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ASSESSMENT OF FREE HEALTH SERVICE PROVISION SYSTEM IN DILLA TOWN, SOUTH ETHIOPIA

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ABSTRACT

Background: Access to basic health services of acceptable quality is still denied to many of the world's poorest people, Identification or application procedure and screening criteria by local kebele administrator for free health services provision at public health facilities are not transparent.
Objective: The aim of the study was to assess free health service delivery system and the extent to which strict criteria are followed in granting free health services to the eligible poor in Dilla town, South Ethiopia.
Materials and method: A cross-sectional study design was conducted in Dilla town, South Ethiopia from November 1-7, 2014.
Results: Forty four percent (n=391) of the respondents were found to be patients' exempted from fees on the day of interview. The occupation and family size of the respondents showed a statistically significant association with fee waiver granting system at the public health facilities.
Conclusion: Lack of knowledge and awareness about the possibilities of free health service provision to the poor at public health facilities has made the system inaccessible to the users. Improving awareness and strict fee-waiver mechanism should be implemented in a properly documented manner to address equitable health services to the community.

INTRODUCTION

Equity is the underlying principle of major global health policies such as the Global Primary Health Care Strategy, the Health for All strategy, and recently, the health sector reforms spearheaded by the World Bank which are based on the assumption that everyone should have the opportunity to attain good health status (Gwartk et al., 2006 and Pierre et al., 2007). The target of equity in health and equal access to health care is based on the principle that health care should be provided according to needs, not according to factors such as the ability to pay for the service (Jantina, 2006). The role and effects of user fees for publicly provided health services in developing countries has evolved during the past ten years. Early proponents believed that fees could help to improve efficiency through appropriate price signals, financial sustainability and also through targeted prices and exemptions (Frank, 2006). However, the introduction of user-payments for health services is frequently followed by a concern about the impact it has on the equity of access for poor people. Governments often try to remedy these inequalities by putting in place safety nets in the form of exemptions and waivers in the user fee system (George, 2007). The central problems in the system of exemptions for the poor are: defining conditions for eligible people in these category, working out an acceptable formula for providing subsidies, and effectively administering exemption scheme. A survey of official cost- recovery policies in 25 countries of Sub- Saharan Africa revealed that exemptions due to poverty or inability to pay are remarkably uncommon (World Bank Discussion Papers, 2005). In 1989, Uganda provided safety nets to ensure equitable access to health care for individuals with limited financial resources. Exemption categories included immunization services for children under the age of five, maternal health services like antenatal and postnatal care including family planning services. In addition, patients suffering from chronic illnesses such as HIV/AIDS, tuberculosis, cancer and poor individuals are exempted from user-fees by the local councils (George, 2007). In Cambodia, Indonesia, and Vietnam, a combination of user-fee exemption mechanisms and poverty certificate has been established for eligible poor and vulnerable populations. Criteria for eligibility are often designed according to the characteristics of a person or a family in relation to ability to pay for health services (Health Sector Financing Reform Project manual in Ethiopia, 2009). Availability of information

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related to the criteria is usually limited in local kebele (small administrative unit), which requires great efforts of people responsible for verifying the eligibility criteria. In places where means testing are frequently organized, implementation of the system may be easier than where means testing is initiated for the first time, because of better administrative capacity and more basic information (Levine, 2006 and New brander, 2007). Ethiopia has been providing free health services for the poor enshrined in Ethiopian law, but the program has never been genuinely operational. Concerns about inadequate funding to provide fee-waivers to all eligible beneficiaries have led to recommendations to establish an "equity fund" to fund fee-waivers as an element of pooled funding. Ethiopia has also been providing certain health services free of charge or exempting public health services to all citizens irrespective of income level, including deliveries at the health facilities, antenatal care and postnatal care, however; the mid-term evaluation of the Health Sector Development Program (HSDP) III found that most of the facilities that advertise exempted services are only partially free in practice. For example, it was found that delivery services in hospital were not provided entirely free of charge, as some clients were charged for supplies used during delivery (Engida, 1999). Despite the fact that, there are clear criteria and guidelines for free health service provision system but limited number of applicants' were granted poverty certificate that allows them to get free health care from public health facilities. And only a few studies have been conducted on this issue. Therefore, this study is aimed at assessing free health care delivery system in Dilla town and the extent to which strict criteria are followed in granting free health services to the eligible poor by the responsible authorities in Dilla town.

