

**The performance and future potential of the user fee exemption and
waiver mechanism in the Dar es Salaam Public Health Delivery
System**

**Guy Hutton, Swiss Tropical Institute, Switzerland
Svenja Weiss, Swiss Tropical Institute, Switzerland
Kate Forrester Kibuga, Consultant, Tanzania
Zuhura Majapa, Kinondoni Municipality, Tanzania
Deo Mtasiwa, Dar es Salaam City Council, Tanzania**

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Attribution for authorship is as follows. The study was planned, supervised and the paper drafted by Guy Hutton. Svenja Weiss contributed to study design, she lead the health facility survey in Dar es Salaam, compiled the data, and contributed to paper drafting. The client survey was conducted by Kate Forrester Kibuga, who also drafted section 6 of the report. The data collection was facilitated and conducted by Zuhura Majapa, who also checked data interpretation.

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We sincerely hope that the results of this study will improve the operation of the exemption and waiver mechanism in Dar es Salaam, and in Tanzania generally, and thus make essential health care financially accessible to all.

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Glossary

CBHC	Community-Based Health Care
EWM	Exemption and Waiver Mechanism
HB	Health Board
HC	Health Centre
IEC	Information, Education and Communication
IPD	Inpatient Department
MCH	Maternal and Child Health
MMOH	Municipal Medical Office of Health
NGO	Non-Governmental Organisation
NHIF	National Health Insurance Fund
No.	Number (total)
OPD	Outpatient Department
Tsh	Tanzanian Shillings

1. Introduction

When user fees for health were implemented in and beyond the African continent in the 1980s and early 1990s, it was recognized that they are one of several barriers to accessing health services, especially for population groups with limited command over resources¹. Hence, accompanying user fee introduction, mechanisms were designed that exempted groups from paying some or all of the user charges. These groups usually included population groups such as young children, pregnant women, the chronically ill, the elderly and the poor. This was the case in Tanzania, where an exemption policy was introduced at the same time as the user fee policy in 1993.

In terms of health service utilization, the literature shows that the impact of user fees has been varied, sometimes through quality improvements achieving an increase in health service utilisation (Litvack 1993, Walraven 1996), but more often user fees have been shown to reduce the uptake of public services (Gilson 1997, Hutton 2004).

Tanzania is a country where several evaluations of user fee impact have already been conducted. These have included studies focusing on a few selected health facilities (Hussein and Mujinja 1997), studies focusing on selected types of service (e.g. dentistry - Matee and Simon 2000), and one country-wide study (Munyetti et al 1999). In general, these studies have shown that user fees have reduced health service uptake, even despite the existence of exemption mechanisms. In the decade 1991 to 2001, the Household Budget Survey reports that households have been shown to increase their spending on medical services from 1.8% to 3.2% of overall household expenditure (National Bureau of Statistics 2002). This is true of all income quintiles where the increase has been roughly 1.5 percentage points. Therefore, the existence of exemptions does not appear to have benefited poorer households, in terms of protecting them from user fees in public facilities. However, this does not reflect a failure of the exemption mechanism itself, but may indicate that an increasing proportion of health services are consumed outside the public sector. This is suggested by data from the household budget survey, where 23% of the poorest quintile group experiencing a recent illness episode sought care from a private hospital, and 8% from a private doctor (National Bureau of Statistics 2002). Surprisingly, these proportions were not greatly different between the poorest income quintile, and the rest of the population.

Studies examining the effectiveness of the exemption mechanism in Tanzania are few. In general, it is clear from the limited evidence gathered that exemption mechanisms have not performed well, thus justifying a more up-to-date study in Dar es Salaam.

- Munyetti et al (1999), in a study drawing on data from selected facilities nationwide, reported that only 16% of patients who were unable to pay for hospital services were exempted from paying user fees. The remaining 84% either borrowed money to pay for hospital care, self-treated or sought traditional health care. In the year 1997-8, the study reports, only an average of 155 patients per hospital (sample of 16 hospitals) were granted an exemption on the basis of inability to pay. Furthermore, many MCH services were reported as being charged for,
- Abel-Smith et al conducted a study in 10 NGO and public hospitals nationwide in 1991 and found that exemptions and waivers were granted, but that many weaknesses existed in the system to ensure an equitable and efficient allocation of exemptions and waivers.
- Oester (1998) reported that in one district hospital in Dar es Salaam, the value of drugs provided free to under fives care accounted for around 30% of the cost sharing revenue. Poor patients fared worse, however, as the value of services exempted for poor patients was less than 1% of the total value of services provided in 1997.
- Manzi et al (2004) showed very low levels of community awareness about exemptions and waivers in Kilombero Municipality, and very limited access to waivers for the poor.

¹ Other barriers (generally) include distance, cost of transport, time away from home or work, low quality of services (especially lack of drugs), poor attitudes of health workers, long waiting times, and preference for traditional medicine.

Since the year 2000, health financing in Tanzania has gone through some important changes, with the introduction of the pooled donor fund ('basket' fund) for priority health actions, the increased decentralization of government budgets, the introduction of the national health insurance scheme for civil servants, and in some municipalities the introduction of community health funds. In fact, during the last 5 years, user fees has been one financing source that has provided a small but secure level of liquidity to the lowest levels of the health system.

Despite these advances in health care financing, the issue of user fees is on the table again, both internationally and in Tanzania. This is for several reasons, including pressure from donors and international NGOs due to mounting concerns about the equity impact of user fees, and linked to this, the high place on the international agenda of meeting the Millennium Development Goals. The health sector in Tanzania faces various choices: to abolish user fees, to promote alternative health financing sources such as health insurance, and/or to work on ways of further improving and refining the implementation of user fees. If the latter is chosen, then it will be important to improve and further refine the user fee exemption mechanism, to ensure equal health service access for poor and vulnerable groups facing user charges at the point of service.

In the light of this background, and given the interest of the Ministry of Health to have equitable, efficient and sustainable sources of health financing, **this study aims to present the strengths and weaknesses of the exemption mechanism in the City of Dar es Salaam, to serve as a case study for improving and refining the exemption mechanism throughout the country.**

This study distinguishes explicitly between two different mechanisms for reducing financial barriers to health service access, based on the classification of Bitran and Giedion (2003). One is to **exempt** certain *services*, thus promoting their consumption, such as antenatal care, vaccination, or sexually-transmitted infections. The rationale is that the value of these services are not fully recognized by the population, and/or they have externalities (i.e. people benefit from someone else being protected, as in the case of vaccination), and/or services are pure public goods (goods whose provision cannot be efficiently provided by the private market). The other mechanism, a **waiver**, is to confer the right to an *individual* to obtain health care at no charge or at a reduced price. The purpose is to improve equity in access and equity in financing of health services. These individuals can be identified on the basis of age, economic status, or social status (e.g. certain ethnic groups).

