THE IMPACT OF COST SHARING MECHANISM IN HEALTHCARE SERVICE DELIVERY IN TANZANIA: A CASE OF AMANA HOSPITAL

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A DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF MONITORING AND EVALUATION OF THE OPEN UNIVERSITY OF TANZANIA

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CERTIFICATION

The undersigned certifies that she has read and hereby recommends for the acceptance by the Open University of Tanzania a dissertation titled; **"*Assessment of the Impact of Cost Sharing Mechanism in Healthcare Service Delivery in Tanzania: A Case of Amana Hospital",*** in partial fulfilment of the requirements for the Master's degree of Monitoring and Evaluation of the Open University of Tanzania.

……..

Dr. Harrieth Mtae

(Supervisor)

……..

Date

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DECLARATION

I, **Gati R. Nyamuhunguru** do hereby declare that this study titled "assessment of the impact of cost sharing mechanism in healthcare service delivery in Tanzania: a case of Amana Hospital" is my own work. I have undertaken the research work independently with the guidance and support of my research advisor. This study has not been submitted for any program in this or any other institutions and that all sources of materials used for this dissertation have been duly acknowledged.

……..

Signature

……..

Date

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ABSTRACT

The cost sharing scheme in health delivery is supposed to cater for the quality, affordable and better services for the Patients. The overall study objective was to assess the impact of cost sharing mechanisms in the delivery of healthcare services in Tanzania. The study was conducted in Dare es salaam at Amana Hospital using a sample of 108 participants where 95 were Patients, 3 doctors, 8 nurses, and 2 accountants. In line to the above mentioned subject, the specific objectives were to assess the accessibility, convenience and affordability of healthcare services to the beneficiaries and stakeholders, the performance of healthcare services delivery and to identify the obstacles facing the hospitals in the delivery. The data from the field were collected through questionnaires, and interview. The results revealed that less than 50% was awarded by participants to accessibility, convenience, and affordability of health services to the beneficiaries and stakeholders. Less than 45% was awarded to the performance of cost sharing scheme in health delivery is negative. Obstacles in this study included little participant's awareness about cost sharing, availability of medicines, long distance to the service centres, unfriendly hospital environment and poor hospital attendance. It can be concluded that the implementation of cost sharing scheme in Tanzania lies far from Tanzanians expectation of the said service. The following recommendations are made; Government should sensitize people on the cost sharing scheme. Prices of health services have to be revised to allow most Tanzanians to access it and lastly improving quality of health delivery is necessary to create confidence on patients to make use of them.

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LIST OF ABBREVIATIONS

CHF	Community Health Fund
HRDS	Human Resources Development Survey
HSRs	Health Sector Reforms
NESP	National Economic Survival Program
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
SHIB	Social Health Insurance Benefit
SAP	Structural Adjustment Program
SPSS	Statistical Package for Social Services
TIKA	Tiba Kwa Kadi
TIRA	Tanzania Insurance Regulatory authority

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

Better health is central to human happiness and wellbeing. It also makes an important contribution to economic progress, as healthy populations live longer, are more are more likely to remain active in the economy and hence productive in their activities. Over the past 10 years, the poorest countries, especially in Africa, have struggled with worsening economic conditions and reduced public finance for health services. Some governments have responded gradually, reacting to internal and external pressures. Others have embarked on major reforms of various aspects of their health systems.

It can be noted that, immediately after independence, 1961, the Government of Tanzania aimed at building human capital by isolating factors that were termed as "major enemies of development": ignorance, diseases and poverty. Disease as an enemy was fought by a massive increase in the number of health facilities and primary health care training institutions, most of them owned by the government. Alongside the public sector existed the non-for-profit health facilities, mostly owned by faith-based organizations such as the Catholics, muslins and evangelicals.

However, Tanzania went through a severe economic crisis in the 1980s, which adversely affected the management and financing of basic social services including health care services (Wangwe, etal.2014).

The health sector faced severe problems such as underfunding that affected the quality and provision of the said services. Underfunding of the health care delivery system at all levels from local to national led to among other problems: shortage of drugs, equipment and medical supplies; overall deterioration of the physical health infrastructure including electricity supply, water and sanitation at the health care facilities; poor management and regulatory framework; and very low wages and other incentives for healthcare workers, which resulted in low staff morale. During this period, the Government was the key provider of free health care services whereas private health care provisions were nearly non-existent except for a few faith-based health care facilities (COWI, et al. 2013).

In addressing these problems, the primary objective of the government since early-1990s has been to address the problem of severe underfunding and a weak management system by implementing Health Sector Reforms (HSRs) in effort to improve provision and access to health care services. As part of these on-going reforms, in 1991, the importance of the private sector in health care delivery was recognized where an amendment to the Private Hospitals (Regulatory) Act, 1977 was done resulting into the establishment of the Private Hospitals (Regulation) (Amendment) Act, 1991.

Following this act, qualified medical practitioners and dentists were allowed to manage private – health facilities with the approval of the Ministry of Health. Consequently, the health sector in Tanzania was appraised to assess its performance and find strategies that would be employed to improve its functioning.

Provision of health care, particularly in the rural areas and facilities, was adversely affected after the economic recession in the 1970s and 1980s, which resulted in an overall deterioration of health care services. This led to the Tanzanian government introducing Cost Sharing in 1993 and following that, instituting other financing options such as a National Health Insurance Fund (NHIF) and a Community Health Fund (CHF) .User fees accompanied the introduction of cost-sharing. Early 1990s the government adopted health sector reforms that changed the financing system from free services to mixed financing mechanisms including cost-sharing policies.

Majority of people cannot afford cost sharing scheme for health service. This is due to an adverse poverty situation, which is dominating the majority of Tanzanians (Shole, 2009). Thus, there is a need to so far to assess the current impact of cost sharing mechanisms following the implementations of various schemes.

1.2 Statement of the Problem

The decision by the government of Tanzania to introduce the cost sharing scheme in health sector in 1991 meant to ease the financial pressure on the government and at the same time to increase the quality of health services in terms of coverage and availability of health care system. Khamis (2008) identifies constraints associated with weak supporting system such as poor drug supply, poor management information system and lack of supervision negatively impact the principal objectives of the cost sharing scheme in Tanzania.

Despite the good promises of the cost sharing scheme to the citizens and the government boasts that the level of health services has improved, the literature on the

subject exhibits a different picture. The level of health care is low accompanied by poor treatment leading to higher mortality rate. However, points out that in Tanzania about 44% of the population receive medical services in Dar es Salaam. The fact that cost sharing in health care system has been implemented from 1991 with claim and counter from the government and private entities claim on the performance of the health scheme is fair to research on the impact of the cost sharing scheme.

However, the continuing disparities in health outcomes between the poorest and the richest in Tanzanians and those in rural versus in urban areas need to be addressed, along with the barriers to service experienced by the poor due to distance, formal and informal health charges, and other obstacles reported according to Poverty and human development report (R&AWG, 2016).

1.3 Objective of the Study

1.3.1 General Objective of the Study

The main objective of the research was to assess the impact of cost sharing mechanisms in the delivery of healthcare services in Amana Hospital in Dar es Salaam Region.

1.3.2 Specific Objectives

i) To assess the accessibility, convenience and affordability of healthcare services to the beneficiaries and stakeholders.

ii) To assess the performance of healthcare services delivery.

iii) To identify the obstacles facing the hospitals in the delivery of health services and implementation of cost sharing mechanisms.

1.4 Research Questions

1.4.1 General Research Question

Does cost-sharing mechanism have an impact in health services delivery in Amana Hospital?

1.4.2 Specific Research Questions

The study is guided by the following research questions.

i) Are the cost sharing mechanisms convenient and affordable to stakeholders/beneficiaries?

ii) What is the performance of healthcare services delivery?

iii) What are the obstacles facing hospitals in the implementation of the cost sharing mechanism?

1.5 Hypothesis

There is no significant relationship between associated factors of cost sharing and accessibility/affordability of health services.

1.6 Significance of the Study

The study is expected to contribute in building a general knowledge base on health care delivery with respect to the cost sharing policy. Scholars and researchers will have an insight into the strategies and challenges health care delivery.

Findings of the study will provide guidance to policy makers and the managers of health services on issues to formulate health strategies and plans to address and optimize health care services.

The policy makers will know the areas in which Tanzanians need to be supported in order ensure access to quality and affordable health care. This study is expected to provide more information on the relationship between the variables of interest in the research on health delivery. Finally, the study will produce a useful reference to Academicians who may be interested to further broaden the subject.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Overview

This chapter presents literature review which covers the already existing conceptual definitions, theoretical and empirical literature reviews as a part of establishing the existing research gap in relation with the research topic. The basis of the theoretical and empirical literature review falls within the limits of the existing knowledge of the concept and perspectives on health care cost sharing scheme in Tanzania.

2.2 Conceptual Definitions

2.2.1 Cost Sharing

Cost sharing is the financial contribution that patients are required to make when they use health care services, amounts that are not reimbursed by their health plan. Cost sharing is a portion of project or program cost note borne by the sponsor (Johnson 2016).

Cost sharing in the form of user fees was introduced in four phases: Phase I from July 1993 to June 1994 to referral and some services in regional hospital; Phase II from July 1994 to December 1994 to regional hospital; Phase III from January 1995 onwards to district hospital and Phase IV, introduced to health centre and Dispensary after completion of introduction to all district hospital (Wenrley, 2012). Before economic liberalization, Government and Voluntary Agencies were the main providers of health service. Nowadays cost sharing for health service has been introduced (Kapinga, 2007).

2.2.2 Health Delivery

Health delivery is the arrangement of people, institutions, and resources that deliver health care services to meet the health needs of the target population. Health service is a very worth investment because of its direct relationship to production and service delivery; hence to poverty reduction. Only a healthy body can be productive.

However, health outcomes in Africa are among the poorest in the world, also current levels of health services in Africa appear to be insufficient in coverage and quality (World Bank, 1994). Among the common health problems in Tanzania are malaria, bacterial and viral infectious diseases affecting all age groups and are responsible for morbidity and mortality. Other problems are such as infestation by hookworms, bilharzias, sleeping sickness and ascaris which cause substantial morbidity, disability and mortality in Tanzania (Kiwara, 1994).

2.2.3 Insurance Schemes

The government of Tanzania operates insurance schemes to help its citizens, with that said, there are basically four health insurance schemes that are publicly owned namely; National Health Insurance Fund (NHIF), Social Health Insurance Benefit (SHIB) established as a benefit under the National Social Security Fund (NSSF) and the Community Health Fund (CHF) and Tiba Kwa Kadi (TIKA). Recent statistics shows that there were about 7 private firms as indicated in the Tanzania Insurance Regulatory authority (TIRA) which were providing health insurance per se, while a few of other general insurance firms combine health insurance benefit under life insurance.

2.2.4 Welfare

Welfare implies the level or standard of living of an individual, household or community. There are two definitions of this concept; the first defines welfare, as needs satisfaction. The more an individual, household or community satisfies its needs, the higher the level of welfare and vice versa (URT, 1999).

The second defines welfare as household's command over resources. This is in terms of health, food, money, property, schooling, working conditions, housing, and security against crime, means of transport, communication and liberty, which enable individuals to lead their lives and satisfy their needs (URT, 1999).

2.2.5 Income

Income is the amount of money that an individual or business receives in exchange for providing a good or service or through investing capital. Income promotes access to basic human needs such as food, shelter and clothing with the current policy reforms, access to health service depends on the earnings of household, due to introduction of cost sharing. Lack of income and production is the major cause and manifestation of the rural poor (URT, 1999).

2.2.6 Who are the Poor?

The poor are defined as those who have little to no money or belongings (Wikipedia, 2018).The definitions and measurements of poverty have evolved overtime. Earlier definitions focused on cost of meeting basic needs necessary for maintaining minimum standard of life. Recent definitions have been made to include socio-economic indicators of well-being. These include; morbidity and mortality,

prevalence of malnutrition, illiteracy, high infant and maternal mortality rate, low life span, poor quality housing, poor social services, inadequate clothing, low per capital income and poor infrastructures. Other factors included are high fertility, low technological expertise, and lack of access to safe and clean water, industrial level, poor education and health services (URT, 2016)

2.3 Theoretical Literature Review

Under the theory of moral hazard, it is postulated that insured people overuse health care services and that patients themselves are a leading cause of health care inflation. If they would just have more "skin in the game" through enough cost-sharing (co-payments, deductibles and other restrictions), it is assumed that costs could be reined in. Overall health care costs are not reduced. Cost-sharing just shifts more costs to patients and families at a time when these costs are already unbearable for many. (John Geyman, 2011)

Meanwhile, the real drivers of health care costs continue unimpeded — perverse incentives within the medical market place that encourage physicians, other providers, hospitals and other facilities to deliver more services, whether appropriate or necessary or not; lack of price controls; blatant profiteering by Big PhRMA, investor-owned hospitals and medical supply companies; introduction of new technologies with lax requirements to document their effectiveness; and excess bureaucracy of our 1,300 private insurers. (John Geyman, 2011)

Although it is now clear that cost-sharing will not fix our cost problems, and will just make patients sicker and increase the numbers of preventable hospitalizations and

deaths, the policy-making community continues to bark up this tree. In fact, all the present trends indicate that increased cost-sharing, promoted especially by the GOP and many willing Democrats, will be imposed across the board in both private and public programs. (John Geyman, 2011)

Cost sharing is the portion of project or programme cost not borne by the sponsor. The "cost share" pledge 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 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, work force and cash.

Meerman (1980), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP. Before introducing cost-sharing policy, Tanzania used to provide basic social services to all citizens free of charge.

The government was the major provider of all health care services and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee. However, following serious economic difficulties, which faced Tanzania during 1980s, traditional donors acquired a new habit of asking for stamp of good economic conduct. This forced

Tanzania to devalue her currency, reduce government expenditures, control credits, raise interest rates and remove subsidies.

Due to this, almost all government owned health centres and dispensaries had no drugs or diagnostic equipment and maternal mortality rates were on the increase (UNICEF, 1990); health workers' morale was at its lowest while attrition was at its highest. In an attempt to arrest the crisis, the government introduced National Economic Survival Program (NESP) for exploitation of local resources and then Structural Adjustment Program (ASP) in which under the economic reforms, the cutbacks on social sector expenditure were affected (Kiwara, 1994). Later in 1991, private practice was officially allowed and government accepted to introduce user fee in all health care providing units under the cost sharing policy.

2.3.1 Structural Adjustment Programmes and the Introduction of Cost sharing

The design and implementation of SAPs in sub-Saharan Africa have come under criticism for not protecting the most vulnerable groups against their adverse impacts. The IMF and World Bank adjustment programmes have for a long time, ignored such issues on the basis that they should be exclusively the prerogative of domestic policy makers (World Bank, 1993).

2.3.1.1 Arguments

The equity argument is quite strong. Sceptics' state that fees affordable to most Africans will not generate enough resources, resulting in a deficit since administrative costs will offset revenues. They further argue that fees will seriously

reduce the access to health, especially for the poor, with important negative effects on health status (Creese, 1991).

Also Gertler (1987) concludes in his study about user fees in Peru that the introduction of user charges reduces access proportionally more for the poor than for the rich, and that they are in that sense regressive. He further argues that while user fees would generate substantial revenues, they would also generate substantial reductions in aggregate consumer welfare with a heavier burden of the loss on the poor. This view is consistent with one of the principles agreed by donors in the Addis Ababa Consensus: "Efforts to reduce costs in the delivery of social services, as well as to increase the efficiency in resources allocations to the primary level, must be considered prior to the introduction of cost sharing" (Ruttens and Dercon, 1998).