MATERIALS AND METHODS

A cross-sectional study designs, employing both quantitative and qualitative methods was conducted from November 1-7, 2014 in Dilla town, South Ethiopia. Dilla town is located 365 km to the South of Addis Ababa. The town has 9 kebeles (small administrative units), which are organized under three sub-cities. The total population of Dilla town projected to date is 94, 400. The town has one hospital and two health centers as public health facilities. The study included patients visiting Dilla University hospital and Dilla health centre, kebele leaders, and administrators of both health facilities. For quantitative study, a structured questionnaire was used while interview with semi-structured questionnaires was carried out for the qualitative study. A total of 434 study subjects were identified from outpatient departments excluding users of exempted health services like maternal & child health services including family planning, tuberculosis treatment, and anti-retroviral therapy. Admitted patients' were also excluded from the study because they already pass through the out-patient departments. The respondents were identified using a systematic sampling technique where the first respondent to be included in the sample was selected randomly by lottery method and every twelfth patient was taken. In cases of non-voluntary respondents, the next patient was interviewed. A total of 11 key informants including Dilla University Hospital and Dilla Health Center administrator, and kebele leaders were identified using purposive sampling technique and then interviewed using semi-structured questionnaires. Respondents' knowledge and awareness towards the possibilities of free health care provision system was assessed by asking several knowledge related questions. A score of 1 was given if the respondents' respond the given questions correctly and 0 if not. The sum and the mean of each response was computed and dichotomized into better and poor knowledge. If respondents scored below the mean, he/she was labeled as having poor knowledge and if the respondents scored above the mean, he/she was labeled as better knowledge.

Data were collected by trained nurses recruited from Yirga Chefee health center. The questionnaire was adopted from World Bank's Living Standard Measurement Survey tools. A semi-structured questionnaire was used to describe the presence of criteria in determining eligibility for exemptions from payment at a public health facility. A structured questionnaire was used to assess knowledge and awareness of exit respondents about the existing free health care provision system with their perceived presence and extent of leakage and under coverage. Quantitative data were entered, cleaned and edited using EPI-Info version 7 and exported to SPSS version 17.0 for further analysis. Descriptive statistics was computed and binary logistic regression model will be used to identify the determinant variables. Variables having $P \leq 0.2$ in bi-variate analysis will be the candidate in to multivariate logistic regression models to control the effect of confounders on awareness and knowledge about the possibilities of free health services the eligible poor. Statistical test were employed and level of significance was set at $p < 0.05$. Qualitative data was also cleaned, edited and analyzed using the thematic framework approach according to the objectives of the study.

RESULTS

Socio-demographic characteristics of the study participants

The study covered a total of (n=391) health facility exit respondents, yielding 90.1% of the response rate. Out of the (n=391) respondents, 228 (58.3%) were found to be females and 173 (44.2%) of the respondents age ranges from 35-44 years but 323(82.6%) of health facility exit respondents are from rural areas. Three hundred twenty nine (84.2%) of the respondents were married and 131 (33.5%) of the respondents were having educational background of first cycle primary school (grade 1-4). One hundred four (26.6%) of the respondents were housewives followed by daily laborers which account 100 (26.6%). The mean monthly income of the respondents was 253.2 (US $15.35) Birr per month. Two hundred sixty one (66.8%) of the respondents had a monthly income of less than 100 (US $6.1) Birr per month. Of the total respondents 139 (35.5%) had more than five family members and 211 (54%) of the respondents had private houses, 179 (45%) rented houses but 307 (78.5%) of the respondents' house is having 1-2 rooms and 84 (21.7%) of the respondents' house is having three and more rooms (Table 1).

Knowledge & awareness of the exit respondents about the possibilities of free health service to the eligible poor

Government employee who had better knowledge & awareness towards the presence of free health service provision system was 4 times [AOR=4.6, (95% CI: 1.945, 10.906)] more likely granted fee waiver than the farmer who had poor knowledge & awareness towards the system. Respondents' who were having more than five family sizes had better knowledge & awareness towards the possibilities

of free health service provision system was 2 times more likely granted fee-waiver as compared to the respondents' having one to two family size [AOR = 2.4, (95% CI:1.964, 5.576)] (Table 2).