Given this classification of exemptions and waivers, it is possible that some groups fall within both an exempt group and a waiver group. For example, in Tanzania the elderly and poor people are not required to pay user charges. For the treatment of hypertension, this would represent an exemption as it is exempted on the basis of being a chronic disease. For dental services, this would represent a waiver, as it is waived on the basis of the individual. Therefore, this paper tries to distinguish between these two types of mechanism, and what was previously referred to as an 'exemption mechanism' is now referred to as an 'exemption and waiver mechanism'. Study questions include:

- How many exemptions and waivers are provided in public health facilities in Dar es Salaam, in terms of numbers and types of patients, value of services, and proportion of total patients?
- What is the understanding of the exemption and waiver mechanism of health authorities? How are health staff provided with up-to-date information on the policy and the working of the mechanism?
- How does the exemption and waiver mechanism operate in the health facilities, and how does practice compare with national or city policy?
- What resources are required to operate the exemption and waiver mechanism?
- What are clients' experiences with the exemption and waiver mechanism, in terms of knowledge, application, use, and attitudes?
- How can the policy and practice of the exemption and waiver mechanism be improved to improve access to health services, while at the same time assuring financial viability?

2. Study methods and data sources

The present study was carried out in the city of Dar es Salaam which is divided into three municipalities (districts) – Temeke, Illala and Kinondoni. The aim of the study was to compile evidence on the functioning of the exemption and waiver mechanism at city level and to recommend measures for its improvement. Data collection took place over a period of two weeks from 4-15 April 2005 in all three municipalities. Due to the limited time horizon for the study, a convenience sample was chosen, to conduct interviews in enough health facilities to ensure that the broad range of issues were brought to the attention of the study team. In total, the three Municipal Medical Offices for Health and 12 health facilities at dispensary, health centre and hospital level were visited. Baseline data was gathered through semi-structured exit interviews with clients and providers, and group discussions were held with key informants at each facility. In addition, routine data on user fee exemptions and waivers was collected in the format available, the Health Board minutes in 75% of the facilities visited were reviewed from the years 2001 to 2005, and the 2005 Municipal Council “Plans of Operation” were examined for activities related to the cost sharing mechanism.

2.1 Facility selection

Facilities were selected from different health care levels in all three municipalities of Dar es Salaam using a comprehensive health facility list from 2001. For each municipality - Temeke, Illala and Kinondoni – there is one publicly-funded district-level hospital, one or two health centres, and between 13 and 22 dispensaries. Therefore, the sample of 3 district hospitals, 3 health centres and 6 dispensaries covered 100% of district hospitals, 75% of health centres, and 11% of dispensaries. In addition, the Municipal Medical Offices for Health were approached for additional exit interviews and data collection. At dispensary level, the facilities were selected randomly to give 6 facilities with a range of daily patient attendance. Referring to the facility list, average daily patient throughput at dispensary level ranged between 200-350 patients per day for the facilities visited. Following the advice of the Municipal Medical Offices for Health and for logistical reasons, two dispensaries originally selected were replaced. Table 1 gives an overview of the visited facilities.

Table 1. Sample of health facilities and municipal offices visited

Municipality	Facility level/type	MMOH
Kinondoni	Mwananyamala Hospital Magomeni Health Centre Mburahati Dispensary Tandale Dispensary	Kinondoni MMOH
Illala	Amana Hospital Mnazi Mmoja Health Centre Vingunguti Dispensary Tabata Dispensary	Illala MMOH
Temeke	Temeke Hospital Kigamboni Health Centre Tambuka Reli Dispensary Rangitatu Dispensary	Temeke MMOH

2.2 Provider survey design and data collection

The aim of the present study was to consider both the provider and client perspectives with respect to the existing exemption and waiver mechanism. Concerning the provider perspective, the methodological framework of the study consisted of semi-structured interviews with facility and MMOH staff, and group discussions with key staff members. In-depth interviews and the group

discussion were conducted with relevant staff members present at the facility, which included the in-charge (clinical officer, or medical officer, or nursing officer), accountants, health administrators, HMIS officers, and at hospital level the social welfare officer. The interview questions aimed at identifying the processes of the exemption and waiver mechanism implemented at each level of care. The language of communication used in the interviews and group discussions was English. Where necessary, clarifications and explanations were given by the researchers in Kiswahili. After the interview, the facility was asked to provide relevant data such as monthly exemption and cost sharing reports, annual plans of operation, and health board minutes. Copies of these were taken wherever possible. The aim of the document review was to quantify the number of people exempted and waived per facility, and to compare it with the annual patient load and total annual revenue collected by the cost sharing system.

2.3 Client survey design and data collection

Semi-structured interviews were also used with individual clients at each health facility in order to elicit the community's perception of exemption and waiver practices. A staff member of the health facility introduced the interviewer to a number of clients waiting for services. The patients were randomly selected by facility staff based on who was available at the time. A total of 52 clients were interviewed in 9 health facilities. Due to the greater number of women at facilities, the sample reflected this (36/52 women; 16/52 men). 5/36 women were pregnant. The age distribution was: 17/52 under 25 years of age; 26/52 age 25-59; 9/52 age 60 and over. 13/17 of those under 25 years of age were under fives, accompanied by their mother or carer.

3. The policy of user fees for health in Dar es Salaam

3.1 User fee policy

In July 1993, the government of Tanzania introduced user fees for health services in the public sector. A health financing study conducted in 1991-92 justified the introduction of user charges in Tanzania on the basis of improving services for all users, given the low quality of health services and the lack of service coverage caused by the severe financing gap in the health sector (Abel-Smith and Rawal 1992). In particular, charging for drugs was argued to enable the public sector to provide drugs at a lower cost through government facilities, rather than patients having to buy higher price drugs on the open market. The symptoms of under-funding in 1992 included (Munyetti et al 1999):

- Over-reliance on foreign aid for essential drugs, inadequate supply of drugs & other supplies;
- Lack of repairs & maintenance of medical equipment, vehicles, buildings; insufficient fuel supply;
- A fall in real salary levels for health workers; severe staff shortages in rural areas;
- Lack of functioning health information systems; and
- Overcrowding at higher level facilities, as patients bypass lower level facilities due to the poor quality of care.

Several research studies suggested that individuals and households were willing to pay for improved health services (Abel-Smith and Rawal 1992), although these studies reported that 28% of the Tanzanian population interviewed found it *very difficult* to pay for health care, and a further 49% found it *difficult* to pay for health care. While on the one hand it was predicted that user fees would negatively impact uptake of health services, on the other hand the existing system was breaking down due to the lack of resources at decentralized levels, quality problems, bribery issues and patients obtaining their drugs from the private sector. The four objectives stated by the Government of Tanzania for the cost sharing policy included (Ministry of Health 1993):

1. Generate additional revenues.
2. Improve availability and quality of services.
3. Strengthen referral system and rationalize utilization of health services.
4. Improve equity and access to health services.

The Ministry of Health understood well that introducing user fees required a cautious approach. A phased approach for implementation of the new user fee policy was adopted as follows:

Phase I (July 1993). Introduce revised charges for Grade I and II patients at referral, regional and district hospitals.

Phase II (January 1994). Introduce user fees for Grade III services at referral, regional hospitals.

Phase III (July 1994). Introduce charges for inpatient and outpatient services at district hospitals.

Phase IV (further phased, starting September 2004 and lasting many years). Introduce user charges at health centres and dispensary levels country-wide.