From research conducted in Kondoa District, if a maternity patient fails to pay the said amount, the normal procedure is that the patient will be given delivery services but will not be discharged until costs are met (TGNP and GBI research, 1997). In a country like Tanzania where communication is difficult, household surveys are expensive and cannot be done every day. Yet those few which were done show important trends.

The most recently available is the Tanzania Human Resources Development Survey (HRDS) 1992/94 used by the Social Sector Review of the World Bank (1996). This survey showed that people were alienated by poor services especially shortage of

drugs caused partly by mismanagement and scarcity of funds. Health workers attempted to supplement their wages through drug sales.

In Tanzania, establishment of cost sharing on health services was commenced in 1991 in higher – level health facilities like district, region and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998,

2.3.1.2 Health Policy Review and Implementation

The present health policy in Tanzania originated from Arusha declaration of 1967, the country's most popular national policy after independence. Arusha declaration proclaims socialism and self-reliance, which has had important impact on the form and content of the present country's health policy in mainland Tanzania.

Much of the wide-spread health care services infrastructure that is evident now in rural areas of Tanzania mainland is a result of the re-emphasis of the Arusha declaration in 1971. In Tanzania, the Ministry of Health has the responsibility for elaborating the health policy, ensuring that strategies and appropriate program are developed to give effect to the policy.

In the present health policy discussed, the goal is seen to have shifted from having one dispensary in each village to one primary health unit in each village. One dispensary is intended to serve several villages together. In Tanzania, according to

the present health policy, the village primary health care are mainly preventive oriented and only being managed by short term trained health staff. The candidate for training in each village is selected, among the village residents, by the villagers themselves. The primary health care system adopted by Tanzania is viewed as the only way through which it can achieve the social goal of health for everyone by the year 2000, provided the present political will which is evident continue, and enough availability of, human, financial and material resources.

Policy and Regulatory Framework is existence of necessary infrastructure which supports the control, direction or implementation of a proposed or adopted course of action, rule, principle or law. In this case it involves policies and legislations to regulate cost sharing in the provision of affordable quality health care services delivery to Tanzanian.

2.3.1.3 National Policy of Cost Sharing in Health Services

According to the economic crisis in 1980s, costs for health services were increased. However, shortage of budget of the government and high population growth caused the government budget especially of the health sector to be dependent to the donors. This caused the health services to be not sustainable and the community failed to own them properly. For this situation, in 1993, the government decided to involve communities in cost sharing for their health services. The aim of this policy is to expand source of fund for health services in order to stabilize and develop source of revenue for the service provision and minimize dependent of the government on donors (URT, 2014)

2.3.1.4 Exemption of Cost Sharing Policy in Health Services

The government of Tanzania determines the presence of people who cannot afford the cost sharing in health services, people who are in special community groups such as old people who are 60 and above years old, those who have no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income.

Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases. Aim of this policy is to enable all people to receive the quality and quantity health services equally (URT, 2007).

2.3.1.5 Willingness and Ability of Tanzanians to Pay for Cost Sharing in Health Services

The Human Development Survey of 1994 on willingness to pay for desired quality health care at low – level health facilities to assess potential repressiveness of user fees has disproportionately higher negative effect of user fees among the poor compared with the rich (URT, 2003).

Nevertheless, report on program review and strategy development by U.N.F.P.A (June, 1996) claims that, Tanzania is one of the world's least developed countries and poverty profile in December, 1993 shows that approximately 50% of all Tanzanians live in Households classified as poor and more than a third of the total

population live in the households categorized as hard core poor. Some studies asked households directly how much they would be willing to pay for better quality health care. This is an often used, even though at times problematic technique in this field.

Studies in Tanzania (Abel-Smith and Rawal (1992)) suggest that typically people are willing to pay relatively modest sums for health care in return for better quality health services. They were willing to pay most for increased availability of drugs.

2.3.1.6 Impact of Cost Sharing in Health Services

Introduction of cost sharing for health sector therefore might have more impact on health status of Tanzanians who have to pay for treatment of various health problems that face them.

According to Semboja (1994), it is widely believed that implementation of Structural Adjustment Program from which cost sharing policy was introduced has negatively affected social services provisions.

2.3.1.7 Achievements of Cost Sharing in Health Services

Meerman (2013), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP. In Tanzania, establishment of cost sharing on health services was commenced in 1993 in higher – level health facilities like district, regional and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing

ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to charge health services. By the end of 1993, a community health fund was introduced in 36 out of 121 districts in Tanzania (URT, 2005).

An expectation of introducing cost sharing was to improve quality of health services to the people. An attempt to raise funding from the consumers of the public services has been initiated by the "Cost Sharing Policy" which started on a limited scale in 1993 in Tanzania.

However, its impact has been less than significant as a source of revenue for health sector development. It has scored a milestone in making Tanzanians aware of the need to pay for their own health services. According to Munishi (2011), the cost sharing revenue between the years 2010 to 2015 increased from 1% to about 5.8% of the total health sector expenditure. This positive development, albeit in a small way, serves to encourage policy makers to create other mechanisms, hence the motivation to focus on cases in which alternative financing mechanisms are experimented with.

2.3.2 Theories to the Study

This study is supported by two theories which help to lay ground on the theoretical foundation. The chosen theories are performance prism and Maslow hierarchy of needs.

2.3.3 Performance Prism

The impact of cost sharing scheme in health services can be explained by several theories and one of them is the performance prism. It was introduced by Neely, Adams et al. (2001). The theory rests on three major premises. First, the organizations has to take into consideration about the wants and needs of all of their key stakeholders and in order to deliver value to each of them this helps the organization to survive and prosper in the long-term. It is no longer acceptable for organizations to focus on one or two of their stakeholders.

Secondly, the organizations have to align and integrate strategies, processes, and capabilities in order to deliver real value to its stakeholders. Thirdly, the relationship between organizations and their stakeholders is reciprocal – stakeholders have to contribute to organizations as well as to expect something from them. The performance prism, as shown in Figure 2.1 is considered as a second-generation performance measurement framework. It builds on and strengthens existing measurement framework on shareholder value.

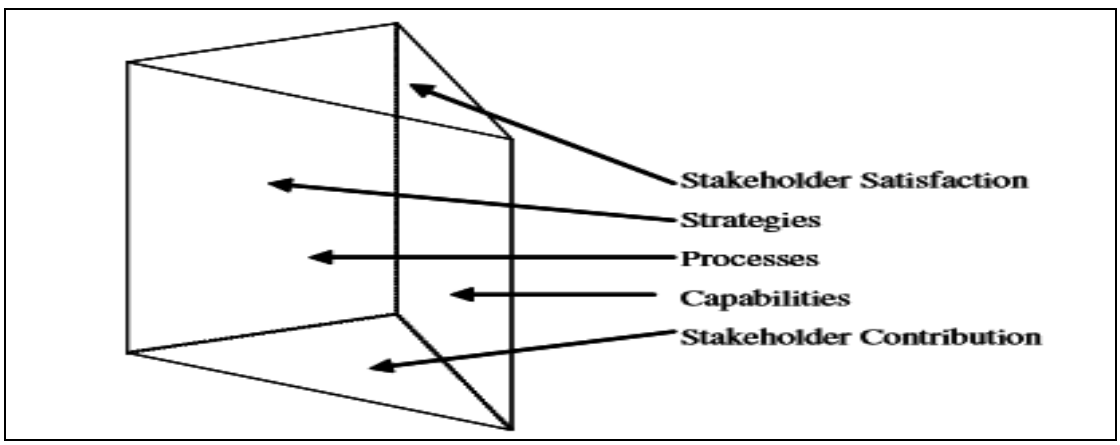

Figure 2.1: The Performance Prism

Source: Neely, Adams et al. (2001)

The rrelevance of the Prism Theory to the Sstudy: The theory emphasizes on the synchronization of key stake holders (patients, government and hospitals) with the organization in making sure that all the activities of the organization are done in line with the needs of the stakeholders in order to satisfy their needs and wants.

Talking about the cost sharing scheme, it implies that hospitals medical services have to focus on the needs of clients who are patients as its key stakeholders. It has been shown in this research work that hospital activities are the reverse of what the theory emphasizes.

The significant feature of the Performance Prism is that the performance measurement should be derived from the stakeholder satisfaction. It changes the usual opinion that is adopted by most performance measurement framework or methodologies, for example, the performance measure should be derived from the strategy technique.

The Performance Prism consists of five interrelated perspectives of performance that pose specific vital questions about:

i) Stakeholder Satisfaction – who are our key stakeholders and what do they want and need?
ii) Stakeholder Contribution – what do we want and need from our stakeholders on a reciprocal basis?

iii) Strategies – what strategies do we need to put in place to satisfy the wants and needs of our stakeholders while satisfying our own requirements too?

iv) Processes – what processes do we need to put in place to enable us to execute our strategies?

v) Capabilities – what capabilities do we need to put in place to allow us to operate our processes?

In the Performance Prism framework, an organization's key stakeholders usually include

i) Investors (principal shareholders, but other capital providers as well);

ii) Customers and intermediaries;

iii) Employees and labour unions;

iv) Suppliers and alliance partners;

v) Regulators, pressure groups and communities.

2.3.4 Abraham Maslow Theory

In the 1940s Abraham Maslow published with his theory of the Hierarchy of Needs. He introduced five categories of needs. The first part relates to for the physiological needs, these are the basic needs such as food, water and sleep. These are all things that people have to possess in order to survive. The second part is consists of safety needs including security of body, employment, property. The third level is for the social needs such as need for love and belonging. The fourth level is for esteem needs. People have a need to feel that they are worth something and are doing

something important. The fifth level is for the self-actualizing needs, a need to have personal growth and to fulfil your potential. (Barnes 2000).

Relevance of Maslow hierarchy of needs to the study: Maslow's hierarchy of needs can also be used when it comes to identifying the impact of health on cost sharing scheme in the hospitals. In this version, the first level is the core product. It is the reason for the customer coming into the hospital for treatment, but many times this part is not paid a lot of attention by medical practitioners in local hospitals. The second level is that of the supporting services and support systems such as extra services and the way health problems are handled. The third level is of technical service such as laboratory services are handled, and this mostly comes into use when something in the first or second level fails and patients need to be able to fix the problem smoothly and to realize to their word. The fourth level is made up by the elements of patient's interactions, or how the health workers treat the patients. The fifth level concerns the emotional elements such as where the feelings of the customer are considered. The totality of the Maslow hierarchy of needs will help to define the level of impact of cost sharing schemes have on local patients in Tanzania.

2.4 Empirical Literature Review

2.4.1 Status of Cost Sharing Policy on Health Delivery World Wide

A 2003 study by the European Commission Directorate General for Employment and Social Affairs found that in all of the 15 European Union countries studied, cost sharing applied to prescription drugs and dental care. About half of the countries (typically those with systems of social health insurance, such as Austria, Belgium,

France and Germany) applied cost sharing to physician and inpatient care, while the half with tax-funded healthcare systems (such as Denmark, Greece, Italy, Portugal, Spain, and the UK) typically did not.

For physician care, cost sharing tended to be co-payments or coinsurance, plus any balance billing by physicians not contracted with the health plan; protection mechanisms included exemptions, reduced rates, or out-of-pocket maximums.

For inpatient care, cost sharing tended to be in the form of a co-payment per day, sometimes also with coinsurance; protection mechanisms included annual out of pocket maximums. For prescriptions, coinsurance was the most common form of cost sharing, with other countries using co-payments, deductibles, and reference pricing (a form of indirect cost sharing); protection mechanisms include exemptions or reduced rates depending on clinical condition, income, or age, and per prescription or annual out-of-pocket maximums. For dental care, cost sharing tended to be co-payments or coinsurance; protection mechanisms included exemptions for children.

2.4.2 Status of Cost Sharing Policy on Health Delivery in Africa

Various studies have been undertaken to assess the impact of user fees on utilisation and efficiency of health services in sub-Saharan Africa but they have yielded conflicting results. First, an increase in demand resulting from quality improvements (Mwabu and Wang'ombe, 1993, REACH, 1994; Maliyamkono and Ogbu, 1999) has been found. Second, some authors have found the tendency of patients to migrate to private sector facilities (Mwanzia and Mwabu, 1992; Deolalikar, 1997). Third, are diction in the utilisation of public services seem to have been the result of the

introduction of user fees in public health facilities (Mwabu and Wang'ombe, 1995; Mwanzia and Mwabu, 1992), coupled by a drop in outpatient attendance for basic curative services by 5 per cent in such hospitals. The drop has been attributed to lack of essential supplies and equipment and failure to control pilferage drugs, bribery ("no money no care") being the common saying, hence resort to use of self-medication or traditional healers.

Finally, an increase in the number of outpatients receiving preventive services in public hospitals but a decrease in private hospitals (Maliyankono and Ogbu, 1999) have been found. Contrary to the above findings, a study by Obonyo (1990) on the impact of cost sharing at Kenyatta National Hospital found declines in utilisation, but also marked improvement in the quality of services provided. However, the study does not point out specific areas/departments where services improved.

On the other hand, where declines in utilisation were recorded, there was a 27 per cent decrease in average monthly utilisation following the introduction of user fees (Quick and Musau, 1994). There were, however, some variations in health facilities across the country—21 per cent at Coast Provincial General Hospital to 31 per cent at New Nyanza and 34 per cent at Nyeri Provincial General Hospital, with no significant recovery during the nine months in which the fee was in effect.

During the period when cost sharing was suspended, the provincial general hospitals experienced significant increases in utilisation. With respect to the effect of cost sharing on quality of services, Quick and Musau (1994) found significant

improvements in the case of provincial hospitals. The study shows that there were significant increases in the percentage of patients rating services provided at the public facilities as good to excellent (24%). Proportions rating the various services and good to excellent were as follows: staff attitude (17%), cleanliness (34%), building appearance (13%), and availability of drugs (27%).Only one indicator - waiting time-were found to have worsened by 10% of those surveyed with 29.

2.4.3 Status of Cost Sharing Policy on Health Delivery Tanzania

Meerman (1980), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP. Before introducing cost-sharing policy, Tanzania used to provide basic social services to all citizens free of charge.

The government was the major provider of all health care services and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee. However, following serious economic difficulties, which faced Tanzania during 1980s, traditional donors acquired a new habit of asking for stamp of good economic conduct.

This forced Tanzania to devalue her currency, reduce government expenditures, control credits, raise interest rates and remove subsidies. Due to this, almost all government owned health centres and dispensaries had no drugs or diagnostic equipment and maternal mortality rates were on the increase (UNICEF, 1990); health workers' morale was at its lowest while attrition was at its highest.

In an attempt to arrest the crisis, the government introduced National Economic Survival Program (NESP) for exploitation of local resources and then Structural Adjustment Program (ASP) in which under the economic reforms, the cutbacks on social sector expenditure were affected (Kiwara, 1994).

Later in 1991, private practice was officially allowed and government accepted to introduce user fee in all health care providing units under the cost sharing policy. In Tanzania, establishment of cost sharing on health services commenced in 1991 in higher – level health facilities like district, region and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to fee health services.

An ability to pay for health service charges is determined by socio economic status of an individual or household, thus, the poor are not able to pay while the rich are able (World Bank 1987, 1993, 1994). Nevertheless, report on program review and strategy development by U.N.F.P.A (June, 1996) claim that, Tanzania is one of the world's least developed countries and poverty profile in December, 1993 shows that approximately 50% of all Tanzanians live in households classified as poor and more

than a third of the total population live in the households categorized as hard core poor.

