services in public hospitals?

   a) Yes [ ]

   b) No [ ]

4. If the answer to question 3 is no, do you have the ability to pay for health care treatment?

   c) Yes [ ]

   d) No [ ]

5. In case you fail to pay for hospital charges, what do you do for treatments?

   ……

6. What challenges do you face when seeking health services in public hospitals?

   .....

7. Can the hospital management address these challenges you have mentioned in four above?

   a) Yes [ ]

   b) No [ ]

8. In your opinion, what measures should be taken by hospital management to ensure the vulnerable groups have free access to healthcare?

   .....

Is the service provided now better than the one provided before cost sharing policy was introduced?

a. Yes [ ]

b. No [ ]

c. Somewhat [ ]

9. Is there efficiency in the health service provided now as comparing to before cost sharing was introduced?

a. Yes [ ]

b. No [ ]

c. Somewhat [ ]

10. What are your recommendations to the government regarding cost sharing and provision of free health care to the vulnerable groups like old people, children and disabled?

.....

Thank you very much for your time and cooperation. I greatly appreciate your contribution to this study.

Appendix III: **Research Questionnaire for the staff**

TOPIC: Impact of Cost Sharing on the Delivery of Health Care Services: A Case Study of Mount Meru Hospital

I am interested in investigating the impact of cost-sharing on the delivery of health care services on the vulnerable populations seeking and receiving health care services

A researcher is a student of Master of Business Administration at the Institute of Accountancy Arusha. So, a study is carried out as a partial fulfilment of the requirements of the degree mentioned above. Findings of this study will lead to clear understanding of the Impact of Cost Sharing on the Delivery of Health Care Services and provide the government and other interested parties as a basis for charting out remedial programmes

Please assist by answering the following questions as honesty as possible. The information given will be treated confidently and used solely for the purpose of this study. There is no need for you to disclose your name otherwise you specifically wish to do so.

1.Respondents' details

Department…….

Age……

Sex……

Marital status……...

Level of education……

1. Explain the meaning of the concept cost – sharing programme?

.....

.....

2. For how long have you been working in this hospital?

a) 1-5 years [ ]

b) 5-10 years [ ]

c) 11 years and above [ ]

3. Do you know that older people children under-five and pregnant women and disabled have a right to access free health care in public hospitals?

   a. Yes [ ]

   b. No [ ]

4. If the answer in question 3 is yes, do they get free healthcare services?

   a. Yes [ ]

   b. No [ ]

5. If the answer in question 4 is yes, which category of medical services are vulnerable groups (children under five, pregnant women, and old people), entitled to access free in this hospital?

   .....

   .....

6. If older people are required to pay for health services, do you think that they have ability to pay?

a. Yes [ ]

b. No [ ]

7. If the answer to question 6 is no, what do you do to help older people to access free healthcare services?

.....

.....

8. Which criteria do you use to identify a person who deserves free healthcare services?

.....

.....

9. Does the government subsidize the medical services for the vulnerable group?

a. Yes [ ]

b. No [ ]

10. If the answer to question 9 is yes, do you receive enough funds annually for supporting vulnerable population medical expenses? Explain

.....

.....

11. In your opinion, are the challenges facing vulnerable population when seeking health care services in this hospital?

…….

……..

12. Do you think that hospital management has the ability to address these challenges?

.....

13. What measures should be taken by hospital management to improve free access to health care for older people?

    .....

    .....

14. Give your recommendations to the government in order to improve provision of free health care services to older people, children under five years, and pregnant women?

    .....

    .....

    .....

Thank you very much for your time and cooperation. I greatly appreciate your contribution to this study.

Appendix IV: Field work time table

Pilot study	25th September
Data Collection	26th, 29th and 30th of September
Transformation of data into a software	1st October – 6th October
Data Cleaning	7th October – 9th October
Processing and Analysis	10th October – 16th October
Dissertation writing	17th October – 23rd October
Report submission to the supervisor	24th October – 3rd November
Defence of Dissertation	5thNovember
Submission of final report	13thDecember