In June 1994, the implementation guideline for cost-sharing in health services in Dar es Salaam was issued by the City Medical Officer for Health (Dar es Salaam City Council 1994). In July 1994, the 3 district hospitals of Dar es Salaam introduced cost sharing, followed by the health centres in September 1994. Pilot cost sharing schemes started operating at dispensary level in Dar es Salaam in June 1996, after which all dispensaries gradually started implementing cost sharing.

It appears from the user fee policy adopted by the Dar es Salaam City Medical Office of Health that quite some freedom was allowed by national level for the exact modality of implementation of user fees, such as differential pricing between facilities and mark-up on drugs. For example:

- There existed different fee schedules at different types of facility with a distinction between rural, rural-urban, urban dispensaries, hospital and dispensaries (Mujinja et al 1993).
- Prices of services and goods at public facilities were 50% of the private sector fees.
- The principle of cross-subsidisation on some drugs was adopted.

While this has caused some discrepancy in prices at different public health facilities in the City of Dar es Salaam, Table 2 shows some indicative prices of selected services at different levels.

Table 2. Prices at different levels of the health system

Type of Services	Referral Hospital (TSH)*	Regional Hospital (TSH)*	District Hospital (TSH)*	Health Centre (TSH)**	Dispensary (TSH)**
Registration (first attendance)	1'000	500	300	300	100
Laboratory Tests					
BS, Urine, Stool, Hb (Grade III)	100	100	100	200	200
VDRL, Wedal, Pregnancy, Other (Grade III)	> 1'100	> 1'100	> 1'100	1'200	500
Surgery: Minor Operations (Grade III)	1'000	500	300	200	200
X-Ray (Grade III)	750	500	400	no x-ray	no x-ray
Ultrasound, ECG, ECHO, Barium meal (Grade III)	1'000	1'000	500	no ultrasound	
Admission Fee (Grade III)	2'000	1'000	500	no admission	
Drugs and Infusions	Fee charged at 50% of the real cost according to prices of the Medical store department				

* Price recommendations for hospitals were given in R/CMOH cost sharing guidelines (1996),

Exchange rates: 1 Tanzanian Shilling = 0.0008795 US Dollar, 1 Tanzanian Shilling = 0.0007246 Euro

** Prices charged at health centres and dispensaries were given by interviews with health providers

3.2 User fee exemption and waiver policy

The 1994 cost sharing implementation guideline issued by the City Medical Officer of Health contains advice on who should be charged, and which categories of patient should receive exemption. Exemption and waiver categories included:

1. **Chronic diseases** (hypertension, heart problems, diabetes, tuberculosis).
2. **Children under 5 years of age**, identified from their MCH clinic cards.
3. **Pregnant women**, until after delivery.
4. **Poor people**, defined as those unable to pay for health services.

Exemption covers doctor's consultation fees, drugs available from the drug kit (containing essential drugs only), laboratory fees and X-ray services. However, the 1994 document states that patients hospitalised for chronic diseases, antenatal hospitalization, and the under 5 should pay the admission fee, but not for the actual cost of stay. Furthermore, if a patient pays some fees before diagnosis of an exempted disease is confirmed, there is no refund for the expenses already paid.

Other categories, while not paying a fee for service, should be covered as follows:

5. **Emergency patients** involved in an accident do not have to pay at the time of treatment, but are expected to pay after they are treated, unless following waiver procedures.
6. **Health workers** and their direct family are covered by their employers.
7. **Prisoners** should be treated free, but Ministry of Home Affairs should pay reimbursements.

The guideline states that disabled people will only be granted a waiver if they fall under the other stated exemption/waiver categories (1-7 above). Similarly, elderly people are not mentioned in the guideline as receiving a waiver, unless unable to pay. There are no reimbursements given to the health facilities for the exemptions and waivers provided. Part of their cost is covered by the delivery of free drug kits to health facilities.

4. Exemptions and waivers granted

4.1 Overall exemptions and waivers

Table 3 summarises the number and value of exemptions and waivers provided by health facility level and Municipality in the City of Dar es Salaam in 2003 and 2004. The number and value of paying patients through cost sharing is also presented, for comparison with the exemptions and waivers provided.

In 2004, the total number of exemptions and waivers stand at around 580,000 for the three Municipalities combined, ranging between 175,000 for Temeke to 200,000 each for Illala and Kinondoni². Spread over the entire population of Dar es Salaam of roughly 2.5 million (from the 2002 Population and Housing Census), this equals roughly 0.23 visits per capita per year. The total number of visits according to the cost sharing system is 1.4 million. Thus 41% of health services are provided free of charge, obtained through the exemption and waiver mechanism. However, there is considerable variation between municipality (27% in Temeke, 47% in Illala, and 42% in Kinondoni). Municipality-specific analyses of health service use and exemptions show the following differences:

- Temeke (population 768,451): 0.83 visits per capita, or which 0.23 exempted.
- Illala (population 634,924): 0.70 visits per capita, or which 0.32 exempted.
- Kinondoni (population 1,083,913): 0.44 visits per capita, or which 0.18 exempted.

² As data were not available from Illala MMOH for 2004 (at the time of writing), 2003 figures are used instead.

Table 3. Exemptions provided in public health facilities, by Municipality

District, and level of facility	Patient load (no. of patients)			Value (Tsh)***		
	Total number	Number exempted	% exempted	Exemption	Cost sharing	% exempted
TEMEKE						
2004						
Dispensary	389'354	76'771	20%	27'708'929	18'983'474 *	59%
Health Centre	36'539	16'102	44%	15'013'100	15'852'693	49%
Hospital	213'868	82'304	38%	192'379'180	160'714'513	54%
Total	639'761	175'177	27%	235'101'209	195'550'680	55%
2003						
Dispensary	396'980	95'549	24%	33'758'920	76'852'885	31%
Health Centre	36'783	16'801	46%	14'601'000	14'585'700	50%
Hospital	179'507	68'590	38%	120'298'400	N/A	N/A
Total	613'270	180'940	30%	168'359'920	91'438'585	35%
ILALA						
2004	<i>Not available: in process of compilation by Illala MMOH</i>					
2003						
Dispensary	169'910	65'661	39%	31'621'131	61'680'125	34%
Health Centre	102'234	64'403	63%	15'455'498	50'787'275	23%
Hospital	169'991	75'909	45%	318'817'800	117'694'720	73%
Total	442'135	205'973	47%	365'894'429	230'162'120	61%
KINONDONI						
2004						
Dispensary **	166'781	68'127	41%	101'349'689	117'896'272	46%
Health Centre	110'132	49'878	45%	26'756'300	61'622'932	30%
Hospital	198'121	81'238	41%	62'549'782	110'538'000	35%
Total	475'034	199'243	42%	190'655'770	290'057'204	40%
2003						
Dispensary	103'343	45'999	45%	N/A	120'825'951	N/A
Health Centre	121'360	53'451	44%	N/A	64'325'905	N/A
Hospital	196'738	58'945	30%	N/A	114'247'565	N/A
Total	421'441	158'395	38%	N/A	299'399'421	N/A

* Some dispensaries have no cost sharing information reported in the exemption forms, hence the 2003 figure is more indicative.