A study in Tanzania showed that private voluntary hospitals and dispensaries report that 70% and 40%, respectively, of their patients may have some difficulty making full payments. Most of these facilities had some exemptions: for example, 90% of the hospitals and 20% of the dispensaries exempt the disabled; less than a fifth of hospitals and virtually no dispensaries allowed children under five, or people with chronic diseases to be treated for free (Mujinja and Mabala 1992).

Massaga, et al. (2000) in the research to study health care financing mechanisms appropriate for the poor and vulnerable groups, carried out in Korogwe district. The study concluded that, although residents finds private health care facilities acceptable, many concerned about how much they need to pay, why they should pay, and what means of payment they can use. Thus, to enhance community participation in payment for health care, efforts needed to educate and sensitize the population regarding the cost-recovery programs that exist.

Shole (2009) in the research on the impact of cost sharing in health services in Tanzania carried out at Geita district. The study concluded that Information on cost sharing policy does not reach well the health service users especially rural people. Therefore, lack of good procedure for sensitizing any policy before starting implementation is a big problem in the study area. Majority 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. Many people have negative attitude on cost sharing for health service. This is because they do not see an expected highly positive improvement of health service delivery.

People have started to deny health service provision under cost sharing. This is due to unavailability of medicine most of the time and low health workers with low education level and low morale to work.

Both heads of household and health workers appreciates traditional healers since they use traditional medicines services by natural trees and at low cost compared to cost sharing in health services also Exemption policy treatment for preferential group i.e. the old and disabled people is not well known to some health workers and the community.

Meerman (1980), noted that the cost of financing the basic human development package of education and health implies budget short falls for average developing countries as high as 17% of GNP. In Tanzania, establishment of cost sharing on health services commenced in 1993 in higher – level health facilities like district, regional and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to charge health services. By the end

of 1993, a community health fund was introduced in 36 out of 121 districts in Tanzania (URT, 2015).

According to Manisha (2001), the cost sharing revenue between 1993 to 1998 increased from 1% to about 5.8% of the total health sector expenditure in 1998. This positive development, albeit in small way, serves to encourage policy makers to create other mechanisms, hence the motivation to focus on cases in which alternative financing mechanisms are experimented.

Generally, before cost-sharing policy commencing in Tanzania, various constraints faced health services includes;

i) Units were without adequate furniture,
ii) Medical structures of facilities were deplorable; some had bats flying all over,
iii) Lacked essential equipment for treatment of diseases, even simple gloves,
iv) Some unit slacked beds and mattresses, clinical officers' and
v) Other lacked decent accommodation, personnel were incompetent and issued wrong prescriptions,
vi) Attitudes toward customers were poor and rude, bribery went with service delivery to customers,
vii) Health personnel had low morale at work, under dosage was a common prescription, opening and closing time depended on staff.

Also in 1980s, some units opened as late as 11 am, drugs shortage was common, drugs available at the beginning of the month, drug shortage caused, under dosage of

Prescription and unnecessary referrals, drug shortages caused overcrowding at the time when drugs are available.

Limited services due to limited drugs and equipment, staff have no uniform, incompetent staff were unable to use available equipment, unmotivated staff, unofficial charges of between Tshs. 2000 to 3000 were common or services which should bear no charge, unqualified staff were employed, poor supervisory services, little or no community public owned units and limited services mix (Urio, 2016).

The government of Tanzania determines the presence of people who cannot afford the cost sharing in health services as people who are in special community groups: such as old people who are 60 and above years old, those with no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income.

Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases. Aim of this policy is to enable all people to receive the quality and quantity health services equally (URT, 2007).

2.5 The Conceptual Framework

Based on the scope of literature reviewed above, a conceptual model is developed as shown in Figure 2.2 to present the relationship between cost sharing and health care service delivery.

In this conceptualized model service environment, obstacles and performance are the explanatory variables while Health care service delivery is the dependent variable. The proposed conceptual linkages of these variables were depicted from the literature review. Several authors suggested the following independent variables in the assessment of the impact of cost sharing mechanism in healthcare service delivery (Ekumah, 2001). Service environment (Ellis, 2000). Obstacles and performance (De Ferrant, 1985).

Service Environment is the hospital environment in which medical service is provided and this involves factors of convenience, affordability and accessibility of service. Obstacles refer to the difficulties that patients experience when they visit the hospital; it includes quality of medical personnel, morale of personnel and the availability of drugs. Performance variable consists of quality of equipment such as laboratory, beds and queuing time as well as the price of medications.

Shole (2009) in the research on the impact of cost sharing in health services in Tanzania carried out at Geita district found that 80 percent disagree that cost sharing for health services provision is affordable while 17 percent could not decide and 3 percent agree. This explains that most of the people in the study area do not afford cost sharing for health services.

Mushi (2014) in the research on the impact of cost sharing on utilization of primary health care services. The findings of the study indicate that quality of primary health

care has improved as a result of the introduction of cost sharing. Attendance and hence utilization in health facilities has increased. Mortality rate, at least for one district has not worsened. By implication then, cost sharing appears to have a positive impact on the provision of primary health care, except for few cases that fail to consult because of the fees. An appropriately managed exemption facility is likely to eliminate the negative impact.

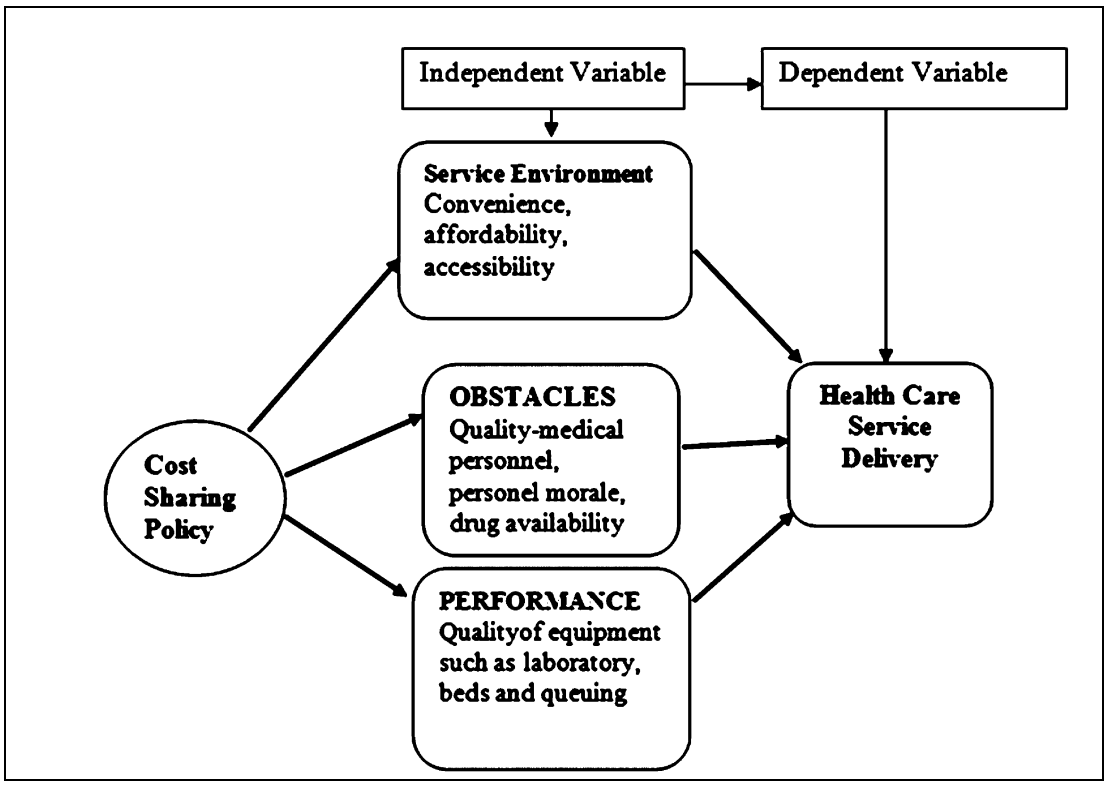

Figure 2.2: The Conceptual Framework of Cost Sharing in Health Service Delivery

Source: Researcher own Developed model, (2018)

The conceptual frameworks explain the relation between dependent and independent variables where by Dependent variable is Healthcare service delivery and independent variable is services environment (Convenience, Affordability and

Accessibility). This signifies that each factor for health care service delivery has got some variables that characterize the respective factors influencing health care service delivery. An attempt was made to find out the extent of the effect of the independent variable on health care service delivery.

2.6 Research Gap

Much has been done by previous researcher concerning the assessment of the impact of cost sharing mechanism in health service delivery in different geographical area, and came up with various findings on the reasons largely centred on the reasons for low enrolment rate, poor coverage and willingness of the community to join health schemes.

Although a number of cost sharing scheme on health services in Tanzania have been implemented but gaps quality of findings still differs in terms of the number of the respondents in the said studies, the time at which these studies have been undertaken and the study area in which previous studies were conducted. This study will be the most current in terms of time to the knowledge of the researcher and the findings in Ilala Hospital will shed light to the impact of cost sharing schemes in Tanzania thus closing the gap of research quality and relevance of time.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 Overview

This section presents research methodologies that have been deployed during the research study. It consists of descriptions of research design, area of study, population of the study, sampling design and sample size, data collection methods and tools, data analysis, reliability and validity and expected results.

3.2 Research Design

The research design is the outline or plan that is used to generate answers to research problems (Kothari, 2015). It is a method of collecting information by interviewing or administering questionnaire to a sample of individuals, the main purpose of the descriptive design is to describe the state of affairs as it exists. Descriptive design is used when the problem is well defined and the research task is to describe the characteristics of something such as people, firms or products (McGregory, 2015). Robert (2016) says descriptive studies are a kind of snapshot analysis about a problem and it is employed when a researcher already knows about a problem. In line to the above mentioned aspects of research design, a descriptive design was used in this study because the researcher wanted to show the snapshot analysis of the

impact of cost sharing scheme in Tanzania and give recommendations for the improvement.

3.2.1 Research Approach

A qualitative research approach was chosen as the methodology for this study because it reinforces an understanding and interpretation of meaning as well as intentions underlying human interaction.

Data was collected using in-depth interviews. In qualitative research the objective is exploratory and descriptive rather than explanatory (Schurink, 1998).

The descriptive nature of qualitative research allows the researcher to provide a description of the experiences of the participants, which sustained the theoretical assumptions on which the study is based (Meyer, 2001). The descriptive nature of qualitative research enables readers to understand the meaning attached to the experience, the distinct nature of the problem and the impact of the problem (Meyer, 2001).

3.3 Area of the Study

The study was conducted at Amana Hospital located in Ilala municipality in Dar es Salaam. Ilala municipality is one of Dar es Salaam's three municipalities; the other two are Temeke and Kinondoni. Administratively, Ilala municipality is divided into 3 divisions, (Ilala, Ukonga and Kariakoo), 26 wards, 65 sub-wards, 9 villages, and 37 hamlets. According to the 2012 National Census, the Ilala municipality had a population of 777,364 projected Population and Housing Census (2012).

Amana hospital was used as a case study to represent other health institutions in the public sector. The reasons for selecting Amana hospital among the existing big hospitals which serve large population based on the accessibility. Amana Hospital was involved in the cost sharing in early days of its implementation in Tanzania Furthermore the researcher is resident in Ilala municipality and as such is familiar with Amana hospital environment.

Amana hospital is located in a municipality with a populous and economically diverse population. The population is expected to provide a sample for this study that informs on cost sharing policy and health service delivery nationally. Also the infrastructure is well developed. The economic activities of the residences range from formal sector employment and informal sectors including petty traders. This provides a wide range of income for persons in the municipality impacting on their ability to share in their medical costs.

Amana Hospital was established in the year 1954 as a dispensary. In 1982 it was upgraded to become a health centre and in 1990 the hospital was upgraded again to become a Municipal/District hospital. In October 2010 the hospital was announced by the Government Gazette as a regional referral hospital with 350 workers of different carders. The hospital has a high number of patients, it is estimated that more than 250 patients visit the hospital daily (URT, 2017)

Amana Hospital serves more than 200 surrounding health centres and District Hospitals. Other patients going to Amana come from other neighbouring districts such as Temeke and Ubungo.

The services offered by the hospital include General Clinical Services Malaria Diagnosis and Treatment, TB Diagnosis, Care and Treatment, Cardiovascular Care and Treatment, HIV/AIDS Prevention, HIV/AIDS Care and Treatment, Therapeutics, Diagnosis Services, Reproductive & Child Health Care, Services, Growth Monitoring/Nutrition and Surveillance, Oral Health Services(Dental Services),Sterilization and Infection Control, Support Services, Emergency Preparedness.

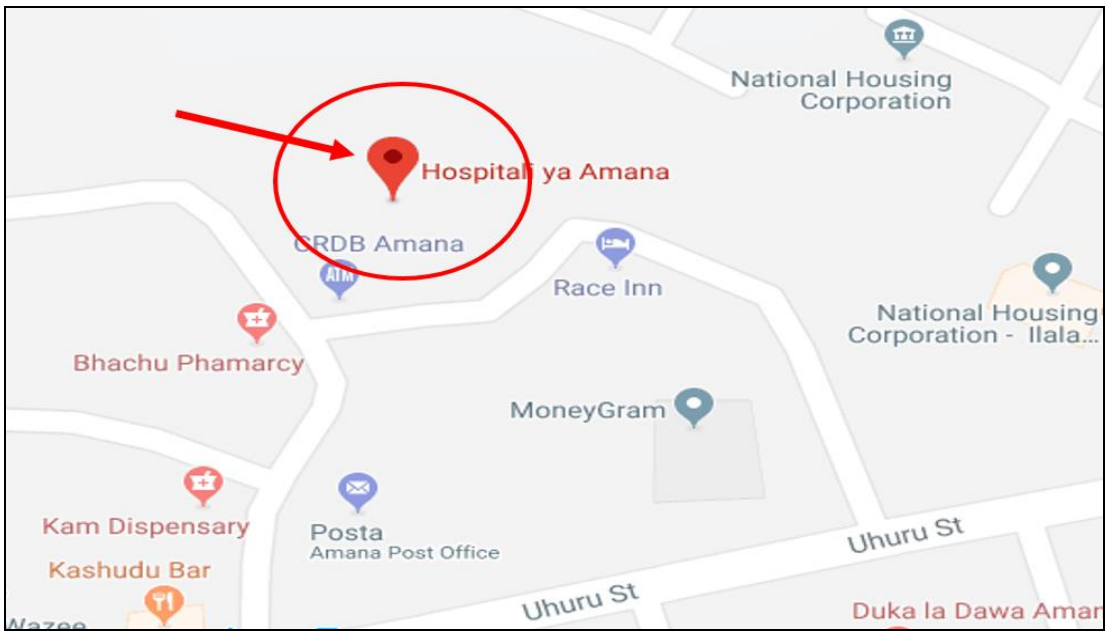

Figure 3.1: A Map Showing the Location of Amana Hospital in Dar es Salaam

Source: Google Map 2018

3.4 Targeted Population

Population refers to a large group of people possessing one or more characteristics in common on which a research study focuses (Creswell, 2012). The target population is a group of subjects from whom the researcher expects to draw conclusions about the research topic (Kothari, 2004). In this study the total targeted population was 150 includes 2 doctors, 5 nurses, 1 accountant and 100 patients at Amana Hospital.

Doctors were be included because of their specialised knowledge in medical treatment and their routine contact with patients, nurses were included because of their frontline role in treatment hierarchy. Accountants are included because of their contact with patients on issues related to payment of medical services and lastly patients because they are the main focus of the study.

