ASSESSMENT OF THE EXTENT OF KNOWLEDGE AND AWARENESS ABOUT FREE HEALTH SERVICE PROVISION SYSTEM IN DILLA TOWN, SOUTHERN ETHIOPIA

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Abstract

Background: Access to basic health services of acceptable quality is still denied to many of the world's poorest people, Identification or application procedure and screening criteria by local kebele administrator for free health services provision at public health facilities are not transparent and eligibility selection procedures have loopholes that allow misuse, and the system therefore created health care inequities.

Objective: The aim of this study is to assess knowledge and awareness about free health service delivery system and the extent to which strict criteria are followed in granting free health services to the poor in Dilla town, Southern Ethiopia.

Method: Health facility based cross-sectional study, employing both quantitative and qualitative designs, was conducted from November 1-7, 2013. Interviewer administered quantitative structured questionnaire was employed to assess the extent of knowledge and awareness of exit respondents of clients' visiting outpatient department of Dilla hospital about free health service provision system, and logistic regression was used to assess the effect of selected variables on awareness about the possibilities of provision of free health services for the poor.

Results: Fifty-six percent of the respondents were reported that they don't have awareness about the presence of health service to the poor free of charge through fee-waiver system whenever they came to public health facilities and 44% had information about the possibilities of fee waiver for the poor who can't afford to pay but they were not exempted from fees for health services. Lack of implementation of guidelines having clearly stated criteria for granting free health services were also noted at public health facilities and local kebele administrator. The occupation (**P=0.001**) and family size (**P=0.005**) of the respondents showed a statistically significant association with fee waiver granting awareness at the public health facilities.

Conclusion: Failure to implement guidelines for granting free health services at public health facilities and local kebele administrator has made the system more difficult for both health care providers and consumers. These findings imply the importance of strict implementation of fee waiver mechanism in a properly documented manner to address equitable health services to the community.

Keywords: Free health services, fee waiver, exemption, leakage, under coverage, Dilla University.

Introduction

Equity is the underlying principle of major global health policies such as the Global Primary Health Care Strategy, the Health for All strategy, and recently, the health sector reforms spearheaded by the World Bank which are based on the assumption that everyone should have the opportunity to attain good health status [1, 2]. The target of equity in health and equal access to health care is based on the

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principle that health care should be provided according to needs, not according to factors such as the ability to pay for service [3]. The role and effects of user fees for publicly provided health services in developing countries has evolved during the past ten years. Early proponents believed that fees could help to improve efficiency (through appropriate price signals), financial sustainability and also through targeted prices and exemptions [4]. However, the introduction of user-payments for health services is frequently followed by a concern about the impact it has on the equity of access for poor people. Governments often try to remedy these inequalities by putting in place safety nets in the form of exemptions and waivers in the user fee system [5]. The central problems in the system of exemptions for the poor are: defining conditions for people in these category, working out an acceptable formula for providing subsidies, and effectively administering exemptions. A survey of official cost- recovery policies in 25 countries of Sub- Saharan Africa revealed that exemptions due to poverty or inability to pay are remarkably uncommon [6]. In 1989, Uganda provided safety nets (granting of exemptions, waivers, and credits) to ensure equitable access to health care for individuals with limited financial resources. Exemption categories included children under the age of five, immunization, antenatal and postnatal care and family planning services.

In addition, patients suffering from chronic illnesses such as HIV/AIDS, tuberculosis, cancer and poor individuals are exempted from fees by the local councils [5].

In Cambodia, Indonesia, and Vietnam, a combination of user-fee exemption mechanisms and free health cards has been established for poor and vulnerable populations. Criteria for eligibility are often designed according to characteristics of a person or a family in relation to ability to pay for health services [7].

Availability of information related to the criteria is usually limited in local kebele administrator, which requires great efforts of people responsible for verifying the eligibilities. In places where means testing are frequently organized, implementation of the means tests may be easier than where means testing is initiated for the first time, because of better administrative capacity and more basic information [8, 9].

Performance of means testing can be evaluated from two dimensions: two type errors and cost-benefit of the targeting. Type I error refers to leakage of the true poor. Type II error refers to coverage of the non-poor. An ideal means testing is to keep the two types errors minimal. However, there is a trade-off between the two types of errors. When type II error is to be reduced, it may increase type I error because some of the true poor could be excluded from a very stringent means test. Health program organizers need to consider the trade-off between accuracy of information and cost for gathering the information. Proportions of administrative costs of means testing accounting for benefits delivered to the target population can be to some extent reflect cost-effectiveness of the means testing [8].