** Some months are missing for some dispensaries in Kinondoni. Therefore, to ensure completeness of the picture, the figures were adjusted upwards proportionately depending on the number of months missing.

*** Exchange rates: 1 Tanzanian Shilling = 0.0008795 US Dollar, 1 Tanzanian Shilling = 0.0007246 Euro

While cost sharing statistics on the numbers of health service contacts may not be fully reliable (compared to HMIS), the differences between municipalities suggested above are considerable, especially between Kinondoni and the other two municipalities. One factor explaining the low use and rates of exemption at public health facilities in Kinondoni may be the fact that it is the municipality with the highest average incomes, and the highest amount of private health facilities.

The value of these 580,000 exemptions totals roughly 800 million Tsh (~ US\$1 million), giving roughly 1300 Tsh (~ US\$1.70) per visit. The proportional value of exemptions and waivers (as % of total cost sharing revenue) is greater than for proportion of patients, at 55% for Temeke, 61% in Illala and 40% in Kinondoni.

The health care level where most exemptions and waivers are granted varies between municipality (4th and 7th columns in Table 3). In Temeke, most exemptions and waivers are granted at dispensary level (61%), followed by the hospital (33%). In Illala, hospital and dispensary have similar proportions (38%), while in Kinondoni the hospital provides 42% of exemptions and waivers, and dispensaries 35%. What is interesting is that the value of exemptions and waivers granted at the hospitals is considerably greater than for the other two levels added together, accounting for 82% in Temeke, and 51% in Illala. However, Kinondoni is different, with a higher share of exemption and waiver value granted at dispensary level.

The proportion of total patients exempted or waived varies between facilities in Temeke District between 8% in Gezaule Dispensary and 64% in Mbande Dispensary. The larger facilities exempt closer to the municipal average, Temeke Hospital giving 38% of patients exemptions or waivers, and Kigamboni health centre giving 44% of patients exemptions or waivers. Comparisons with 2003 show some general similarities as well as major differences, suggesting that the municipal offices may need to examine why year-to-year variations are taking place³. Similar differences exist between health facilities in Illala District, with the two Tabata Dispensaries recording very low rates of exempt and waiver patients (1-6%), rising to a high for Msongola dispensary at 77%. In Kinondoni, data reporting follows a different format and the same data were not available. However, large variations in numbers and values of exemptions and waivers granted are observable between health facilities.

4.2 Exemptions and waivers by category

Tables 4 to 8 present data for selected health facilities, representing the most complete and detailed available data on exemptions and waivers by category. These data were collected at health facility level, usually in more detailed format (monthly), which were compiled into annual figures for 2004 for the purpose of this present study. One early observation that can be made is that data are summarized in different ways at facility level, because different facilities have different forms – not only basic data entry, but also summary forms for aggregating patient numbers into monthly reports. For example, Rangigatu Dispensary (Table 4) distinguishes between male and female under fives and poor people, but does not report summary statistics for other categories such as chronic diseases or the elderly. In Magomeni HC, the category of ‘poor’ is omitted from the summary reports, while for Mburahati Dispensary the category ‘emergency cases’ is omitted.

Data from Rangitatu Dispensary show that children account for over 80% of exempted and waiver cases, equally split between girls and boys. Pregnant women constitute the next most common exemption, with 15% of cases in 2004. The poor are the last category, making up only 4% of cases, split equally between men and women but with some year to year variations observable.

Table 4. Total exemptions and waivers, by group, in Rangitatu Dispensary (Temeke), 2002-4

Year	Exempted and waived groups										Total	
	Children				Pregnant women		Poor				No.	Value
	F	%	M	%	F	%	M	%	F	%		
2002	3483	44%	3457	44%	618	8%	133	2%	171	2%	7862	5'730'500
2003	4720	44%	4551	42%	1001	9%	264	2%	236	2%	10772	7'840'400
2004	4437	43%	4042	39%	1562	15%	162	2%	172	2%	10375	5'965'300

F: Female; M: Male

³ The differences are largely explained by incomplete data, as some figures do not include 12 months of data. However, differences can also be due to year-to-year changes in practice of some health facilities, changes in population behaviour, or random differences.

Data from Amana Hospital presented in Table 5 also show that children constitute the highest proportion of exempted and waiver cases, at 70% or higher, followed by pregnant women with 22%. Other categories such as accidents, prisoners, the elderly or poor each constitute 2% or less of the total exempt or waiver cases. The percentage value of services exempted or waived by category mirrors more or less the patient load, except accidents which clearly have a higher cost per case, accounting for 11% of the value of exempted and waived services.

Table 5. Total exemptions and waivers, by group, in Amana Hospital (Illala), according to Summary Form A, 2004

Exempted groups	Patient load (2004)		Total Exemption Value (Tsh)*
	Number exemptions	% exemptions	
Men	1'296	2%	-
Women	638	1%	-
Pregnant women	14'532	22%	-
Children (IPD/OPD)	45'994	70%	-
Prisoners	299	0%	-
Poor	597	1%	-
Accidents	320	0%	-
PF3	331	1%	-
Old	824	1%	-
Accommodation/food	980	1%	-
Total	65'811	100%	263'777'490

* Exchange rates: 1 Tanzanian Shilling = 0.0008795 US Dollar, 1 Tanzanian Shilling = 0.0007246 Euro

Table 6 similarly shows that children are the main beneficiaries of the exemption and waiver mechanism, with 84% of patient load and 76% of service value. This is followed again by pregnant women, but with a lower proportion than in the health facilities above at 6-7%. Emergency cases represent quite an important proportion of waiver caseload with 6% of cases and 8% of value.

Table 6. Total exemptions and waivers, by group, in Magomeni HC (Kinondoni), 2004

Exemption Category	Patient load (2004)		Exemption value (2004)	
	Number exemptions	% exemptions	Tsh*	%
Children	36'497	84%	22'686'800	76%
Pregnant women	2'454	6%	2'193'000	7%
Old	1'305	3%	2'138'700	7%
Chronic diseases	542	1%	360'200	1%
Emergency cases	2'805	6%	2'356'100	8%
Total	43'603	100%	29'734'800	100%

* Exchange rates: 1,000 Tanzanian Shilling = 0.72465 Euro; 1,000 Tanzanian Shilling = 0.87951 US Dollar

Table 7 presents a similar picture concerning the two main beneficiaries of exempted or waived services, with under fives and pregnant women topping the list. Importantly, the poor (9%) and chronic diseases (8%) appear as the next main beneficiaries, in contrast to data presented for other facilities above.