Table 1. Socio-demographic characteristics of the study participants, Dilla town, South Ethiopia, December 2014

Demographic variables	n=391	%
Sex		
Female	228	58.3
Male	163	41.7
Age		
15-24 years	21	5.4
25-34 years	116	29.7
35-44 years	173	44.2
45-54 years	61	15.6
≥55 years	20	5.1
Address		
Urban	68	17.4
Rural	323	82.6
Marital status		
Married	329	84.2
Single	50	12.8
Widowed	4	1
Divorced	8	2
Educational status		
Illiterate	63	16.1
Grade 1-4	131	33.5
Grade 5-8	98	25.1
Grade 9-12	74	18.9
College & University	25	6.4
Occupation		
Farmers	41	10.5
Housewife	104	26.6
Daily laborers	100	25.6
Merchants	39	10
Government employee	63	16
Students	34	8.7
No job	10	2.6
Demographic variables	n=391	%
Monthly income		
<100 Birr	261	66.8
101-385 Birr	52	13.3
>385Birr	78	19.9
Family size		
1-2	111	28.4
3-5	141	36.1
>5	139	35.5
House ownership		
Rented	211	54
Private	179	45.7
Don't have house	1	0.3
Number of rooms		
1-2	307	78.5
3 and above	84	21.5

The entire respondent from local kebele explained that only three committee members from local kebele administrator and two urban female health extension workers from each kebele were engaged in eligibility determination and poverty certificate is provided after a onetime assessment of the applicant's socio-economic situation. The address of the respondents and their knowledge about the possibility of getting free health care at public health facilities showed no statistically significant association (P=0.721) (Table 3).

Leakage and under coverage

According to Dilla University Hospital leader, entire health care providers and their families, University students, and emergency patients or causalities brought by police men were given health services free of charge which leads to significant leakage of the scheme intended for the poor. And it was noted that, budget allocated by Dilla town mayor office for the community for fee waiver reimbursement to health centre is not sufficient to access recognizable list of beneficiaries at the poverty level.

Table 2. Comparison of demographic variables with waiver granting knowledge and awareness at public health facility, Dilla town, South Ethiopia, December 2014

Variables	Waiver granting awareness				
	Aware	Not aware	COR	95% CI	p-value
Sex					
Female	102	126	1.116	(0.608, 2.050)	0.723
Male	70	93			
Age					
15-24 years	6	15			
25-34 years	47	69			
35-44 years	78	95	0.763	(0.191, 3.038)	0.701
45-54 years	29	32			
≥55 years	12	8			
Total	**172**	**219**			
Address					
Urban	148	24	0.724	(0.260, 2.019)	0.538
Rural	174	45			
Marital status					
Married	152	177			
Single	14	36			
Widowed	1	3	2.393	(0.453, 12.646)	0.304
Divorced	5	3			
Educational status					
Illiterate	19	44			
Grade 1-4	60	71			
Grade 5-8	39	59	3.026	(0.890, 10.291)	0.076
Grade 9-12	41	33			
College & University	13	12			
Occupation					
Farmers	16	25	1.299	(0.606, 2.783)	0.501
Housewife	48	56	1.015	(0.456, 2.259)	0.970
Daily laborers	39	61	0.593	(0.230, 1.528)	0.279
Merchants	12	27	0.757	(0.243, 2.360)	0.63
Gov't employee	46	17	4.606	(1.945, 10.906)	**0.001***
Students	7	27	1.216	(0.82, 5.238)	0.793
No job	4	6			
Monthly income					
<100 Birr	107	154	0.456	(0.192,1.9082)	0.075
101-385 Birr	18	34			
>385 Birr	47	31			
Family size					
1-2	30	81			
3-5	73	68	3.073	(1.964, 5.576)	0.501
>5	69	70	2.410	(1.305, 4.451)	**0.005***
House ownership					
Rented	94	118	0.866	(0.468,1.606)	0.645
Private	78	101			
Number of rooms					
1-2	128	44	1.211	(0.661,2.219)	0.536
3 and above	179	40			

Table 3. Awareness about the possibilities of free health care for the poor with the educational status and address of the respondents, Dilla town, South Ethiopia, December 2014

	Awareness				
Variables	Aware	Not aware	COR	95% CI	P-value
Address					
Urban	174	24	0.724	[0.260,2.019]	0.721
Rural	148	45			
Educational status					
Illiterate	19	44			
Grade 1-4	60	71			
Grade 5-8	39	59	3.026	[0.890,10.291]	0.538
Grade 9-12	41	33			
College & University	13	12			

Under-coverage will be a constant problem when the poor do not utilize free or subsidized health services because health facilities are not in position to select eligible poor and whom to exempt from fee for services. But public health services having ''public good nature'' like Voluntary Counseling and Testing for HIV, Anti-Retro Viral Therapy (ART), Leprosy & tuberculosis treatment, epidemic investigation & management,

Fistula management, Maternal and Child Health services including family planning were exempted for every clients' irrespective of their income level.