Ethiopia has been providing for free health services for the poor enshrined in Ethiopian law, but the program has never been truly operational. Concerns about inadequate funding to provide fee waivers to all eligible beneficiaries have led to recommendations to establish an “equity fund” to fund fee waivers as an element of pooled funding. Ethiopia has also made certain services free (or exempted) for all citizens irrespective of income, including deliveries at the primary health care unit level, and post and antenatal care. However, the mid-term evaluation of the Health Sector Development Program (HSDP) III found that most of the facilities that advertise exempted services are only partially free in practice. For example, it was found that deliveries at the hospital level were not provided entirely free of charge, as some clients were charged for supplies used during delivery [11].

Methods and materials: Health facility based cross-sectional study, employing both quantitative and qualitative designs, was conducted from November 1-7, 2013 in Dilla town, Southern Ethiopia.

Four hundred thirty four study subject were identified by systematic random sampling technique and included among patients visiting Dilla University hospital, Dilla health centre, including kebele leaders, and administrators of both health facilities.

A total of 12 key informants including Dilla University, College of Health Sciences & School of Medicine and Referral Hospital chief executive director, Dilla health center head, and local kebele administrators were identified using purposive sampling technique and then interviewed using semi-structured questionnaires.

Interviewer administered quantitative structured questionnaire was employed to assess the awareness of exit respondents about the existence of free health service delivery system with their perceived presence and extent of leakage and under coverage while semi-structured questionnaire was carried out for qualitative study to describe the presence of eligibility criteria in every health facilities and kebeles for granting free health services at public health facilities.

Data were collected by trained nurses recruited from Yirga chefee health center, and the questionnaires were adopted from the tools developed by World Bank's Living Standard Measurement Survey tools 2006.

The questionnaire were pre-tested in Wonago health center by taking 5% from the total sample size and data processing and analysis was made using Statistical Program for Social Sciences (SPSS) version 20.0 for windows.

Descriptive statistics was computed and logistic regression was used to assess the effect of selected variables on the extent of knowledge and awareness about the provision of free health services. Qualitative data were also analyzed by theme identification according to the objectives of the study.

Result:

Demographic characteristics of the study participants

The study covered a total of 391 health facility exit respondents, yielding 92.7% of the response rate. Out of the 391 respondents, 228 (58.3%) were found to be females and 173 (44.2%) of the respondents age ranges from 35-44 years but 323(82.6%) of health facility exit respondents are from rural areas. Three hundred twenty nine (84.2%) of the respondents were married and 131 (33.5%) of the respondents were having educational background of first cycle primary school (grade 1-4). One hundred four (26.6%) of the respondents are housewives followed by daily laborers which account 100 (26.6%). The mean monthly income of the respondents was 153.2 Ethiopian Birr per month. Two hundred sixty one (66.8%) of the respondents had a monthly income of $\leq$470, 00 Ethiopian Birr per month. Of the total respondents 139 (35.5%) had more than five family members and 211 (54%) of the respondents had private houses, 179 (45%) rented houses, and 1 (0.3%) don't have a house at all but 307 (78.5%) of the respondents' house is having 1-2 rooms and 84 (21.7%) of the respondents' house is having three and more rooms. A total of 12 individuals including nine kebele administrator, two health facility head (Dilla University Hospital & Dilla Health Center), and one deputy mayor from Dilla City Administration were the key informants for the qualitative study (Table 1).

Table 1: Demographic characteristics of the study participants, Dilla town, Southern Ethiopia, December 2014

Demographic variables	n=391	%
Sex		
Female	228	58.3
Male	163	41.7
Total	391	100
Age		
15-24 years	21	5.4
25-34 years	116	29.7
35-44 years	173	44.2
45-54 years	61	15.6
≥ 55 years	20	5.1
Total	391	100
Address		
Urban	68	17.4
Rural	323	82.6
Total	391	100
Marital status		
Married	329	84.2
Single	50	12.8
Widowed	4	1
Divorced	8	2
Total	391	100
Educational status		
Illiterate	63	16.1
Grade 1-4	131	33.5
Grade 5-8	98	25.1
Grade 9-12	74	18.9
College & University	25	6.4
Total	391	100
Occupation		
Farmers	41	10.5
Housewife	104	26.6
Daily laborers	100	25.6
Merchants	39	10
Government employee	63	16
Students	34	8.7
No job	10	2.6
Total	391	100
Monthly income		
470,00Birr	261	66.8
471,00-1000,00 Birr	52	13.3
>1000,00 Birr	78	19.9
Total	391	100
Family size		
1-2	111	28.4