3.5 Sampling Design and Sample Size

3.5.1 Sampling Design

According to Kothari (2004) sampling design and procedures involves the decision to the type of sample and technique to be used in selecting the items for given sample.

3.5.1.1 Sampling Technique

Due to the nature of the study, stratified and non-probabilistic (judgmental) techniques was used in the sample selection. This sampling technique is applied where a researcher based on established criteria would choose respondents (Robert, 2015). The respondents who delivered data included Doctors, Nurses, Accountants, Administrators and Patients. The various categories of Amana hospital employees are determined in expectation of providing required data by focusing on respondents

with the necessary expertise or experiences with regard to health care service delivery. Patients were randomly selected on the hospital premises after having been stratified into outpatients and inpatients and they were guaranteed of anonymity and confidentiality.

3.5.2 Sample Size

Sample size refers to the number of items to be selected from the population to constitute a sample (Dryden, 1995). The size of the sample should be optimum (Kothari, 2014) and an optimum sample is the one that fulfils the requirements of efficiency, representativeness; reliability and flexibility (Dryden, 1995). Therefore, the size of sample needed depends in part on the size of the margin of error that is acceptable to the researcher and the size of the population from which the sample was drawn (Saunders et al., 2009). As such the final sample size is both a matter of judgement and calculation (Colin Fisher et al. 2010).

In this study a total sample size of 108 was selected. The study targets 95 patients as respondents and 3 respondents were Doctors, 8 Nurses, and 2 Accountants. The selection of the sample was derived from Saunders et al (2009) suggest that the size of the population at 95 percent confident level with 5 percent margin of error the targeted population of 150 is represented by a sample size of 108 The said sample size is manageable in terms of time and resources available. This enabled the researcher to finish a research project in time. Be it known that a research project in an academic project has specified duration upon which a student has to finish one’s work.

Table 3.1: Sampling Plan

S/N	Respondents	Number of Respondents	Percentage of Respondents (%)
1	Patients	95	88
2	Doctors	3	3
3	Nurses	8	7
4	Accountants	2	2
Total		**108**	**100**

Source: By Researcher, 2018

3.6 Data types and sources

Data collected for this study was of two forms, that is primary and secondary data.

3.6.1 Secondary Data

Secondary data are information gathered from other previous studies, e.g. published material and information from internal sources such as raw data and unpublished summaries (Mbogo et al., 2012). Documentary review entails gathering information from recorded documents (Best and Khan, 2013). Review of documents is a process of reading with or associated with issues related to what the researcher is studying (Borg and Gall, 2015).

The secondary data for this study came from various sources such as ministry of Health which provided information on health policies and services, Amana Hospital provided documents on the impact cost sharing and problems encountered by stakeholders visiting the facility and on line journals such as EMERALD provide the worldwide view of the practise of cost sharing on health services that may print a picture on the relationship between cost sharing and health care delivery. Other

Libraries such as REPOA, ESRF and the Open University of Tanzania provided information related to the subject.

3.6.2 Primary Data

Primary data are afresh information gathered directly from fields (Mbogoet al., 2012). Primary data is fresh, first-hand information and original in character intended for the research being undertaken (McGregor, 2015). Primary data is important for all areas of research because it is the direct information about the results of an experiment or observation.

3.6.3 Primary Data Collection Methods and Tools

The following data collection tools was used to gather primary data that include interviews and Questionnaires. In each method a tool relevant to it has been outlined.

3.6.3.1 Interview

Mbogoet al. (2012) defined interview as a data collection technique that involves oral questioning of respondents, either individually or as a group. According to (Kothari, 2004) the interview is a type of data collection method which involves presentation of oral-verbal stimuli and reply in terms of oral- verbal responses. In this study the researcher used the face-to-face interview as it offers high accuracy data (Kothari, 2014). To add on that interview in this study offered the following advantages: it is highly flexible, allows a more permissive atmosphere than the case when using other techniques of investigation (Young, 2001). A tool used in this study was a structured

questionnaire employing a 5-point Likert-type rating scale was used to collect the required data. Also open and closed questions were used where appropriate.

3.6.3.2 Documentary Review

Documentary review enables the researcher to learn what has been written by other scholars on the same or similar subject and thus being able to pointing out what knowledge gaps still exist. Indeed, this method is more economic as it saves time and money since the data already exist for answering research questions (Kothari, 2004). Documentary review in this study was involved to review of existing literatures that provided key concepts currently in use in the area of interest. The researcher also consulted various material records documents, books, journals and websites with information relating to research topic. This method of data collection is suitable because participants may fail to respond to all imposed questions due to lack of correct memories and shortage of time.

3.7 Reliability and Validity of Data

Reliability and validity are two important aspects of a research project, they show the correctness of the Instrument (questionnaire) used to collect data and therefore that can be relied upon. If the two criteria (reliability and validity) are met in a given research, then the chances are high that the research work is of the desired quality and can be used with confidence to whoever the research work is intended to.

3.7.1 Validity

Validity refers to degree to which the instrument is capable of measuring what it is supposed to measure accurately, effectively and efficiently (Omari, 2011).It is the extent to which inferences, conclusions and decision made on the basis of test scores are appropriate and meaningful(Banks, 2005). The researcher took a number of different steps to ensure the validity of the study; Data were collected from reliable sources, Questions to be based on the literature review and conceptual framework and the questionnaires were pre-tested by a small number of carefully selected respondents to make sure that they are well understood and measure what they are supposed to measure.

3.7.2 Reliability

Reliability is whether the instrument is likely to give consistent results across time, place, similar instrument, irrespective of who is using it, (Omary, 2011). Also Reliability is concerned with consistency of responses with which the repeated measure produces the same results across time and respondents (Saunders et al. 2007).

3.7.3 Ethical Considerations

Research ethics refers to the type of the agreement that the researcher enters into with the research participants. According to Best & Khan (2014) ethical issues in research fall into one of the five categories, which are protection from stress, harm, or danger; informed consent; right to privacy; confidentiality; and honesty with professional colleagues.

Before conducting the study, the researcher addressed important issues as follows: first, obtaining permission from The Open University of Tanzania and from the Amana Hospital seeking and consent from the respondent second, participant's confidentiality was guaranteed as none of them had to fill one's name on a questionnaire. Thirdly the subject matter was introduced in the introductory note attached to questionnaire. Other aspects include: -

(i.) Participation in the research is voluntary

(ii.) Participants must be fully informed.

(iii.) Participants were assured that their answers would be treated as confidential and used only for academic purposes and only for the purposes of particular research during the conduction of the research.

3.8 Data Analysis

According to Kombo and Tromp (2015) Data analysis refers to examining what has been collected in survey or experiment and making deductions and inferences. This implies computation of certain measures along with searching for patterns of relationship that exists among data groups (Chamwali, 2007). Data analysis usually involves reducing accumulated data to manageable size, developing summaries, looking for patterns and applying statistical techniques (Cooper and Schindler, 2006). Data collected in this study through questionnaires were edited, coded, summarized, classified, tabulated and finally analyzed by using the appropriate computer software package (SPSS V.20). The findings are presented using frequencies, tables and graphs. Linear regression Model was used to test the

Hypothesis (There is no significant relationship between associated factors of cost sharing and accessibility/affordability of health services).

3.9 Scope

The scope of this study was be restricted to Dar es Salaam where Amana hospital in Ilala district is taken as a representative for the experience of other areas of Tanzania. As such it can be a reflection of the health sector in Tanzania mainly focused on the impact of service environment, obstacles and performance in terms of cost sharing on heath service delivery.

3.9.1 Delimitation and Limitation of the Study

This study is expected to meet hurdles on the way; financial constraint is one of them. The meagre financial resources at the disposal of a researcher may negatively affect the timely preparation of the research report. Money is needed for stationery work and a paid third part (Language Editor) is needed for proof reading the entire. Time is not friendly to a researcher, the short time available between proposal work and time of submission may negatively affect the intensive of information presented in the final report.

Health issues bear sensitivity. Some respondents are not used to filling the questionnaire health issues as they equate to it as revealing their health status. Moreover, some would think money would be a given to those participating in the study. Despite the above limitations, the researcher is confident that the data collected are reliable.

3.10 Expected Findings

It is expected that the findings of this study assisted a researcher to come up with new findings on the impact of cost sharing in health care delivery. The said findings show a light at the end of the tunnel on how to manage the cost sharing scheme in Tanzania as far as health care delivery is concerned.

CHAPTER FOUR

4.0 RESULTS AND DISCUSSION

4.1 Overview

This chapter focuses on the results of the study and some important issues surfaced up during the study. The results and discussion of the findings have been presented in line with the study specific objectives.

4.2 Demographic Characteristics of the Respondents

The section presents background information concerning the respondents; it presents respondents variability in their profiles based on the questions asked. This intends to explore composition of respondents in terms of age, gender, occupation, level of education, marital status, and monthly income at Amana Hospital.

4.2.1 Age of the Patients Respondents

The study results in figure 4.1 below indicate that out of 95 patient respondents 1.1 percent belongs to age group 64 and above. 3.2 percent came to be the age group 10-18 years. The age range 19-27 made up 8.4 percent. However, 28-36 age category made up 29.5 percent 34.7 percent consisted of 97.9 percent and lastly the respondent's age between 55 and 63 made up of 2.1 percent.

From the finding shown in figure 4.1 it shows the majority of the respondents falls under the age group 37-45 forming the 37 percent, this age group is awareness of health issues and are regular hospital Goers. On top of that this group has the ability

to pay for health services. It comprises of people who are active and engage in working activities that help the respondents earn income for living.

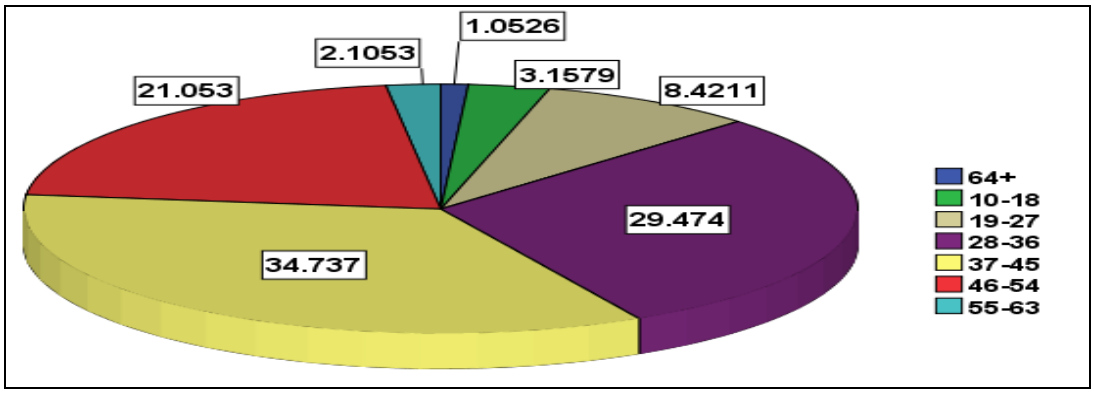

Figure 4.1: Age of the Patients Respondents

Source: Field Data, 2018

4.2.2 Gender

The Figure 4.2 below show the survey results of 95 participants. It was revealed that 33.7 of the patients were males and 63.3 percent were females. The findings show the majority of the respondents are women. It has happened so because women due to the nature of their biological make up fall sick more often than men and they are the ones who carry children and other relatives to the hospital.

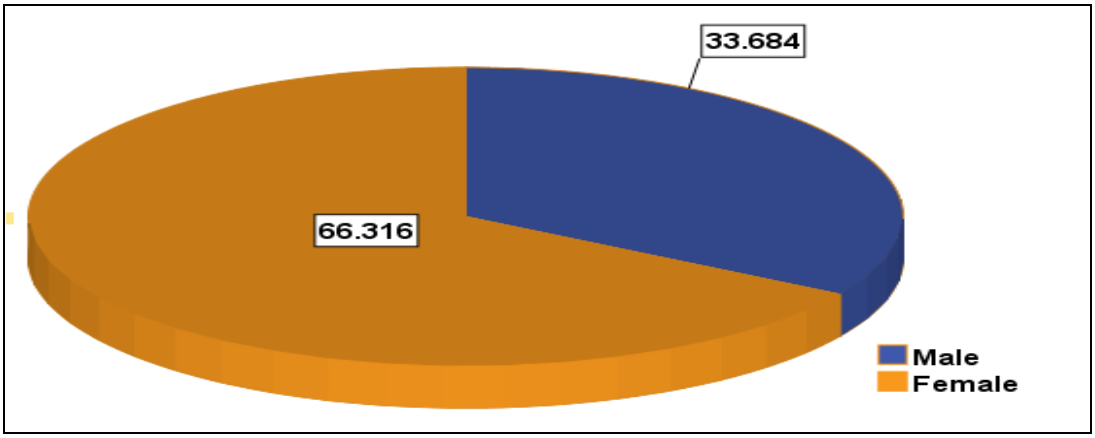

Figure 4.2: Gender

Source: Field Data, 2018

4.2.3 Occupation

The survey results show that patients who were self-employed were 13.7 percent. Civil Servants were 21.1 percent. However, entrepreneurs were found out to be 47.4 percent. The unemployed made up 14.7 percent. Lastly the private sector employee made up 3.2 percent. The majority of the respondents have employed themselves (entrepreneurs) because of high rate of unemployment in the country.

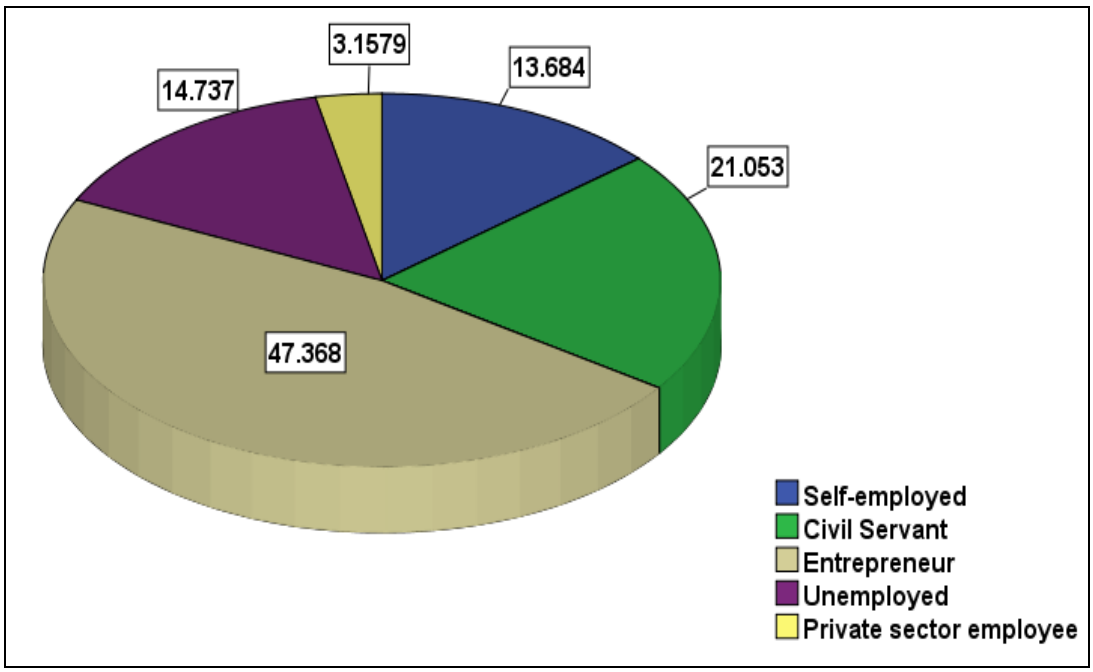

Figure 4.3: Occupation

Source: Field Data, 2018

4.2.4 Level of Education

From the figure 4.4 below it shows that patients who had educational background were 5.3 percent, for the primary school the percentage accounted for was 34.7. In addition, 33.7 percent was connected to secondary school participants. Lastly the participants whom had college or university education were 26.3 percent. The findings show that most of the respondents (33%) have secondary school education a

situation caused by rigorous efforts by the government to provide free education to its citizens. On top of that the rate of passing examination at primary school has gone up thus pushing more students to secondary school level. With secondary level education it means citizens are becoming aware of health of health issues.