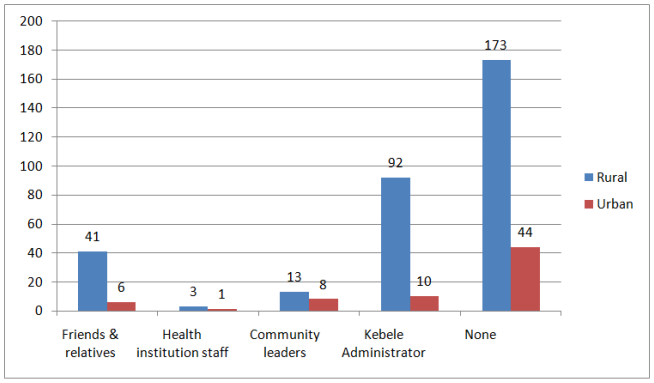

Figure 1. Figure representing the sources of information about free health services and address of respondents, Dilla town, South Ethiopia, December 2014

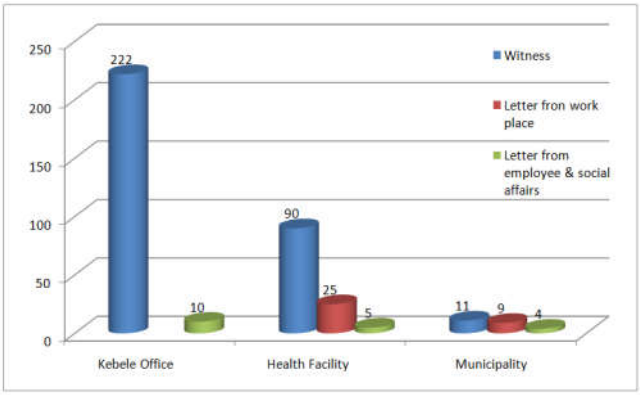

Figure 2. Figure representing evidences required to be eligible for free health services with the place of application of the respondents, Dilla town, South Ethiopia, December 2014

However, the usual place of first health service seeking during the time of illness or health problems showed no statistically significant association with their knowledge about the possibility of free health care system(P= 0.230).

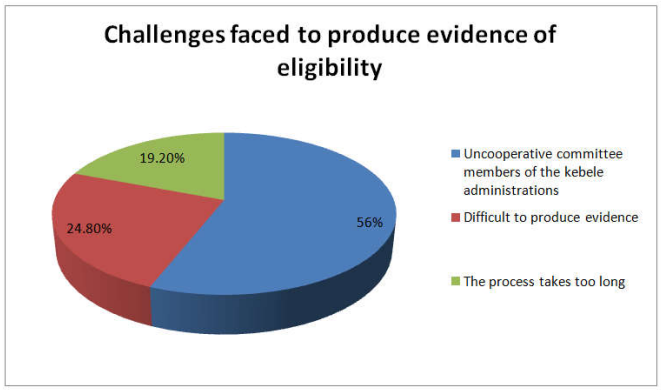

Figure 3. Pie chart showing challenges faced by respondents' to produce evidences to be eligible for free health services, Dilla town, South Ethiopia, December 2014

Out of the total respondents, 253(64.7%) of the patient' heard about the possibility of free health services to the eligible poor some years back, while 30(7.8%) heard recently and the rest did not remember when they had the information. Ninety two (90.2%) of respondents from rural area and 10(9.8%) from urban area heard about the possibilities of free health services to the eligible poor from kebele leaders (Figure 1). Respondents from all kebeles stated that; "The responsibility of granting user-fee exemption is given to the female health extension workers and the three committee members from kebele administrator" Fifty six percent of exit respondents said that they were served with payment on the day of the interview. These individuals were asked whether they deserved free health care or not. A majority of them, 364 (93.1%) replied that they do deserve free health services because of being poor and assuming free health services is a fundamental human right. Of these 222 (56.8%) have applied to their respective kebele administration offices with the remaining percentage of respondents have applied directly to health facility for free health services. According to the local kebele leader and female health extension workers, the most common prerequisite required by the applicants' for fee-waiver granting was being a resident of the respective kebele and being unable to pay for health care as witnessed by three residents of that kebele. Similarly, among the respondents who were given health services with payment on the day of interview, the majority of exit respondents claimed that the evidence required to be eligible for free health services is having three witnesses who should be the residents of the respective kebele. The remaining respondents should produce a letter from work place, employer & social affairs (Fig. 2). Majority of the respondents claimed the presence of challenges in getting support letters of eligibility for free health services. Types of difficulties or challenges mentioned by 56% of the respondents was uncooperative committee members of the kebele administrator, difficulty to produce evidences, and the process takes too long time (Figure 3).