3-5	141	36.1
>5	139	35.5
Total	391	100
House ownership		
Rented	211	54
Private	179	45.7
Don't have house	1	0.3
Total	391	100
Number of rooms		
1-2	307	78.5
3 and above	84	21.5
Total	**391**	**100**

Awareness of the exit respondents about the presence of free health service for the poor

The majority of the exit respondents 219 (56%) have reported that they don't have awareness about the presence of free health care provision system whenever they came to public health facilities and only 172 (44%) had information about the possibilities of fee waiver for the poor who can't afford to pay but they are not exempted from fees.

In the binary logistic regression models, comparing waiver granting awareness of the respondents with demographic characteristics, occupation (**P=0.001**) and family size (**P=0.005**) of the respondents have statistically significant association but no association was observed regarding sex, age, address, marital and educational status, monthly income, number of rooms and house ownership of the respondents.

Government employees were four times more likely aware of waiver granting than farmers (OR = 4.6 and 95% CI = 1.945, 10.906), and respondents who were having more than five family size were three times more likely aware of waiver granting than those respondents having one to two family size (OR = 3, and 95% CI = 1.964, 5.576) (Table 2).

Table 2: Comparison of demographic variables with waiver granting awareness at public health facility, Dilla town, Southern Ethiopia, December 2014

Variables	**Waiver granting awareness**				
	Aware	**Not aware**	**COR**	**95% CI**	**p-value**
Sex					
Female	102	126	1.116	(0.608, 2.050)	0.723
Male	70	93			
Total	**172**	**219**			
Age					
15-24 years	6	15			
25-34 years	47	69			
35-44 years	78	95	0.763	(0.191, 3.038)	0.701
45-54 years	29	32			
≥55 years	12	8			
Total	**172**	**219**			
Address					
Urban	148	24	0.724	(0.260, 2.019)	0.538

Rural	174	45			
Total	**322**	**69**			
Marital status					
Married	152	177			
Single	14	36			
Widowed	1	3	2.393	(0.453, 12.646)	0.304
Divorced	5	3			
Total	172	219			
Educational status					
Illiterate	19	44			
Grade 1-4	60	71			
Grade 5-8	39	59	3.026	(0.890, 10.291)	0.076
Grade 9-12	41	33			
College & University	13	12			
Total	172	219			
Occupation					
Farmers	16	25	1.299	(0.606, 2.783)	0.501
Housewife	48	56	1.015	(0.456, 2.259)	0.970
Daily laborers	39	61	0.593	(0.230, 1.528)	0.279
Merchants	12	27	0.757	(0.243, 2.360)	0.63
Gov't employee	46	17	4.606	(1.945, 10.906)	**0.001***
Students	7	27	1.216	(0.82, 5.238)	0.793
No job	4	6			
Total	172	219			
Monthly income					
470, 00 Birr	107	154	0.456	(0.192,1.9082)	0.075
471,00-1000 Birr	18	34			
>1000,00 Birr	47	31			
Total	172	219			
Family size					
1-2	30	81			
3-5	73	68	3.073	(1.964, 5.576)	0.501
>5	69	70	2.410	(1.305, 4.451)	**0.005***
Total	172	219			
House ownership					
Rented	94	118	0.866	(0.468,1.606)	0.645
Private	78	101			
Total	172	219			
Number of rooms					
1-2	128	44	1.211	(0.661,2.219)	0.536
3 and above	179	40			
Total	**305**	**84**			

The entire respondent from local kebele administration explained: Only three committee members from local kebele administrator and two urban female health extension workers from each kebele were engaged in eligibility determination and poverty certificate is provided after a onetime assessment of the applicant's situation

Out of the total, 322(82.4%) respondents were aware of the presence of a possibility for poor patients to receive free health services at a public health facility. The address of the respondents and their knowledge about the possibility of getting free health care at public health facilities showed no statistically significant association (P=0.721) (Table 3).