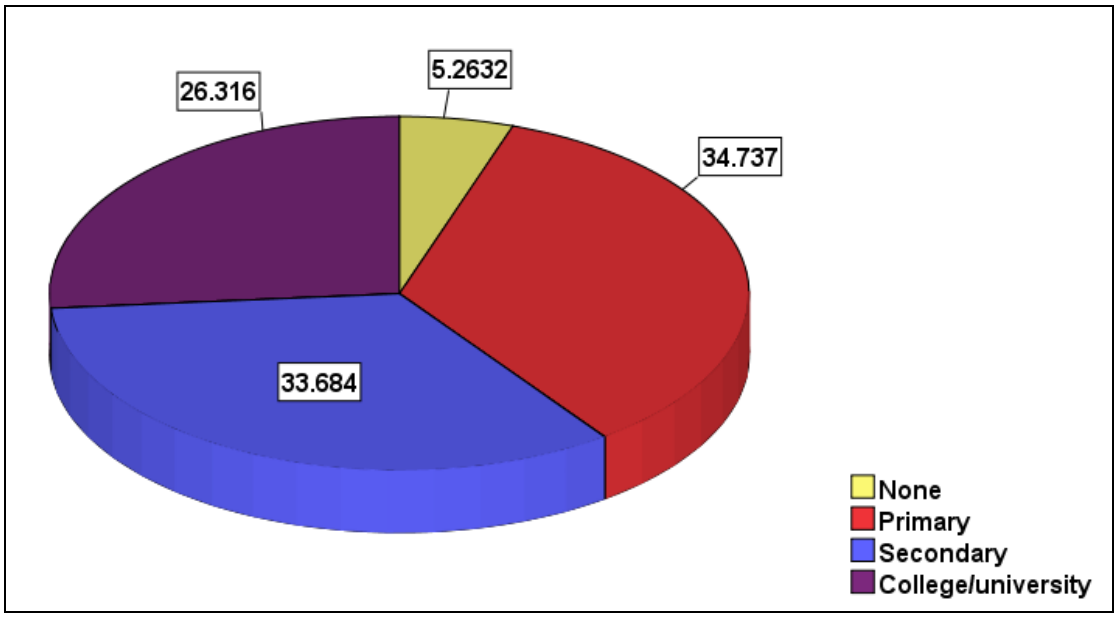

Figure 4.4: Level of Education

Source: Field Data, 2018

4.2.5 Marital Status

The findings on the marital status are portrayed by the figure 4.5 below; the participants who were single were 45.3 percent, married made up 44.2 percent, divorced were 5.3 percent and widows were 5.3 percent. The findings show that married couples form the majority of the respondents because of the roles they play in a society; they are raise children and take care of family members in important issues including sending some of the family members to the hospital.

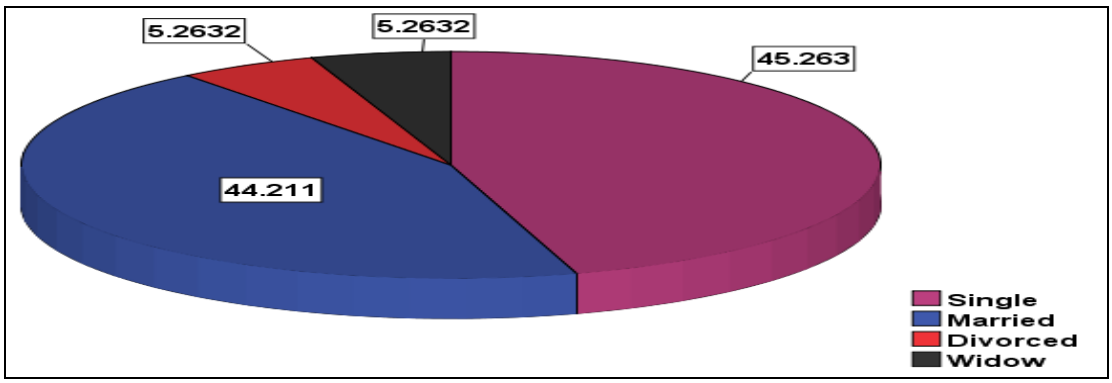

Figure 4.5: Marital Status

Source: Field Data, 2018

4.2.6 Monthly Income

From the survey results, it has been revealed that participants with income of more than 620,000 and above were 7.4 percent.12.6 percent was attributed to participants with income below 200, 000.the income range 220,000-300.000 made 23.2 percent. 320,000-400,000 were 27.4 percent. The participants with income range 420,000-500,000 made up 189 percent. Lastly, participants with income 520,000-600,000 made up 10.5 percent. Respondents with income level between 320,000-400,000 form the majority (27.3%) of the sample because they are small entrepreneurs and the said income level is the average income earned per month by this group.

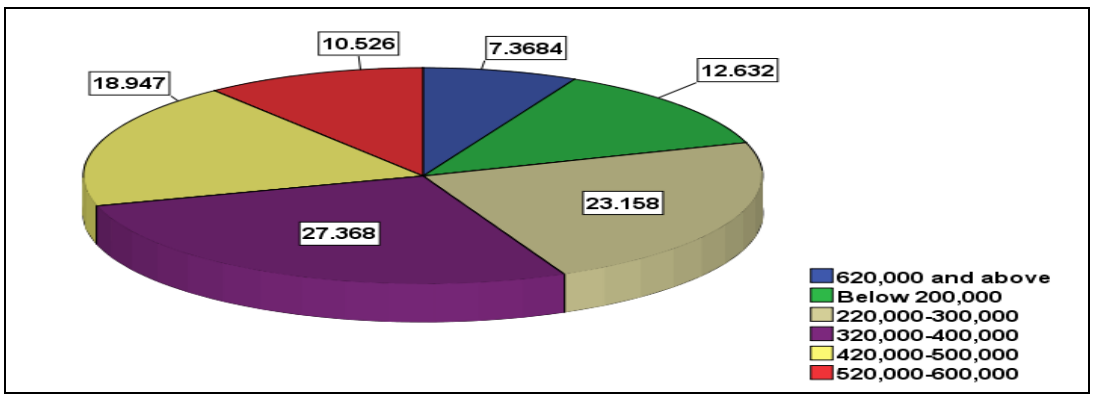

Figure 4.6: Monthly Income

Source: Field Data, 2018

4.2.7 Management Composition

The study revealed that management composition consisted of doctors (15.4%), nurses (69.2%) and accountants (15.4). The figure 4.21 below potray the study findings.

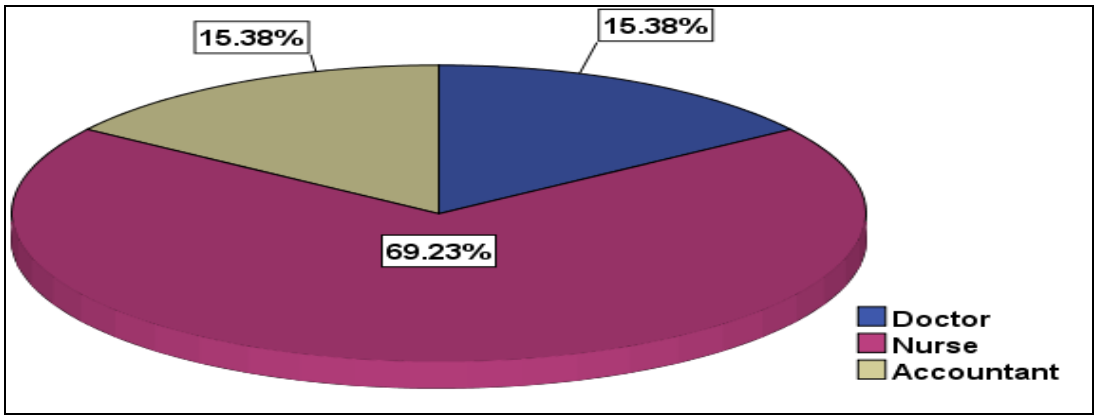

Figure 4.7: Management Composition

Source: Field Data, 2018

4.3 Healthcare Accessibility

Accessibility to heath care formed the first part of the specific objective. Response was thought from participants to answer questions pertained to the said objective. Both heath workers and patients were asked a series of questions in order to solicit for the answers.

4.3.1 The Extent of Heath Care Services Accessibility (Health Care Information)

This question was posed to patients who went to Amana hospital for treatment. From the figure 4.7 below it was revealed that 21.1 percent of the patients had no opinion on the subject matter, 21.1 percent of the 95 participants said that the services are not

accessible. However, 43.2 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 13.7 percent.

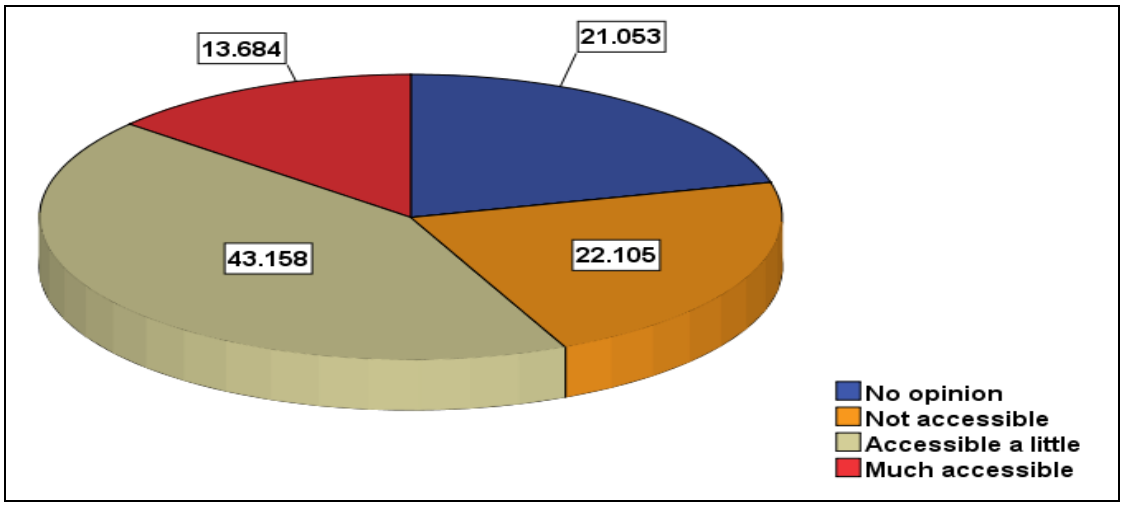

Figure 4.7: The Extent of Heath Care Services Accessibility (Health Care Information)

Source: Field Data, 2018

The above findings show that the majority of participants have little access to medical services. Little information means people are not aware of the health matters. This finding is supported by a study done by Stephen 2016 on Cost Sharing and Access to Health Care in Tanzania. He revealed that Tanzanian citizens have little access to medical services and rely on herbal medicines. Little access is caused by the lack of information on health issues basic rights in accessing medical services.

4.3.2 The Extent of Heath Care Services Accessibility (Retrieve of Patients Records)

From the figure 4.8 below it shows that that 16.8 percent of the patients had no opinion on the subject matter, 35.8 percent of the 95 participants said that the

services are not accessible. However, 29.5 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 17.9 percent.

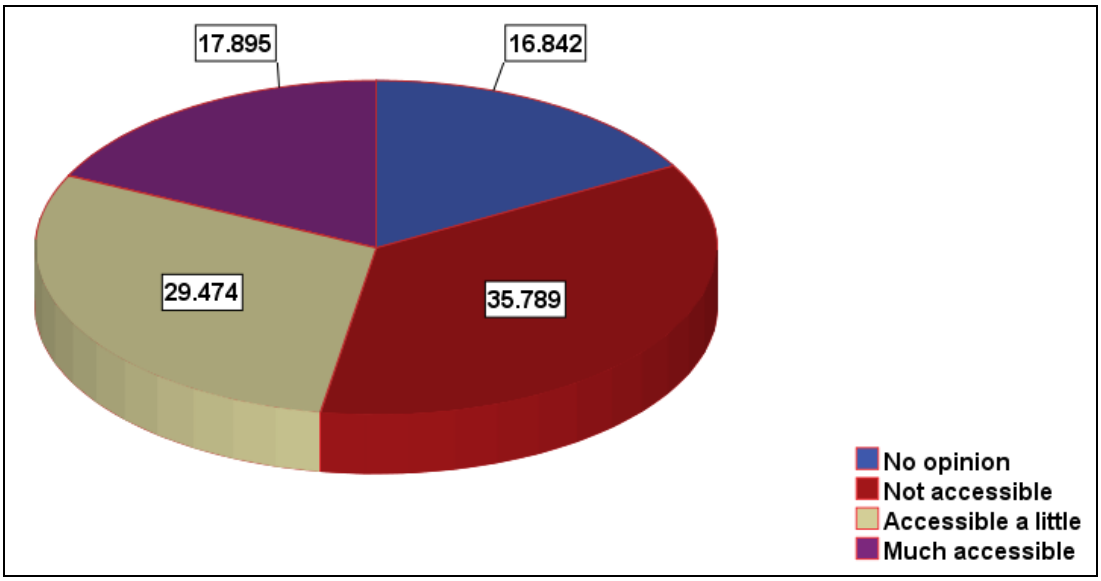

Figure 4.8: The Extent of Heath Care Services Accessibility (Retrieving of Patients Records)

Source: Field Data, 2018

From the figure 4.8 above it shows that majority of participants about 65 percent having the opinion (not accessible and accessible little) admit that patient's records can hardly be retrieved easily. A situation where a patient takes a long time to wait for the records retrieval means dissatisfaction of the service and chances of the same patient to seek the same service is minimal.

This finding is supported by a study done by (Chamwali, 2006) who found that difficulties in retrieving patient's records were common in African countries and Tanzania in particular. Weak network continues to pose problem in retrieving

patients record, during a study a researcher observed some patients waiting for quite some time because computer network went down.

4.3.3 The Extent of Heath Care Services Accessibility (Distance)

From the figure 4.9 below it shows that 2.1 percent of the 95 participants said that the services are not accessible. However, 45.3 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 52.6 Percent.