Table 7. Total exemptions and waivers in Mburahati Dispensary (Kinondoni), 2004

Exemption Category	Patient load (2004)		Exemption value (2004)	
	Number of exemptions	% exemptions	Tsh*	%
Old (>60 years)	1'074	5%	1'610'000	5%
Poor (6-59 years)	1'871	9%	2'806'500	9%
Chronic diseases (psychology, TB, HIV)	1'653	8%	2'479'500	8%
Pregnant women	3'936	19%	5'904'000	19%
Children (< 5 years)	11'762	58%	17'715'500	58%
Total	20'344	100%	30'515'000	100%

* Exchange rates: 1 Tanzanian Shilling = 0.0008795 US Dollar, 1 Tanzanian Shilling = 0.0007246 Euro

Tables 8 shows the exemptions and waivers provided in Tandale Dispensary for the years 2004. Of these, the largest proportion was accounted for by children under 5 (19%) and pregnant women given Fesolate (19%). Other groups benefiting include those with laboratory tests (12%) although it is not sure which categories this refers to, followed by others with cards (9%), the poor (7%), the old (4%) and chronic diseases (2%). Comparing the proportion of value of exempted or waived services consumed, there are some differences, with a higher proportion for children (24%), the poor (13%), the old (7%), and a lower proportion for pregnant women fesolate (4%).

Table 8. Total exemptions and waivers in Tandale Dispensary (Kinondoni), 2004

Exemption Category	Patient load (2004)			Exemption value (2004)	
	Number of exemptions	%	% of total OPD visit	Tsh*	%
Old (>60 years)	911	4%	1%	816'900	7%
Poor (6-59 years)	1'808	7%	3%	1'579'200	13%
Chronic Diseases (psychiatric, asthma)	433	2%	1%	647'000	5%
Pregnant Fesolate	4'746	19%	7%	529'400	4%
Pregnant SP	2'593	10%	4%	839'700	7%
Pregnant Mebendazole	2'497	10%	4%	1'052'900	9%
Pregnant HB level	2'136	8%	3%	1'521'880	13%
Other lab/dressing	3'024	12%	5%	1'387'056	12%
Children (<5 years)	4'925	19%	8%	2'834'600	24%
Others (cards)	2'299	9%	4%	689'700	6%
Total	25'372	100%	39%	11'898'363	100%
Total OPD visits			64'816		

* Exchange rates: 1,000 Tanzanian Shilling = 0.72465 Euro; 1,000 Tanzanian Shilling = 0.87951 US Dollar

4.3 Exemptions and waivers over time

One question that could be partially addressed by the information collected concerns the time series trend of waivers and exemptions. Figure 1 shows the total exemptions and waivers given in Kinondoni Municipality from 2001 to 2004. While this figure should be interpreted with some caution (as some data for 2004 is missing) it indicates that there is no trend – either upward or downward – for the number of exemptions granted in that municipality.

Figure 1. Variation over time in number of exempted patients in Kinondoni Municipality.

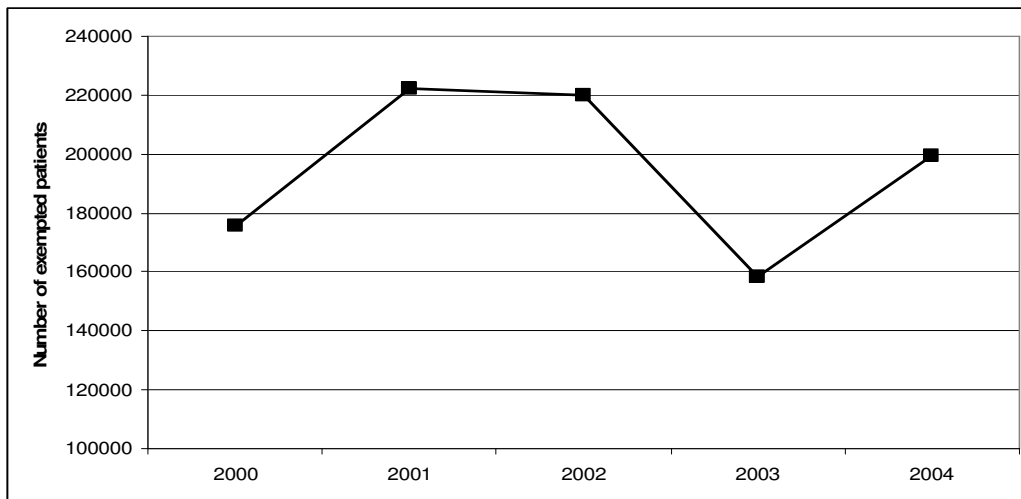
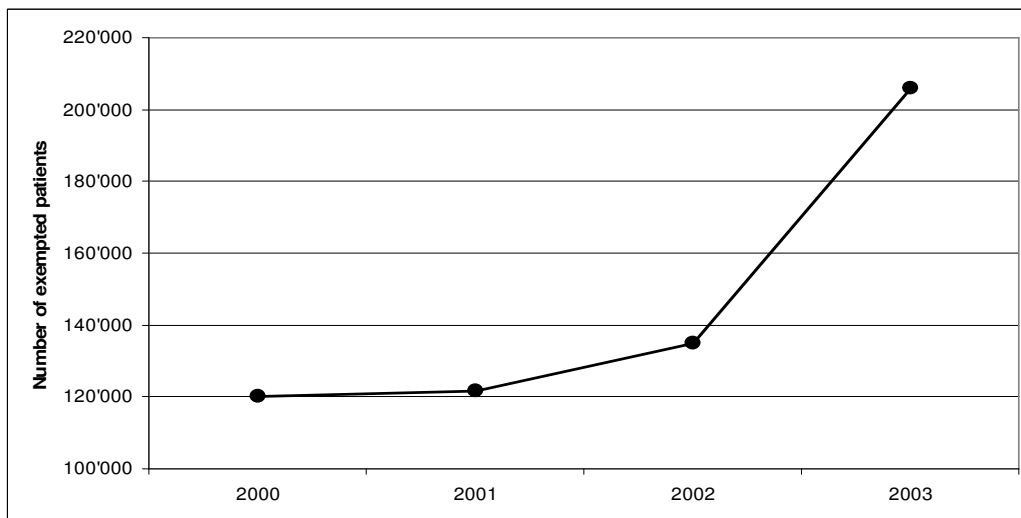


Figure 2 shows the total exemptions given in Illala District from 2000 to 2003 (2004 not compiled yet). From the year-on-year increase in exemptions provided, the conclusion is that there is a clear time trend towards more exemptions and waivers.

Figure 2. Variation over time in number of exempted patients in Illala Municipality.



A third assessment of trends over time is that of Rangitatu Dispensary (Temeke), shown above in Table 4. The data show that the total cases exempted and waived has increased in 2003 and 2004 by around 35% compared to the 2002 statistics. However, the increase in exempted and waiver cases does not translate into higher value of exemptions for 2004. Also in Tandale Dispensary (Kinondoni) there is an increase from the year 2003 to 2004 (Table 8a), an increase of 14% in exempted patient numbers, and 25% in the value of services provided to exempted patients.

5. User fee exemption and waiver operation

This section presents a description of how the exemption and waiver mechanism operates in the sampled health facilities, concluding some strengths and weaknesses and areas for improvement from the perspective of the health providers.