Table 3: Awareness about the presence of free health care for the poor with the educational status and address of the respondents, Dilla town, Southern Ethiopia, December 2014

	Awareness				
Variables	**Aware**	**Not aware**	**COR**	**95% CI**	**P-value**
Address					
Urban	**174**	**24**	**0.724**	**[0.260,2.019]**	**0.721**
Rural	**148**	**45**			
Total	**322**	**69**			
Educational status					
Illiterate	**19**	**44**			
Grade 1-4	**60**	**71**			
Grade 5-8	**39**	**59**	**3.026**	**[0.890,10.291]**	**0.538**
Grade 9-12	**41**	**33**			
College & University	**13**	**12**			
Total	**172**	**219**			

Leakage and under coverage

According to the head of Dilla University, College of Health Sciences & School of Medicine and Referral Hospital eligibility criteria fail to adequately capture the poor as many non-poor like the entire health professionals working in Dilla University hospital, staff families, University students, emergency patients or causalities brought by police men, who can't afford to pay and who don't have third parties to reimburse health service fee after having treatment for 24 hours in emergency room were eligible and getting health services free of charge but fee for health services for the prisoners were reimbursed by Gedeo zone prison institution but many poor are not eligible for free health services.

And it was noted that, budget allocated by Dilla City Administration for waiver reimbursement is not sufficient to access recognizable list of beneficiaries at the poverty level in Dilla health centre.

Under-coverage will be a constant problem when the poor do not know they are eligible for free or subsidized health services and when health facilities (Dilla University Hospital) are not in position to select eligible poor and whom to exempt from fee for services except for public health services like VCT, Anti-Retro Viral Therapy (ART), Leprosy & TBc DOTs treatment, Epidemic diseases, Fistula, MCH including immunization services having **''public good nature''** and to promote its consumption and achieve the three directly health related MDGS but these exempted public health services were not collectively posted

However, the usual place of first health service seeking in times of illness or health problems showed no statistically significant association with their knowledge about the possibility of free health care (P= 0.230). Out of the total respondents that have the knowledge about the possibility of free health services to the poor, 253(64.7%) said they have heard about it some years back, while 30(7.8%) of them said they heard about the possibility of free health services recently and the rest did not

remember when they had the information. The source of information about free health services at public health facilities were kebele administrations 92(90.2%) for rural inhabitants and 10(9.8%) for the respondents from the urban inhabitants but 173 (44.3%) and 44(11.3%) of the informants from rural and urban areas respectively don't have information about the presence of free health services to the poor (Figure 1).

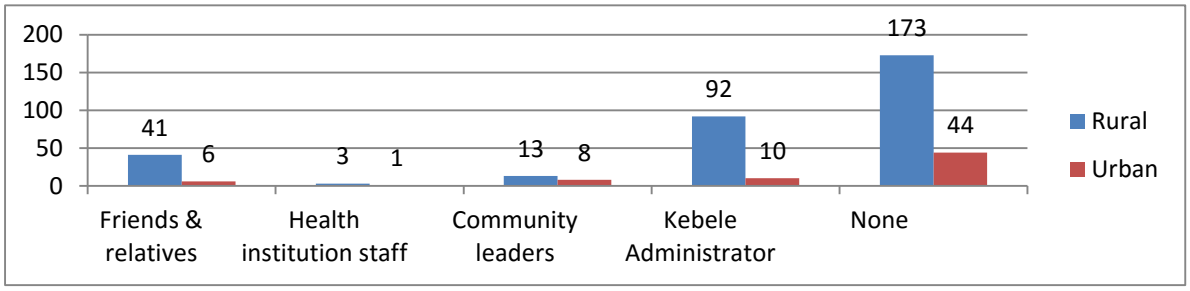

Figure1: Chart representing the sources of information about free health services and address of respondents, Dilla town, Southern Ethiopia, December 2014

Respondents from all Kebeles stated; "The responsibility of granting user-fee exemption is given to the health extension workers and the three committee members from kebele administrator are expected to know most, if not all, of the Kebele residents together with information on their economic backgrounds."

Three hundred ninety one (100%) of exit respondents said they were served with payment on the day of the interview. These individuals were asked whether they deserved free health care or not. A majority of them, 364 (93.1%) replied that they do deserve free health services. Two reasons mentioned by these respondents were being poor (87.2%) and assuming free health services as an individual's right (12.8%). Of these 222 (56.8%) have applied to their respective kebele administration offices with the remaining percentage of respondents having a health facility, municipality and others as a place of application for free health service.