DISCUSSION

This study assessed the presence of selection criteria, the system of application to determine eligibility for granting fee-waivers and users' knowledge and awareness towards the possibilities of existing free health care provision system to the poor. Despite the fact that, majority of the respondents in the exit interview were getting health services with payment but few respondents were exempted from user-fees. This implies that the existing selection criteria for granting free health care service privilege haven't been critically applied. Hospital and health centre leaders including kebele administrator have agreed on the importance of fee-waiver at public health facilities, most have agreed on the idea of granting free health services to the eligible poor. As it was noted in other studies, the problem lies on the absence of clearly stated criteria and means testing while granting fee-waivers but failure to implement the guidelines by kebele administrator for granting free health services at public health facilities to eligible poor was the major problems observed in the study area (Gwartk, 2007; Pierre, 2007 and Jantina, 2006).

The proportion of respondents having knowledge about the possibilities of free health services to the eligible poor was also higher in the urban than the rural area. Similar trends were also reported from the studies conducted in Kenya and Tanzania where lack of knowledge about fee-waivers for the poor was shown, huge majority of the poor indicating that, they must pay for services at government health facilities (Frank, 2006 and George, 2007). In this study, the possible source of information about the presence of free health care to the eligible poor was friends & relatives. The study conducted

in Kenya showed that, information from health facility staff was the most important source (World Bank Discussion Papers, 2005). The discrepancy of the source of information may be due to lack of effective communication between health facilities staff and health service consumers' on the existing fee-waiver system. The responsibility of fee-waiver selection and eligibility determination vary among countries. In Kenya and Ghana eligibility is determined by health facility staff; in Zimbabwe by social welfare officials; in Thailand, Indonesia, and in certain provinces of Cambodia by the combined and coordinated workforce of health staff, village leaders and clerks. In this study local kebele administrator and female health extension workers were involved in screening process but those who engaged in eligibility determination shouldn't aware of the selection criteria, not adequately trained to carry out the screening activities, and not well informed about the financial and other constraints governing the protection of the eligible poor, this leads to misuse of free health services by non-poor (leakage) which was intended for the poor (Frank, 2006).

Official criteria for screening eligible poor that was introduced in 2009 by South Regional Health Bureau in collaboration with USAID shows that street children, displaced individuals or families as a result of man-made or natural disaster and emergency for 24 hours patients were eligible and getting health services free of charge but kebele administrator and female health extension workers define individuals or families who deserve fee-waivers in terms of monthly income, family size and being elderly are considered as a measure for eligibility. This implies that a proper and well-organized means testing is lacking in the system (Health Sector Financing Reform Project manual in Ethiopia, 2009). The guideline for granting fee-waiver is having clear screening criteria but in the study area the responsibility has apparently given to local kebele administrators leading to loophole to make their own judgments, which widens the chance for the mean testing to be poorly implemented. In addition to hidden agendas by those who might have been motivated by rent seeking behaviors, the possibility that the poor is paying while the ''rich'' or better off have been benefited from fee-waivers scheme that was intended for the poor becomes evident; a situation that has been similarly reported from Uganda and Tanzania1(Levine, 2006 and New brander, 2007).

Fifty six percent of patients' in this study were getting health services with payment during the interview but this findings is consistent to the study conducted in Jimma town revealed that, 42.2% of exit respondents were not served for free on the day of the interview, this might be due to the failure of implementing the guideline to serve the genuinely disadvantaged group of the population (Woldie, 2003 and Engida, 1999). But out of the respondents who were paying, 90 (54.7%) claimed that they deserve free health care, the justification for most respondents (72.9%) was low household income. In addition, out of the entire respondents, 219 (56%) of them mentioned that, the presence of uncooperative committee members of the kebele to get support letter which state one as a free patient. This findings is much more higher compared to the findings registered in the study mentioned earlier [10]. The proportion of respondents having knowledge about the possibilities of exemption and fee-waiver privileges in the utilization of health services by the poor was 44.5% and 37.9% for urban and rural inhabitants respectively, but the study conducted in Bahir Dar area (North Ethiopia) revealed that, the level of awareness and source of information was 82.7% for rural and 94% for urban respondents, this finding is much more higher when compared to this study. The sources of information for the majority of rural respondents were kebele administrator when compared to the study conducted in the household survey in Bahir Dar area (Engida, 1999). This indicates that lack of commitment by health facility staff that strongly considers the importance of disseminating the information about the presence of free health services to the eligible poor. Lack of awareness of the community about the presence of free health services for the eligible poor and the mechanisms for properly utilizing these measures are noted and high proportion of respondents that suspect the possibility of leakage and under-coverage could be an indication that the communities were not confident enough about the selection process.

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