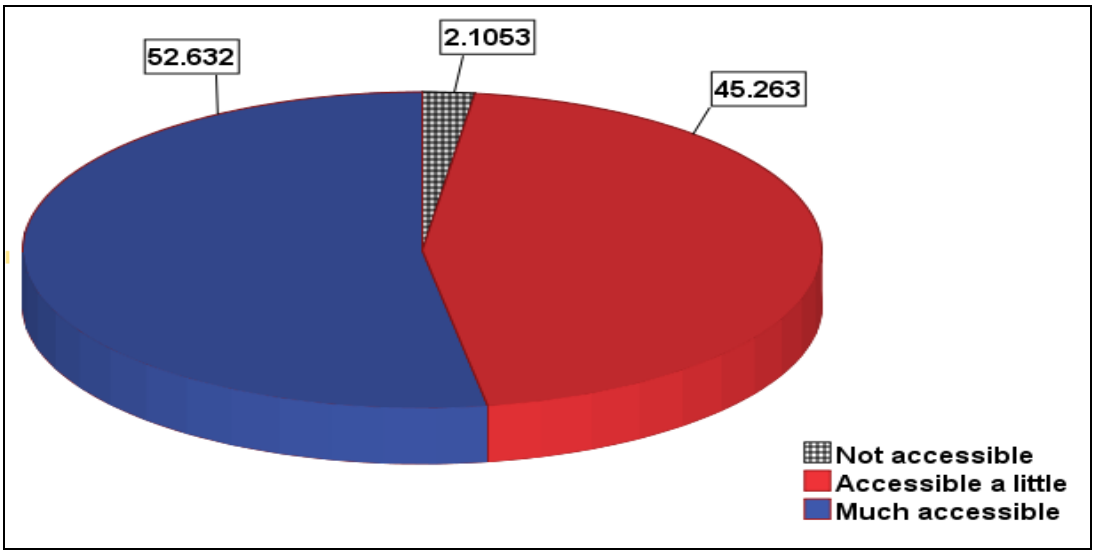

Figure 4.9: The Extent of Heath Care Services Accessibility (Distance)

Source: Field Data, 2018

The Figure 4.9 above show that a bigger portion (45%) of the participants have difficult in accessing the medical services because of the distance. This finding implies that people a considerable percentage of people do not attend hospital treatment because of distance especially in rural areas where road infrastructure is highly impaired. In the case of pregnant women this scenario means high death rate

because of home delivery. This finding is supported by a study done by (Ntahosanzwe, 2013) who found that medical centres built a big distance from the people's localities continue to pose serious problems in Tanzania.

4.3.4 The Extent of Heath Care Services Accessibility (Drug Availability)

From the figure 4.10 below it shows that 4.2 percent of the 95 participants said that the services are not accessible. However, 61.1 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 34.7 Percent.

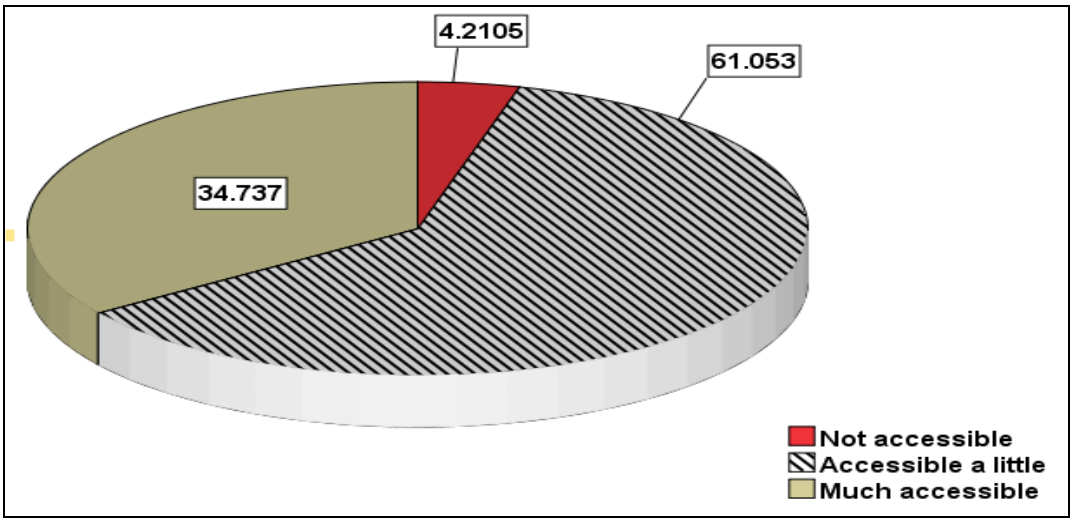

Figure 4.10: The Extent of Heath Care Services Accessibility (Drug Availability)

Source: Field Data, 2018

The majority of the respondents (61%) have little access to health care services due to drugs availability. This situation causes some patients to seek improper medical services such going to the traditional healers or seek medical advice from non-medical people such as friends. This finding is supported by a study conducted by

(Ntahosanzwe, 2013) who found that majority (85%) of respondent revealed that lack of essential medicine in public hospitals in Tanzania is a major challenge.

4.3.5 The Extent of Heath Care Services Accessibility (Administration Process)

From the figure 4.11 below it shows that 21.1 percent of the 95 participants said that the services are not accessible. However, 41.1 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 37.9 percent.

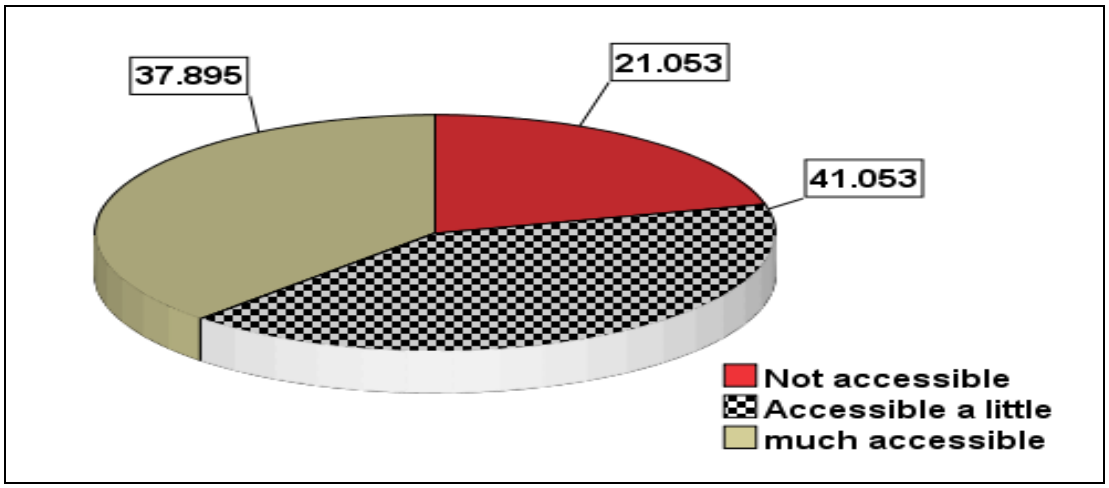

Figure 4.11: The Extent of Heath Care Services Accessibility (Administration Process)

Source: Field Data, 2018

The study has revealed that 62 percent of the respondents (not accessible and accessible little) maintain that they have little access to medical services because of the administration process. The situation where people cannot access medical services because administration process is cumbersome it means patients become dissatisfied and seek short cut ways to services including giving corruption to some

unethical staff. This finding is supported by (GDC, 2009) who found that administrative process such as locating patients record takes a long time in public hospital in Tanzania.

4.3.6 The Extent of Heath Care Services Accessibility (Level of Information Provided)

From the figure 4.12 below it shows that 7.4 percent of the 95 participants said that the services are not accessible. However, 47.4 said that the services are accessible a little. The section of the participants who said that the service was much accessible was 45.3 percent.

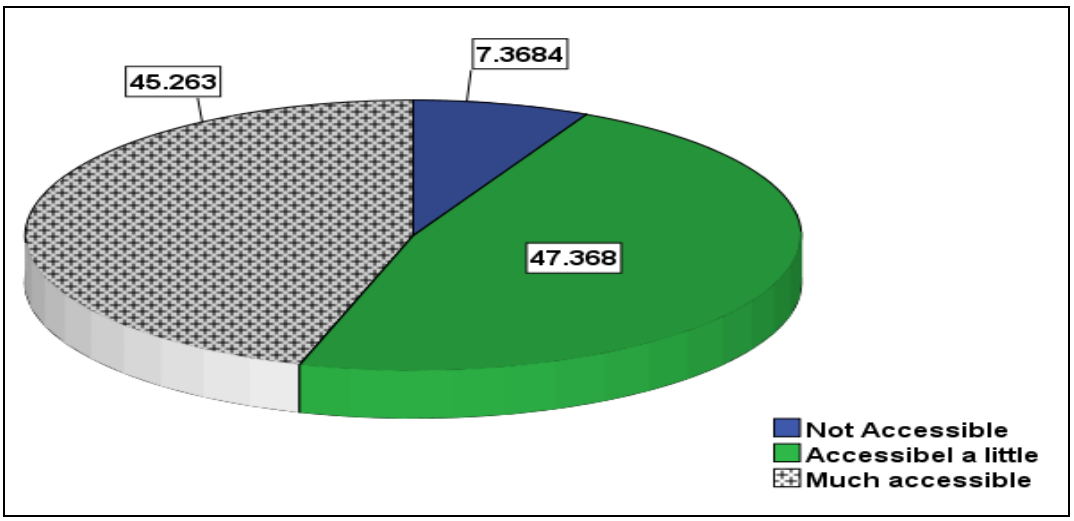

Figure 4.12: The Extent of Heath Care Services Accessibility (Level of Information Provided)

Source: Field Data, 2018

From the table above it has been found that the majority of participants 55 percent have no information about the cost sharing scheme meaning that they don't know

their rights and obligation when accessing medical services. This finding is supported by a study of (Ellis, 2000) who found that 50% of the respondents in rural Mombasa in Kenya have no correct information on their health issues and commented the same problem is still prevalent in East African Countries.

4.3.7 The Extent of Heath Care Services Is Affordable (Cost)

From the figure 4.13 below it shows that that 3.2 percent of the patients had no opinion on the subject matter, 10.5 percent of the 95 participants said that the services are not affordable. However, 63.2 said that the services are affordable a little. The section of the participants who said that the service was much affordable was 23.2 percent.

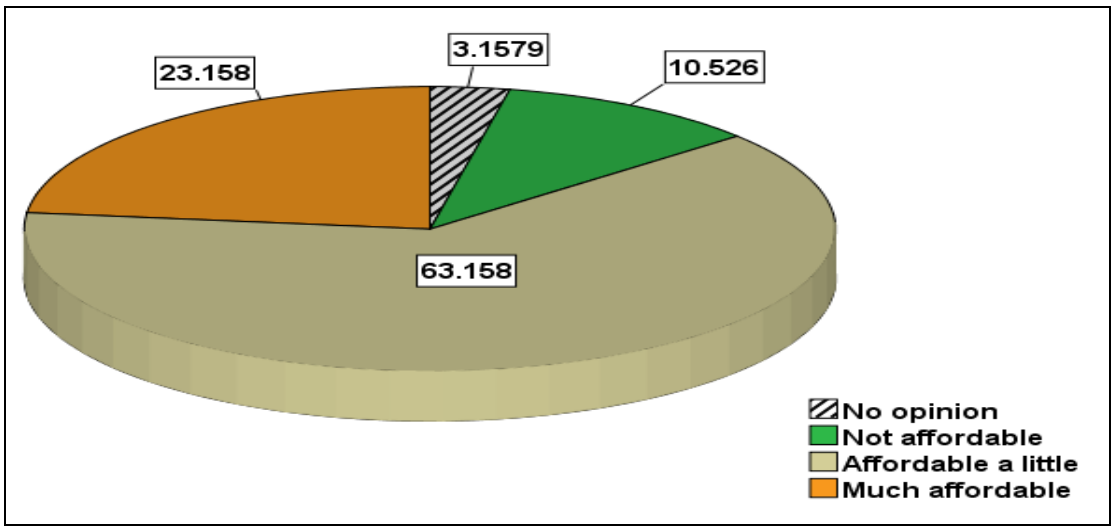

Figure 4.13: The Extent of Heath Care Services Is Affordable (Cost)

Source: Field Data, 2018

Figure 4.13 above reveal that Majority of respondents 73 percent do not have an ability to meet the cost of health service. This is due to an adverse poverty situation

which is prevailing in Tanzania. It means people are dying because they have no money for treatment. The Tanzania bureau of statistics show that 60 percent of Tanzanians live with less than one dollar per day and eat once in a day. A study by (Nindi, 2015) support the study findings where he found that cost of health care is still a problem in Tanzania especially in the rural areas where a good number of civilians are below poverty level.

4.3.8 The Extent of Heath Care Services is Affordable (Willingness to Pay)

From the figure 4.14 below it shows that 13.7 percent of the respondents said that the services are not affordable. However, 40 said that the services are affordable a little. The section of the participants who said that the service was much affordable was 46.3 percent.

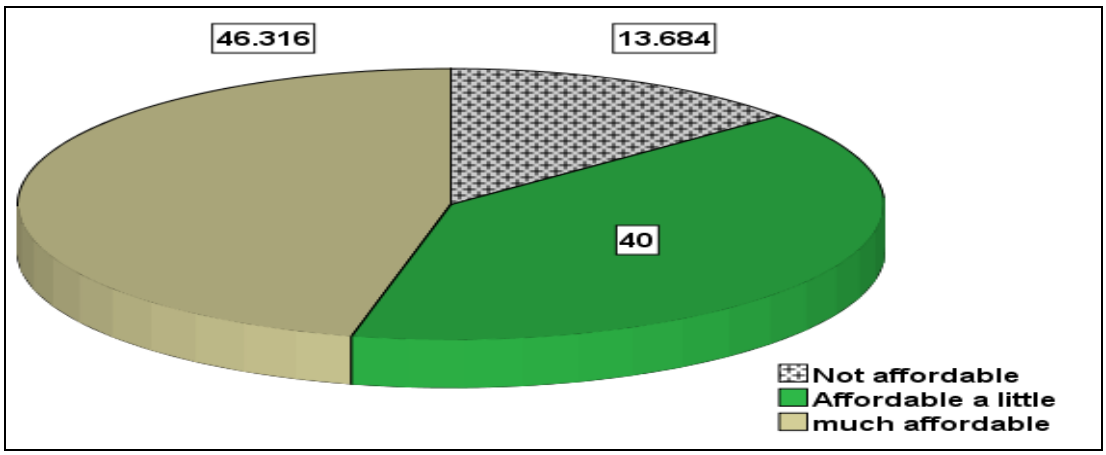

Figure 4.14: The Extent of Heath Care Services is Affordable (Willingness to Pay)

Source: Field Data, 2018

The results portrayed by the figure 4.14 above show that majority of the participants not (affordable and affordable little) make up almost 70 percent meaning that un able

to effect medical payment or just decline to do so. In a complicated situation where there is poor service clients may be reluctant to pay for the same. The above arguments are supported by Maslow theory of motivation that poor services act as de motivators to act positively.

4.4 Performance of the Cost Sharing Mechanism in the Improvement of the Healthcare Services Delivery

The above heading forms the second pillar of the specific objective of this study.in order to meet the research objective negative and positive performance were identified using the research questions. However, the responses to the same questions are provided below.

4.5 Negative Performance

The negative performance includes items identified during the study through research questions whose response from the study participants appeared to contradict the level of expectation on cost sharing scheme goals in Tanzania. However, satisfaction of the service, obstacles and complaints handling have been major hurdles toward achieving workable health cost sharing scheme.

4.4.1 Satisfaction of the Service

From the figure 4.15 below it shows that 18.9 percent said that the services are satisfactory However, 81.0 said that the services are not satisfactory.