5.1 Exemption and waiver categories

The stated policies on the exemption and waiver mechanisms for the three municipal offices and the sampled health facilities were examined for similarities and differences. There was a high level of agreement among all those interviewed for the following categories of exemption and waiver:

- **Chronic diseases**– the most commonly cited being tuberculosis, leprosy, and HIV/AIDS.
- People who are **disabled**, including mental health cases.
- The **elderly**, over 60 years of age.
- **Children under 5**, with presentation of the MCH card 1. The guideline states children without an MCH card will be charged, although in practice this is not done.
- **Pregnant women** for maternity services until delivery, on presentation of MCH card 4. This generally does not include more expensive services such as ultrasound or X-rays. Also, abortions and delivery are sometimes not exempted. Furthermore, as stated in the user fee policy, most facilities confirmed that they do not provide free care to pregnant women for non-pregnancy related illnesses such as malaria.
- **Emergencies** and **accidents**. Most facilities stated that only a temporary exemption is provided, and the patient is asked to come back and pay later.
- Those **unable to pay**, on presentation of a letter from authorised community leaders stating that the individual is too poor to pay for health services. The 1994 cost sharing implementation guideline states that their case will be reviewed every year.
- **Police cases** (cases brought by the police), which usually means prisoners from local prisons or police stations, but this can also cover rape and accident cases who are brought by police.

Some qualifications are needed for the above stated categories:

- **Other chronic** and some **infectious diseases** were also mentioned by some health facility staff as being exempted, including asthma and diabetes, typhoid, cholera, non-HIV sexually transmitted infections, and other epidemics.
- **Other temporary waivers** are sometimes granted to those not granted a waiver, but recognised as not being able to pay at the time of service demand. It is understood that these cases should return and pay at a later date.
- For those **claiming to be over 60**, there are often problems of not being able to prove their age from birth certificate or other records. To address this, often staff request that a street chairman or ward leader should sign a letter to say the person is over 60 (e.g. Temeke MMOH; Vingunguti Dispensary in Illala).
- There were major differences observed in the **length of exemption for the poor**, once their status has been recognised. Some interviewees cited that a signed letter should be provided for every new illness case (Amana Hospital, Tandale Dispensary in Kinondoni), while some facilities work on the basis of a one year validity (e.g. Mnazi Mmoja Health Centre in Illala), while other facilities grant more or less permanent exemptions or that the period is undefined (Rangitatu Dispensary in Temeke, Magomeni Dispensary in Kinondoni, and Mwananyamala Hospital).
- When **waived patients are referred** to a higher level of care, there is no standard practice for whether the patient would automatically continue to get exemption at the higher level or would need to undergo a further interview.

Table 9 shows a summary comparing the policy with the practice of exemptions and waivers by category. While there are some differences between the 1994 policy and the practices observed in the health facilities visited, in general the exemption and waiver mechanism is working.

Table 9. Comparison of exemption and waiver policy and practice

Category	Policy (1994)	Practice (2005)
Chronic diseases	Exemption	Exempted, but less clear for some diseases and what free care is actually to be provided
Children under 5 years of age	Exemption with MCH card, except hospital admission fee	Exempted
Pregnant women	Exemption except hospital admission fee	Exempted
Poor people	Waiver, with documentation	Waiver provided for most deserving cases, with documentation by community leader(s) or by interview with health staff
Emergency patients	Temporary waiver, to be paid later	Waiver provided, with variable repayment rate
Health workers	Waiver	Paid by insurance (NHIF)
Prisoners	Temporary waiver, to be paid by Ministry of Home Affairs	Waiver provided, but MOH not reimbursed
Disabled	Only waiver if for another category (above)	Disabled people are generally given waivers
Elderly	Waiver for those not able to pay	Waiver, usually requiring proof of age and sometimes proof of not being able to pay

5.2 Information and knowledge

Circulation of information about exemptions and waivers is discussed at two levels: information for **health staff** on the application of the exemption and waiver mechanism, and information for **patients and the community**.

Information on exemption and waiver issues is claimed to be fairly regular to **health staff**. When user fees were introduced in 1994, the national exemption policy was distributed to all the different health levels, and since then document updates or workshops have been provided on an irregular basis. Also, the topic of exemptions and waivers is claimed to be raised regularly in routine (daily and weekly) staff meetings, on-the-job supervision and through information letters from the MMOH. One of the main tasks of the Social Welfare Units in hospitals is to educate hospital staff and the general public about exemption and waiver procedures.

- From in-depth interviews with facility in-charges and others dealing with exemptions and waivers, it appears that health staff are generally very accepting of the exemption and waiver policy. However, some complained that the proportion of exempt and waiver patients is too high, and that some patients in these categories are in the position to pay for the services.

Information to the **community** comes primarily through the Health Board representatives. At health centres and dispensaries, four out of the five members of the Health Board are representatives from the community: one from the ward administration, and three members representing health facility users. At hospitals, five of the 13 Health Board members are from the community.

Community representatives on Health Boards are responsible for informing the community about the exemption policy and other topical issues. The Health Board meets every quarter, where cost

sharing and exemption policy issues are said to be discussed, among other matters. Health Board minutes were reviewed for the years 2002-5 in 9 selected facilities (Amana Hospital; Kigamboni HC; Mnazi Mmoja HC; Magomeni HC; Tambuka Reli Disp; Rangitatu Disp; Tabata Disp; Tandala Disp; Mburahati Disp). Only one discussion on exemption policies could be found in all these minutes in Magomeni HC. In this instance, the facility complained that the number of exemptions were too high, especially police cases, threatening the financial viability of the facility.

The community representatives on the Health Boards play a dual role, not only bringing issues raised by community members to the Health Board for discussion and clarification, but also communicating Health Board discussions back to the community through individual meetings at street and house level, and through general community meetings (e.g. District Council; Ward Meetings). However, while there were some notable instances of patients being informed personally of their exemption status by the Street Leader, questions should be raised over whether the community representatives in the Health Board have much time to play their role in this two-way reporting. Furthermore, the scope for information sharing through personal contact is limited, as the average catchment population per public health facility in Dar es Salaam is 42,000.

As well as the Health Board route, there is a Community-Based Health Care (CBHC) staff member who informs the community about exemptions during health days (one week per year) and health education is provided on several health topics. During health days, health staff (Clinical Officer, Public Health Nurse) go to the wards and organise community meetings, to inform the population on a wide range of health issues. Other District staff, such as the IEC/RCH Officer, should provide information on exemptions to the community as part of their day-to-day work.

One further channel that is used is the media. Interviewees reported that the availability of exemptions and waivers is mentioned during health messages on the radio and the television (see findings in section 6). However, the Household Budget Survey shows that in Tanzania radio ownership stands at 41% of households for the poorest quintile and television ownership for the same population at 0.4% (National Bureau of Statistics 2002), suggesting that the potential for reaching poor and vulnerable groups through these channels, especially television, is limited.

Once at the facility, the patient may find the information on the information board at the entrance of the facility. Also, at registration, depending on the identification of the patient, information should be given on whether they qualify for an exemption or not. At the hospitals, there are social welfare officers, whose job it is to inform people about their rights. However, some facilities admitted that the facility does not routinely inform patients unaware of free service provision.

Also, from the interviews conducted with health staff, it appears that the information on collection and use of cost sharing funds, including exemptions and waivers granted, is not routinely shared with the community. The one main opportunity for sharing this information, the Health Boards, is not used. Also, Bulletin Boards at the facility level do not routinely advertise this information.