According to the local kebele key informants the most common prerequisite required by the health extension workers and committee members from kebele administrator in granting waivers was being a resident of the respective Kebele and being unable to pay for health care as witnessed by three residents of that Kebele who are responsible for any inappropriate suggestions they may give. Similarly, of all the respondents who were given health services with payment on the day of interview the majority of exit respondents claimed that the evidence required to be eligible for free health services is having three witnesses who should be the residents of the respective kebele. Others include producing a letter from a work place, or from employee & social affairs (Fig. 2).

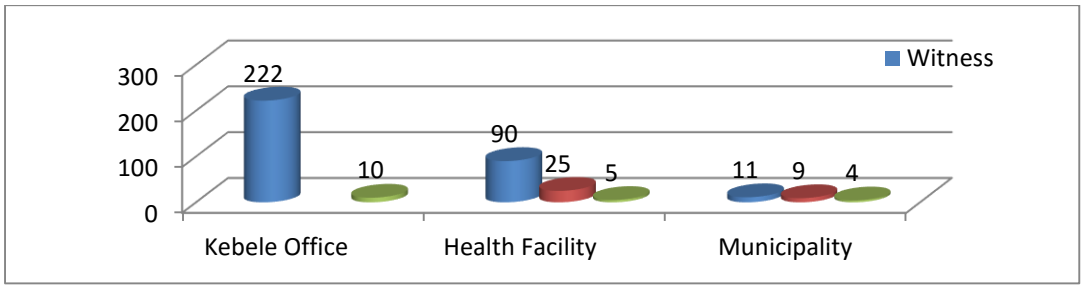

Figure 2: Chart representing evidences required to be eligible for free health services with the place of application of the respondents, Dilla town, Southern Ethiopia, December 2014

Health facility exit respondents who claimed the presence of challenges in getting supporting letters stating that one as free patient were 389 (99.5%). Types of difficulties or challenges mentioned by these respondents include uncooperative committee members of the kebele administrations 219 (56%), difficulty to produce evidences 97(24.8%), and the process takes long time 75 (19.2%) (Figure 3)

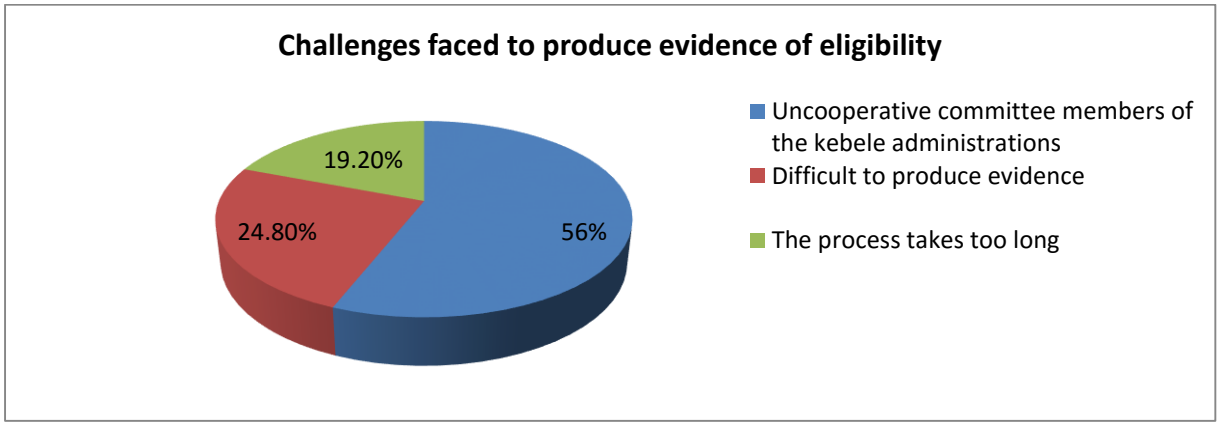

Figure 3: Pie chart showing challenges faced by respondents' to produce evidences for free health services, Dilla town, Southern Ethiopia, December 2014.

5.2 Discussion

The study assessed users' knowledge and awareness towards the existing free health care delivery system, the presence and extent of under coverage and leakage of fee waiver, and the system of application to determine eligibility in granting free health services for the poor.

Despite the fact that the entire respondents in the exit interview were getting health services with payment, no one was exempted from user-fees, and clearly stated selection criterion for granting free health care service privilege hasn't been critically applied.