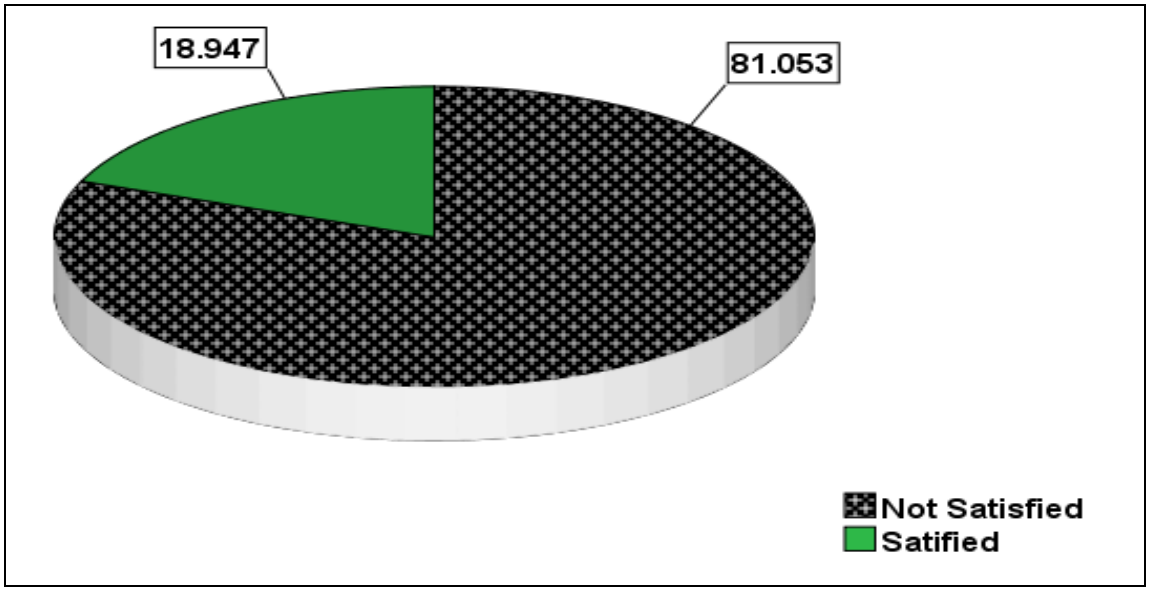

Figure 4.15: Satisfaction of the Service

Source: Field Data, 2018

From the Figure 4.15 above it shows that respondents are not satisfied by the cost sharing schemes in health service delivery. It means therefore some people dodge attending medical services government due to dissatisfaction.

A study by (Ellis 2000) supports this finding where he revealed that dissatisfaction is a r sign of poor performance in cost sharing scheme involving health care delivery. Dissatisfied individuals spread negative image of the service to other people and a result the entire community is disappointed by the services offered by the government hospital.

4.4.1.1 Reasons for Dissatisfaction of the Health Service

This study reveals the distribution of participant's response as to why they are dissatisfied with the service provided by the Amana hospital. The percentages are given in brackets. Drugs are not available (21.1%) waiting time is long (31.6%) No

money (10.5%) investigation is not on time (21.1%) services are not good (15.8%). It appears that most respondents 31.1% complain about too much time spent in queue waiting for medical services this means that they don't see any meaning of cost sharing. This line of argument is supported by a study by (Mushi 2014) who found out that time spent by patients in hospital is unnecessarily too long.

4.4.1.2 Reasons for Satisfaction of the Health Service

The study reveals the respondent's opinion on health services in the form of cost sharing. Each response has been assigned a percentage shown in brackets; services are good (52.6%), Services are done on time (32.6%), no complaints (10.5%) and you get all services if you have money (4.2%) percent.

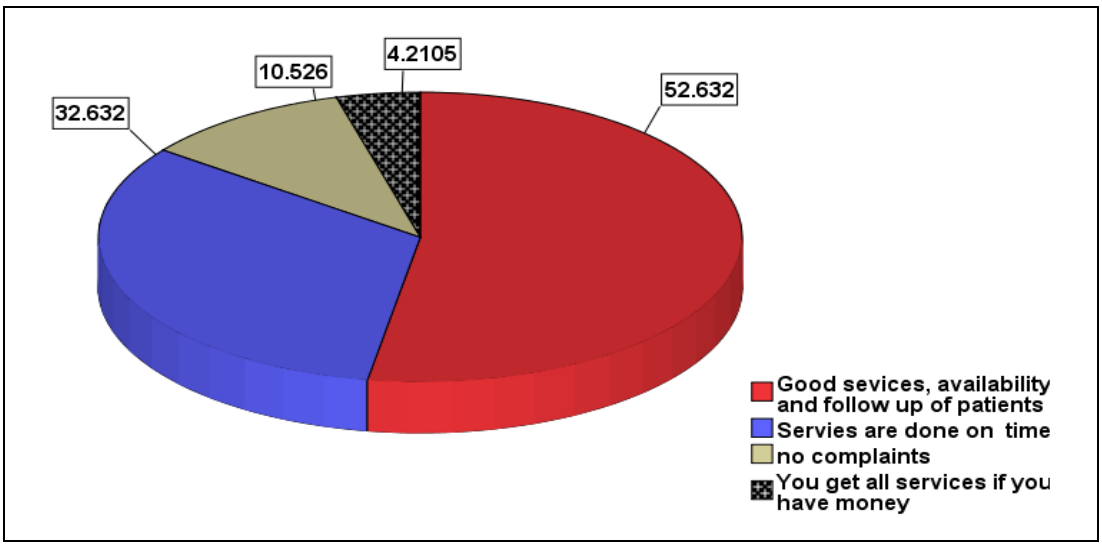

Figure 4.16: Reasons for Satisfaction of the Health Service

Source: Field Data, 2018

Figure 4.16 The majority (63%) of the few respondents commented that they are satisfied by the health services means that they are not regular attendees of public hospital where majority of common respondents expressed their dissatisfaction with

service. The above positive picture may distort the truth that most of the public hospital suffer serious problems such as lack of medicines and facilities. A study by (Gertler, Locay, and Warren 1987) concurs that despite problems with cost sharing schemes, there are individuals who contend that the cost sharing schemes have positive image.

4.4.2 Obstacles (Yes)

The study revealed that some obstacles stay on the way in accomplishing the cost sharing scheme. Participant's response is given with their percentage in brackets: lack of enough fund and employment (46.2%), funds available determine the service (15.4%), absence of facilities (15.4), exemption is not realistic (7.7%) and lack of healthcare information (15.4%). The distribution of the findings is shown in the figure 4.17 below.

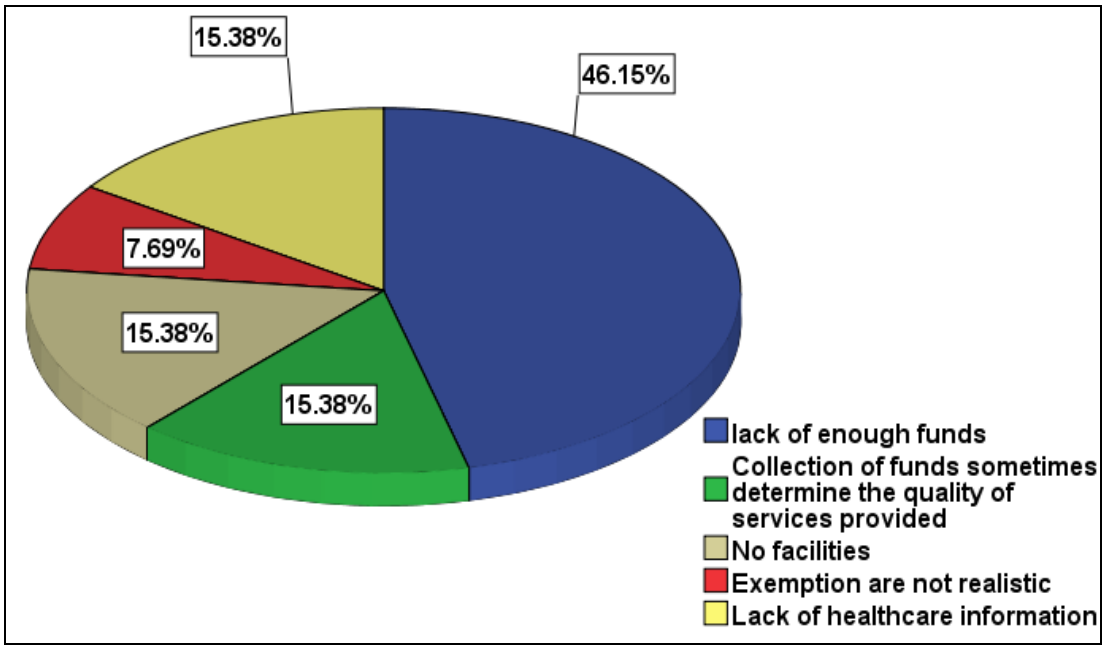

Figure 4.17: Obstacles (Yes)

Source: Field Data, 2018

From the findings shown on the figure 4.17 it shows that of all the problems mentioned by the respondents (health workers) the lack of funds is a big the big one (46%). It means that shortage of funds leads to shortage of medicines all other problems such as lack of healthcare information follow suit. A study by (Essel 2001) in his finding he found that little funds in health care system cause serious problems.

4.5 Complaint Handling

The study has revealed that participants had different opinion to the way opinions are being handled. Those who said there is a better way of handling complaints were 38.5 against those with notion that it is worse when it comes to complaint ladling (23.1%). However those who said that there is a better system of handling complaints were 30.8 %.

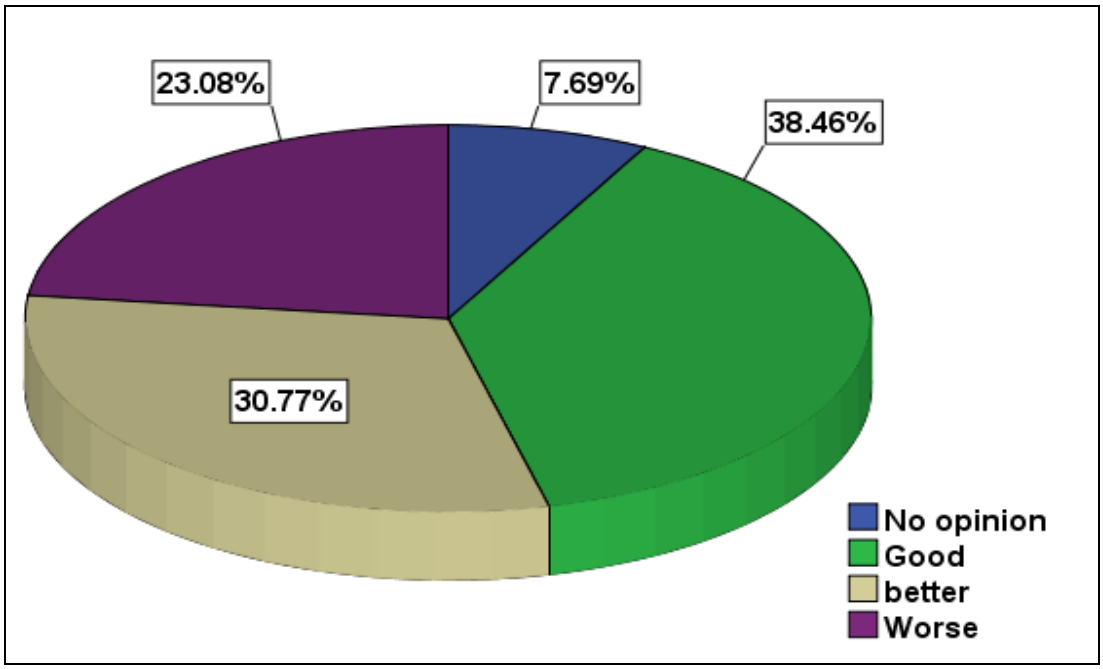

Figure 4.18: Complaint Handling

Source: Field Data, 2018

4.6 Positive Performance

The positive performance include items identified during the study through research questions whose response from the study participants aligned with the expectation of the opinion of the study population. In this category items identified include matters related to social cultural factors and water supply.

4.6.1 Social Cultural Factors

A question on social cultural factors was asked to health workers including doctor's nurses and social workers, the aim was to identify some of the performance benchmark for the cost sharing mechanism in the delivery of health services in Tanzania.

4.6.2 Treatment of Old People

The survey results have shown that 100% of the respondents say that old people are being treated free at the hospital.

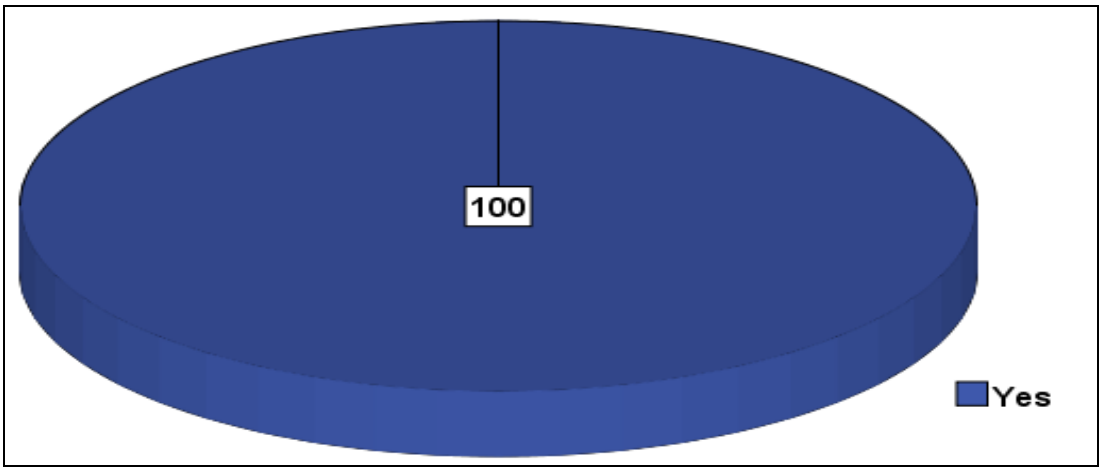

Figure 4.19: Treatment of Old People

Source: Field Data, 2018

4.6.3 Treatment of Pregnant Women

Question on the pregnant women was asked to health workers, the aim was to know if the said category of patients attend the hospital. The figure below show that all the health worker had the same point of view that pregnant women go to hospital and are treaded freely.

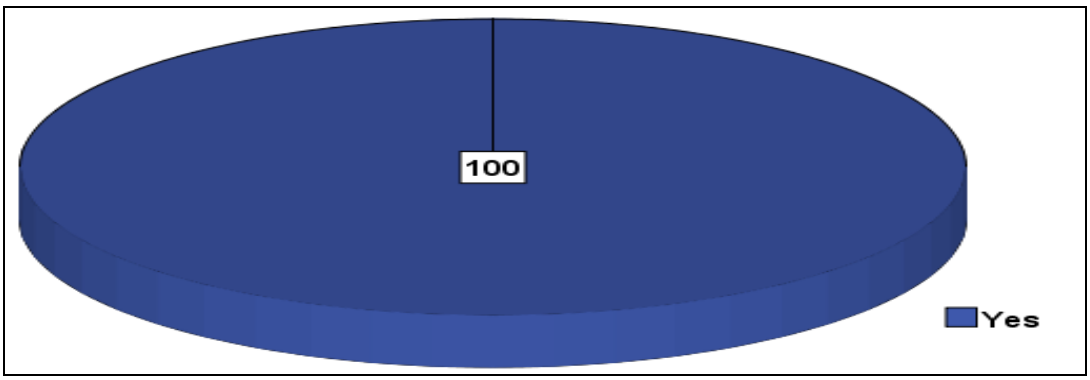

Figure 4.20: Treatment of Pregnant Women

Source: Field Data, 2018

4.6.4 Treatment of Disabled People

Question on the pregnant women was asked to health workers, the aim was to know if the said category of patients attends the hospital. The figure below show that all the health worker had the same point of view that disabled people are treaded freely.