Looking into the future, the 2005 plans of operation were reviewed for each Municipal Council, for specific actions on cost sharing and the exemption mechanism. In general, the objective of all the Councils is to improve community and IEC services, through regular meetings with CBHC implementers and community-based organisations, orienting new CBHC implementers, supporting Health Board functioning, and conducting meetings with the Ward Health Officers. At facility level, many activities are planned for improving the knowledge of staff and the community on cost sharing issues. At Amana Hospital, Buguruni HC, Mnazi Mmoja HC and the dispensaries in Illala this included recruiting social welfare officers, providing care to poor patients, orientation of nurses on social welfare ethics, and improving report generation. Dispensaries also plan to train street leaders and health boards in the CBHC concept. In general, less activities related to exemption and waivers are planned in Temeke and Kinondoni Municipalities.

5.3 Obtaining exemption or waiver status

In general, there is a common procedure in place for obtaining exemptions and waivers, with some but limited differences observed at the health facilities visited and between different districts. Once the patient arrives at the facility, their first stop is the registration desk, where their exemption or waiver status is identified. In some facilities, especially health centres and hospitals, the person fills in an exemption form. For patients at dispensaries, the only proof of exemption may be that 'exemption' is written on their receipt, if they have not been given an exemption card. For most exempt and some waiver categories, the identification of the patient's exempt status is fairly clear – whether it be their age (<5 or over 60) or their condition (disease type, pregnancy). In general, health staff only grant an exemption if the patient has their paper work with them, such as an MCH card, birth certificate, or a letter from a community leader.

The process for poor people to obtain a waiver appears not to be clearly described in the user fee implementation guidelines. One section of the guideline briefly states the procedure for those that cannot obtain a letter from their community leader – but no guidance is given on how such a letter should be organized and how community leaders should decide eligibility for waiver. Despite the lack of guidance, a number of practices have developed that appear to be more or less standard across the entire city. The process of obtaining a waiver for poor people, and sometimes for the elderly, should be initiated at the lowest unit of urban organization – the Tencell or the Street – where leaders are approached by the individual for a letter attesting to waiver status. This letter should sometimes be corroborated by the Ward leaders, who give their agreement in the form of a signature on the same letter. When presented to the health facility, such a letter should be sufficient to obtain a waiver. If there are any doubts, or if there is no letter, then the patient is referred by the medical recorder to a nurse or the facility in-charge, who interview the patient and make a decision. At the hospital, the Social Welfare Officer is responsible. At night, when the in-charge is not present, the nursing in-charge or the medical officer in-charge makes the decision. The question of how the community leader makes a decision was not discovered in this study from interviews with health staff at MMOH and health facility levels. It is not clear what communications have been made to community leaders on identifying those eligible for waiver status and if there are limits on how many waivers can be granted per month or per year.

While correct identification of poor people is an important concern for health staff, only one of the interviewed facilities said they need a passport picture with the letter to obtain a waiver (Rangitatu Dispensary in Temeke). Clearly, if the patient did not look poor, there would be further interviews with senior staff, where they have the right to reject their application or demand further proof.

Once exemption or waiver status is obtained, some health facilities fill out an exemption or waiver card, to be kept by the patient. These are often colour-coded (e.g. pink for old people – Mwananyamala Hospital). If no card is given to the patient, then 'Exempted' or the like would be filled in by hand on the patient's treatment card or receipt.

For accounting purposes, exempted and waived patients are given receipts for the value of the services consumed. This is either in the form of a written receipt, or in the form of coloured receipts (100, 300, 500, or 1000 Tsh) which are added to sum to the value of the consumed service. The other half of the receipt or voucher is kept with the facility for accounting purposes. This procedure ensures that an exemption or waiver cannot be provided without giving a receipt, and enables calculation of the exact revenue not collected from cost sharing.

In addition to the generally standard procedure described above, some non-standard practices were noted in some facilities:

- In Vingunguti Dispensary (Illala), it became apparent that those exempted or waived are not charged the consultation fee, but for everything else they have to pay.
- In some facilities (e.g. Rangitatu Dispensary in Tem eke), retrospective waivers are

occasionally (but rarely) given.

- In some facilities, it was stated that partial payment is accepted, where it can be negotiated. For example, if the patient cannot pay 1500 Tsh, then they are asked for 1000 Tsh instead.
- Patients are often given temporary exemption. In addition to emergency cases discussed earlier, this may be poor people, or people who just did not bring enough money with them that day. But few providers seem to trust that patients will come back with the money.

5.4 Financial procedures

When cost sharing was introduced, staff were trained at all levels on how to do cost-sharing and how to open a bank account. All payments made by the patient are accounted for by a two part receipt, one of which is kept by the facility. After the revenue is collected, the revenue is given to the main cashier at the end of each day with the receipts, including exemption and waiver receipts. The collections are noted down in a special book by the main cashier who makes the daily recordings for all the collection points.

The accountant in each facility makes monthly reports including cash books, which allows comparison of the financial books with the bank balance. Every few days, the money is taken to the bank and a bank pay in slip is filled in. One facility noted that 3 copies exist: 1 for the bank, 1 for the facility and 1 is attached to the RCCB. The accountant supervises the cashier. Most commonly he or the facility In-Charge write the monthly reports to the MMOH and in some cases to the Health Secretary and quarterly to the Ministry of Health.

Revenues from user fees can be spent according to the annual council comprehensive health plan. The user fee revenue is deposited in the health facility's bank account. To use the money, permission should first be sought from the MMOH's office, with reference to the expenditure item in the annual plan of action. In order to release the money from the bank account, the signatures of a member of the Health Board as well as the facility In-Charge are required.

5.5 Recording and reporting of exemptions and waivers

The process of recording and reporting of exemptions and waivers is, on the surface, quite a standard and well followed one. Information from each patient is noted down in the exemption registers book by the Nursing Officer I/C and the HMIS I/C daily, and the numbers and value of exemptions compiled at the end of each day. The Clinical Officer In-Charge, Assistant Medical Officer, or Nurse In-Charge write the monthly reports and send them quarterly to the MMOH. This report includes the number and value of different types of exempt or waiver patients. However, during interviews in different health facilities, it emerged that there exist several different types of summary forms, which are sent to the MMOH. In some, poor patients are not mentioned. In others, it only distinguishes between staff and non-staff exemptions given. Forms used by some facilities have many columns for exempt categories (e.g. pregnant women – see Table 8) disaggregated into exactly which services they received. This means that different types of information are being communicated to the MMOHs, making aggregation at municipal level difficult.

Reports are either sent monthly and/or quarterly from all facilities to the MMOH on the number and value of exemptions and waivers. At the MMOH, either the Planning Unit, the HMIS unit, or the Accountant is responsible for compiling and writing the reports to the Municipal council, in electronic form. In Illala MMOH, it was stated that if a facility does not provide the necessary forms, a supervisory visit is conducted. The exemption and cost sharing reports are sent to the Ministry of Health. The information is presented to the annual meeting of the Dar es Salaam Health Board Administration (per facility/per year). However, no routine feedback is provided to the health facilities from the MMOH.