Though all key informants have agreed on the importance of user-fees at public health facilities, most have agreed on the idea of granting free health services for the poor. However, as it has been seen in other studies the problem lies on the absence of clearly stated criteria and means testing while granting waivers but failure to proper implementation of guidelines for granting free health services at public health facilities and local kebele administrator was the major problems observed in the study area [1, 2, 3].

The proportion of respondents that were aware of the presence of free health services for the poor was also higher in the urban than the rural area. Similar trends were also reported in studies conducted in Kenya and Tanzania where lack of knowledge about fee waivers for the poor was shown, with a majority of the poor indicating they must pay for services at government health facilities [4, 5].

For exit respondents in the current study that responded as knowing about fee waivers, the most important source of information were friends & relatives. In the study conducted in Kenya information from health facility staff was the most important source [6]. This shows that there is no active communication between Kebele administer along with health facilities staff and health service consumers' on the existence of the fee waiver system, the process of obtaining waivers and exemptions, the criteria for obtaining free health services, and the legal consequences of misuse of

free health services by non-poor which was intended for the poor. Even though the possible explanation might be busy work schedule on top of even lack of awareness about such privilege for the poor and it should not be impossible for health professionals to disseminate information about the presence of fee waivers and exemptions during information, communication and education sessions to individual clients' or groups. The fact that most of the exempted disease categories are those with **"public good nature"** makes this activity worth the additional effort.

In Kenya and Ghana eligibility is determined by health facility staff; in Zimbabwe by social welfare offices; in Thailand, Indonesia, and in certain provinces of Cambodia by the combined and coordinated work of health staff and other government officials (for example village leaders) and clerks; There is no single answer to who should be responsible for fee waiver selection process but those engaged in eligibility determination should be aware of the selection criteria, adequately trained to carry out the screening activities, and informed about the financial and other constraints governing the protection process of the eligible poor [4].

The Amharic version official procedure or criteria for screening the poor that was introduced in 2009 by South Regional Health Bureau in collaboration with USAID (Health Sector Reform Project) shows that those individuals having less than an objectively defined minimum family income based on the estimated cost of basic needs for survival, street children, displaced individuals or families as a result of man-made or natural disaster and emergency patients or causalities brought by police men, and who can't afford to pay and who don't have third parties to reimburse health service fee after having treatment for 24 hours were eligible and getting health services free of charge but only local kebele administrator and health extension workers were involved in screening process [7].

Only a few of the respondents mentioned monthly income, family size and being elderly as a measure for eligibility. This implies that a proper and well-organized means testing is lacking in the system.

The government cost-sharing policy is having clear criteria or definition of individuals/families who deserve fee waivers has apparently given to local kebele administrators leading to loophole to make their own judgments, which widens the chance for the policy to be poorly implemented. In addition to hidden agendas by those who might have been motivated by rent seeking behaviors, the possibility that the poor have ended up paying while the **''rich'' or better off** have benefited from fee waivers intended for the poor becomes evident; a situation that has been similarly reported from Uganda and Tanzania1[8, 9].

Three hundred ninety one exit respondents' (100%) in this study were getting health services with payment but according to the similar study conducted in Jimma town, 139 (42.2%) of exit respondents were not served for free on the day of the interview which is not comparable with the finding of this study [10, 11]. But out of the respondents who were paying, 90(54.7%) claimed that they deserve free health care, the justification for most respondents may be (72.9%) being low income. This may imply the failure of the system to serve the genuinely disadvantaged group of the population. In addition, out of all the respondents, 219 (56%) mentioned the presence of uncooperative committee members of the kebele in getting support letters-stating one as a free patient. This finding is twice compared to the finding registered in the study mentioned earlier [10].

The proportion of respondents that are aware of the presence of exemption and waiver privileges in the utilization of health services by the poor was 44.5% and 37.9% for urban and rural inhabitants respectively, but in the study conducted in Bahir Dar area (north Ethiopia), the level of awareness and

source of information was 82.7% of the rural and 94% of the urban respondents knew about exemption and waiver policy, the finding is much more twice to this study. The sources of information for the majority of rural respondents were kebele administrations as was compared to the study conducted in the household survey of the study in Bahir Dar area [11]. This indicates that there is no government body or health facility staff that strongly considers the importance of disseminating the information about the presence of free health services to the poor.

Lack of awareness of the public about the presence of free health services for the eligible poor and the mechanisms for properly utilizing these measures are noted and high proportion of respondents that suspect the possibility of leakage and under-coverage could be an indication that the communities were not confident enough about the selection process.

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