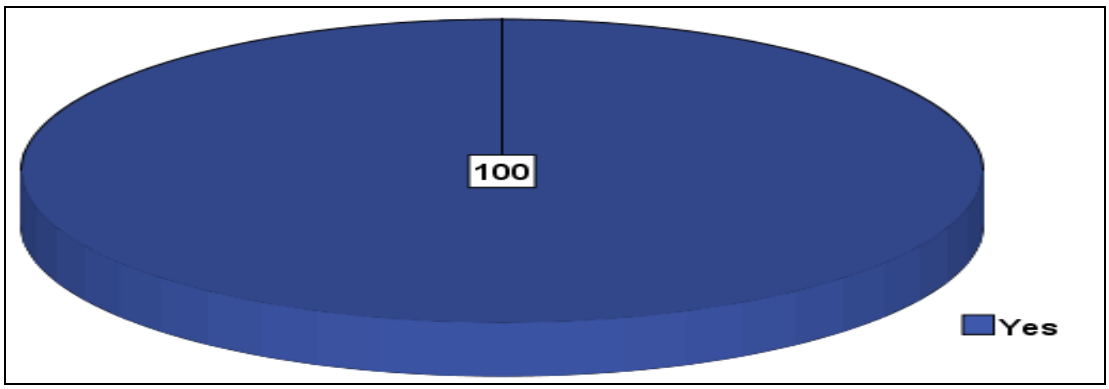

Figure 4.21: Treatment of Disabled People

Source: Field Data, 2018

4.6.4.1 Water Supply

Water supply which is key to health services the participants had different opinion on the same. 69.2 percent said that water supply is good. However, 30.8 percent said that water supply was better meaning that water system is function. The figure 4.23 below summarizes the findings.

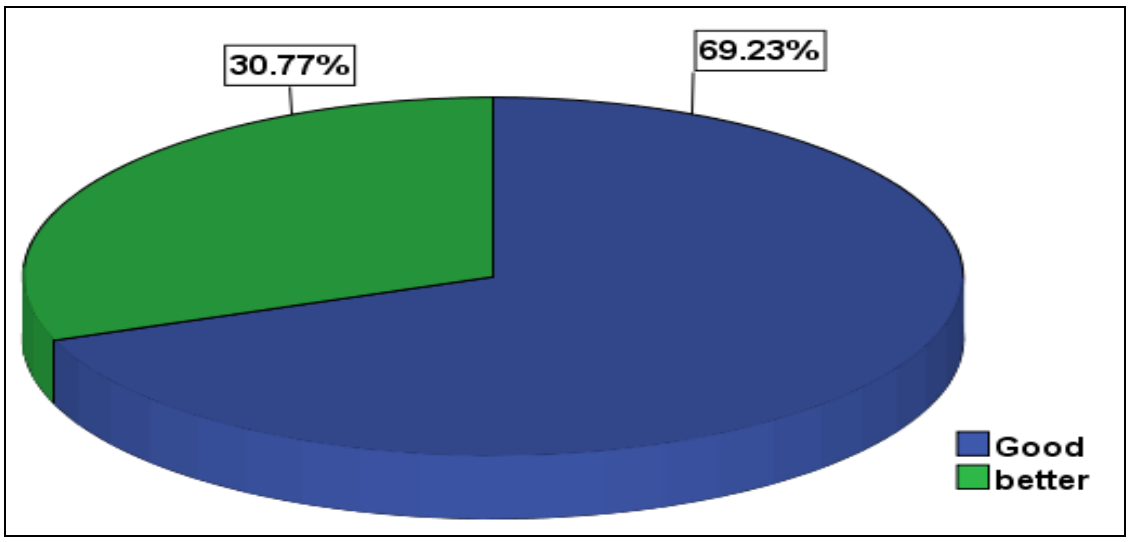

Figure 4.23: Water Supply

Source: Field Data, 2018

Table 4.1 : Linear Regression Factors that Influence Convenience, Accessibility and Affordability of Health Service Under Cost Sharing Scheme. Health Service under Cost Sharing

Variable	B-Statistic	T- Statistic	Probability
Ability to pay	0.04	-1.08	0.20
Availability of medicines	0.37	3.59	0.00
Information on cost sharing	-0.03	-0.2	0.84
Professional service	0.22	2.22	0.03
R square = 0.508			

Significance P<=0.05			

Source: Field Data, 2018

4.6.4.2 Ability to Pay

Ability to pay was found to be not significant variable that determines ones to attend and afford health service in terms of coast sharing, since probability was 0.84. Beta statistic was -0.03 (Table 4.1). These meant that increased level of Ability to pay does not make people attend public health service under cost sharing, as rich people have alternative means of meeting their health needs through private hospitals.

4.6.4.3 Availability of Medicine

Availability of medicine was found to be a significant variable that determines accessibility and affordability of health service under cost sharing, probability was 0.003, Beta statistic was 0.35 (Table 4.1). Moreover, when medicines are available the attendance of patients at public health service increased also, the vice versa is also true.

4.6.4.4 Information on Cost Sharing

Health service delivery is determined by Information on cost sharing. Results in Table 4.1 show the most significant relationship between Information on cost sharing and accessibility/affordability of health service under cost sharing, probability was 0.001 and Beta statistic was 0.37. This meant that Information on cost sharing is likely to make customers attracted to use it.

4.6.4.5 Professional Service

The results indicate a significant relationship between access/affordability and Professional service under cost sharing, probability was 0.03 while Beta statistic was 0.221 (Table 4.1). This finding revealed that as the number of people perceives that cost sharing lacks professional service.

4.6.4.6 Testing the Hypothesis

Null hypothesis stated that, there is no significant relationship between associated factors/variables of cost sharing (ability to pay, availability of medicines, information on cost sharing and professional service) and accessibility/affordability of health service. More variables tested above show there is a significant relationship between associated factors/variables of cost sharing and accessibility affordability of health services. Therefore, from these evident results by linear regression model, alternative hypothesis is true, which states that there is significant relationship between associated factors of cost sharing and accessibility/affordability of health services.

4.7 General Observation

Form the study findings under performance of cost sharing it can be seen that positive performance related to the general truth that in government hospital all people regardless of their social status have equal right to treatment. The above scenario is being observed in the said hospitals. Findings have shown that people such as the elderly, pregnant women and disabled all had equal right to treatment at the time this study was undertaken.

Moreover, negative performance which outweigh the positive performance related to serious issues which are at the core of the health cost sharing mechanism. The study participants ranked very low on issues such as satisfaction of the services, complaints handling and several obstacles still lie on the way that make the achievement of the goals of the said scheme to remain aloof.

CHAPTER FIVE

5.0 SUMMARY OF THE FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introductions

This chapter gives out the detailed explanations of the results findings and conclusions involved in the study while the recommendations are ways proposed as a means of improving cost sharing scheme in health delivery. It also presents areas for further study.

5.2 Summary of the Main Findings

Focusing on the findings obtained from the analysis of the 108 participants at Amana Hospital in Dare salaam the following summaries of findings were made: The study was guided by assessment of the three specific objectives namely; the accessibility, convenience and affordability of healthcare services to the beneficiaries and stakeholders, obstacles facing the hospital and the performance of healthcare services deliveries and the obstacles facing the hospitals in the delivery of health services and implementation of cost sharing mechanisms.

The results show Tanzania still faces significant challenges in implementation of cost sharing in health services as major benchmark in the research remain low. It was found that 43 percent of the respondent said that in cost sharing health services are not accessible. However, 53 percent of them said that cost sharing services are not affordable. 60 percent of the respondents said that health services are not convenient.

The study showed that 76 percent of the health services users face problems in cost sharing schemes. In addition to that 81 percent of the respondents said that they are not satisfied by the health services offered in the cost sharing scheme.

5.3 Implications of the Findings

The findings of this study have drawn the following implications;

The government of Tanzania has to ensure that desirable environment in its hospitals are well set because as per Vroom theory, realized that an employee's performance is based on individuals' factors such as personality, skills, knowledge, experience and abilities.

The theory suggests that although individuals (doctors and nurses) may have different sets of goals, they can be motivated if they believe that: There is enough support from the government to make sure that medical workers and hospital environment are aligned toward satisfying patient's needs.

The government of Tanzania can take a lesson that health services resting on pillars such as affordability, accessibility and convenience help to make sure that cost sharing schemes are successful. Patients have to be satisfied in terms of medicines, technical services and performance of hospital staff for better health services.

In order to improve the convenience, accessibility and affordability of health services the government has to improve on important factors that have shown direct relationship with health care service delivery. These factors include the ability to pay

of its citizens, availability of medicines in hospitals, information on cost sharing scheme and professional service at public hospitals.

5.4 Conclusion

This study was undertaken to assess the impact of cost sharing mechanisms in the delivery of healthcare services in Amana Hospital in Dar es Salaam Region. It can therefore be concluded that

i) The level of Accessibility, convenience and affordability in health service delivery in Tanzania is still low therefore the government has to improve on the same to upgrade the performance of this scheme.
ii) The performance of the cost sharing in the delivery of healthcare service delivery is negative, problems have been observed in the satisfaction of services, long waiting time, low ability to pay and lack of drugs.
iii) Public hospitals still face obstacles on the way that negatively affect the delivery health care services such as lack of enough funds, low quality services provided, lack of healthcare information and fewer facilities.

5.5 Recommendations

From the conclusions of this study, the following recommendations are made.

i) Government especially health policy makers should aim at making extensive sensitization of any new programme to all stakeholders before implementation takes place.
ii) There should be a survey to determine people who are very poor in order to exclude them from paying cost sharing for their health service. Nevertheless, a

big loss of people may happen because of failing to pay for their treatments at hospital.

iii) Health workers especially leaders in collaboration with government should make sure that money obtained through cost sharing must reflect the objectives of improving health service delivery and not otherwise.

iv) There should be simple procedure used to identify the old and disabled people in order to exclude them from cost sharing in health services.

Findings revealed that majority of the old and disabled people are not simply excluded because of complex procedure existing at public health service facilities, but the policy for exempting them from cost sharing in health service is clear defined and stated by the government. It seemed that the policy actors such as health worker's management are the source of problem. Therefore, the government should work on this in order to serve its people.

5.6 Suggested Area for Further Study

The study recommends the future research also should look at the best ways to motivate medical staff so that they participate effectively in cost sharing mechanism scheme as far as health services delivery are concerned.

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APPENDICES

Appendix 1: QUESTIONNAIRE TO PATIENT

Date of interview……..……..…

Questionnaire number…….……

Location/Mtaa…….……

Ward……

Division……...

Health facility……..……

PART A: DEMOGRAPHIC INFORMATION **Please put tick in the provided box**		
1.1 Sex	Male	
	Female	
1.2 Age	10-18	
	19-27	
	28-36	
	37-45	
	46-54	
	55-63	
	64 above	
1.3 Occupation	Peasant	
	Teacher	
	Businessperson	
	Officer	
1.4 Education level	None	
	Primary	
	Secondary	
	College/university	
1.5 Marital status	Single	
	Married	
	Divorced	
	Widow	
2.0 SOCIAL ECONOMIC FACTORS		

2.1 Income (Money) earned per month	Below 200,000	
	220,000 - 300,000	
	320,000 - 400,000	
	420,000 - 500,000	
	520,000 - 600,000	
	620,000 and above	

3.0 SOCIAL CULTURAL FACTORS		
A. Are the old people being treated free at hospital	YES	NO
B. If the answer is No, why?		
C. Are disabled people being treated free at hospital?	YES	NO
D. If the answer is No, why?		
E. Are the pregnant woman being treated free at hospital	YES	NO
F. Do you get service at hospital when you do not have money?	YES	NO
G. If the answer is No, why?		

PART B (Questions)

Put √ in the applicable box

(i.) To what extent are the healthcare services accessible

Role	**No opinion**	**Not accessible**	**Accessible Little**	**Much Accessible**
Healthcare information				
Retrieve of the patience records				
Distance				

(ii.) To what extent are the healthcare services conveniences?

Role	**No opinion**	**Not Convenience**	**Convenience Little**	**Much Convenience**
Drugs availability				
Administration process (Time consuming)				
The level of information provided to patience				

(iii.) To what extent are the healthcare services are affordable

Role	No opinion	Not Affordable	Affordable Little	Much Affordable
Cost in paying of healthcare services and drugs				
Willingness to pay				

PART C: TO ASSESS THE PERFORMANCE OF COST SHARING MECHANISMS IN THE IMPROVEMENT OF HEALTHCARE SERVICES DELIVERY

1. Were you satisfied with the services?

   (a.) Satisfied

   (b.) Not satisfied

2. If yes explain……...……

3. If no explain……

Appendix 2: HEALTH SERVICE WORKERS QUESTIONNAIRE

Date of interview……..……..…

Questionnaire number…….……

Location/Mtaa…….……

Ward……

Division……...

Health facility……..……

PART A: DEMOGRAPHIC INFORMATION (Please put tick in the provided box)		
1.1 Sex	Male	
	Female	
1.2 Age	10-18	
	19-27	
	28-36	
	37-45	
	46-54	
	55-63	
	64 above	
1.3 Occupation	Peasant	
	Teacher	
	Businessperson	
	Officer	
1.4 Education level	None	
	Primary	
	Secondary	
	College/University	
1.5 Marital status	Single	
	Married	
	Divorced	
	Widowed	
2.0 SOCIAL ECONOMIC FACTORS		

2.1 Income (Money) earned per month	Below 200,000	
	220,000 - 300,000	
	320,000 - 400,000	
	420,000 - 500,000	
	520,000 - 600,000	
	620,000 and above	

3.0 SOCIAL CULTURAL FACTORS		
A. Are the old people being treated free at hospital	YES	NO
B. If the answer is No, why?		
C. Are disabled people being treated free at hospital?	YES	NO
D. If the answer is No, why?		
E. Are the pregnancy woman being treated free at hospital	YES	NO
F. Do you go to hospital when you become sick	YES	NO
G. If the answer is No, why?		

PART B (Questions)

Put ‘’✓” in the applicable box

(i.) To what extent are the healthcare services accessible

Role	**No opinion**	**Not accessible**	**Accessible Little**	**Much Accessible**
Healthcare information				
Retrieve of the patience records				
Distance				

(ii.) To what extent are the healthcare services convenience

Role	**No opinion**	**Not accessible**	**Accessible Little**	**Much Accessible**
Drugs availability				
Administration process (Time consuming)				
The level of information provided to patience				

(iii.) To what extent are the healthcare services affordable

Role	**No opinion**	**Not Affordable**	**Affordable Little**	**Much Affordable**
Cost in paying of healthcare services and drugs				
Willingness to pay				

(iv.) What is the performance of healthcare services delivery?

Management Staff

Role	No opinion	Good	Better	Worse
Technical Quality Interpersonal quality Amenities Work Attitude Professional Knowledge Complaint Handling Appearance and Courtesy 24-hour Service Hotline Service Water Supply System Lighting System CCTV System				

Nurses and Doctors

Role	No opinion	Good	Better	Worse
Attendance Appearance and Courtesy Responsibility Alertness and Adaptability				

Other comments or suggestions

……

……

……

PART C: To identify the obstacles facing the hospitals in the delivery of health services and implementation of cost sharing mechanisms;

(i.) Are there obstacles facing hospital

(a.) If yes explain.....

(b.) If No explain.....

Thank You for Your Cooperation