5.6 Resource costs for implementation of exemption system

Given that collecting money through cost sharing and granting exemptions and waivers all take time and require materials, these costs need to be compared with the money collected from the cost sharing system, to calculate net revenue. While this was not the aim of this present study, it is interesting for the Government of Tanzania to know what resource costs the exemption and waiver system has, as it is a contributing cost to the cost sharing system. During the interviews, therefore, staff were asked about the time and materials required to operate the exemption and waiver mechanism. Inputs are divided into 3 principle types:

1. Time for registration and identification of exemption or waiver status; form filling; taking patient to provider. The standard time estimate for registration was around 5 minutes per patient for most exemption cases, while for complicated cases (such as those showing up without the necessary documentation), it can take considerably longer.
2. Time for record keeping at the facility; computation of totals; and further compilation (aggregation) at all levels. Health staff said that these tasks are carried out at the facility usually in the afternoon, when the patient load has reduced. Filling out the monthly and quarterly summaries takes more time than the daily summaries.
3. Materials for exemptions and waivers – registers (one line per patient); exemption forms (1 A4 page per patient); exemption cards (one per patient, but only in some facilities); receipts.

It appears that the exemption policy does not require a large amount of resources while in comparison with the costs of revenue collection – including the revenue collection points, accountancy and spending procedures – more resources are used for the cost sharing system.

5.7 Stated strengths and weaknesses of the exemption and waiver mechanism

During the interviews and discussions with health staff, the interviewee was questioned over their perceptions of the exemption and waiver mechanism. Results are summarized below.

- The poor and deserving have access to health services, through the offer of free services.
- The operation of the exemption and waiver mechanism allows valuable funds to be generated from patients who are able and willing to pay
- The community is formally represented in the health system through the exemption and waiver mechanism (the Health Board member, street leaders and ward leaders), and waivers are granted by those who are in the best position to know a person's economic status.
- Accidents get treated immediately, with no delay while the patient arranges payment.
- The quality of services for exempted/waived patients is the same as for paying patients.
- The local government authority has adopted the exemption policy.
- The stated weakness, which also gained some agreement across those interviewed, include:
- Identifying those to be given an exemption or waiver is sometimes a problem. This means that some deserving groups are apparently neglected. For example, people from rural areas who do not have relatives in Dar es Salaam, can present a problem for Street Leaders who do not have a reference point for assessment of deservingness.
- The exemption mechanism is not clearly explained and the policy is not fully defined in all instances. For example, chronic diseases that are exempted are not specified and there is confusion about what maternity services are exempt from cost sharing.
- The system apparently cannot afford the high number of exemptions and waivers provided – especially as the drug kits often run out. Health facilities and Health Boards complain that too many exemptions are provided (refer to Table 2 and Annex 1 tables). One Health Centre complained that they have to treat too many police cases (prisoners) – more than 10 per day without receiving refunds from the MMOH.
- Linked to the above point, health staff complain that some exempted patients (e.g. the old and

pregnant women) are not poor.

- Staff are not always motivated to respect the system, and therefore do not want to provide exemptions or waivers to those that qualify. This may come back to the point that services provided free are not refunded to the health provider.
- No training has been offered to those dealing with exemptions (claimed by Tem eke Hospital).
- The community is hardly involved in the exemption process, according to some providers.
- There is apparently little top-down feedback in the system.

6. Exemptions and waivers from a client's perspective

6.1 Client knowledge and information sources

From the 52 patient interviews conducted, it appears that the knowledge of clients about the exemption and waiver mechanism varies a lot. Most had a vague idea about the mechanisms – for example, 71% (37/52) were aware that children under 5 years of age were exempt; 58% (30/52) knew that older people are exempt; 48% (25/52) knew about pregnant women; 31% (16/52) the poor; 23% (12/52) the disabled; 15% (8/52) those with chronic diseases; and under 5% about orphans, police cases, accidents or refugees. Patients seemed to know very little about the cost recovery mechanism, or what cost sharing contributions were used for. Most patients had no idea that a Health Board existed. Knowledge was often highly related to the personal situation of the patient. For example, young women pregnant for the first time knew that pregnant women are exempt but didn't necessarily know that under fives were exempt.

The category which presented the most doubts seemed to be that of older people. Many patients felt that older people should be exempt, but the rich older people should pay. A man at Mnazi Mmoja Health Centre with tuberculosis said that he knew about the exemption status for chronic diseases because he had been told by the hospital. Not many others were aware of this exemption status, but those who mentioned it usually said that it was for tuberculosis and leprosy. Only 10% (5/52) were aware that HIV/AIDS falls into the exempt category, and only two mentioned other sexually transmitted diseases.

Clients had very little information about the decision making processes of health boards concerning the exemption and waiver mechanism, since the majority didn't even know of the existence of the health boards. Of the 17 people who claimed to have heard of health boards, only four had any idea of their function. Most people when asked said that if they wanted to make a complaint or suggestion to the health facility, they would talk to the doctors or nurses.

In general, the people in the middle age category (25-60) were better informed than the younger or older respondents, and men were better informed about wider health issues than women, although women knew more about pregnancy and childhood issues.

The main sources of information are presented in Table 10. Many people said that they acquired their information from the radio or from newspapers. Some said that they had read information presented on official signboards or posted on doors in the health facilities.

Table 10. Sources of information on exemptions and waivers

Source of information	No. of clients	% of clients
Media (newspapers, radio, television)	18	35%
Heard from other patients at the health facility	11	21%
Heard from friends	7	13%
Told by a staff member at the health facility (about a condition which didn't concern them directly)	7	13%
Signs/posters/brochures at the health facility	6	12%
Heard at a community meeting	3	6%
Assumption	2	4%

Note: these data do not reflect those people who heard about exemptions and waivers when they visited a health facility.

It becomes apparent that people generally know what they need to know about their own condition and that medical staff are generally good at informing people of their rights to exemptions, although some exceptions were cited. For example, one woman at Kinondoni District Hospital explained 'The ones who don't know end up paying, and the ones who do know remind the staff, so they don't pay'. Thus, health facilities could do more to clarify the rules and to provide information on exemption and waiver mechanisms.

6.2 Client experiences with exemptions

A total of 24 people with exemptions were interviewed: 13 children under 5 (where their guardian was interviewed); 5 pregnant women; 5 elderly people; and 1 chronic disease (tuberculosis).

In general, the interviews revealed that the presence of a child under five, a pregnant woman or a chronic disease seems to ensure that exemption status is granted automatically. A woman has a pregnancy test and is immediately issued with an MCH card. When her child is born, the child receives a card, which lasts until the fifth birthday. The tuberculosis patient, a man of 32 at Mnazi Mmoja Health Centre, said that he had been seen at Muhimbili Hospital where they issued him with a card entitling him to free treatment and drugs in his local health facility. A pregnant woman of 20 at Tabata dispensary explained that she had never been to a government facility before, since she had always attended private hospitals. When she heard that treatment was free for pregnant women at government dispensaries, she began attending Tabata dispensary MCH clinic.

Exceptions included a man at Vingunguti dispensary who brought his 3 year old nephew to Amana District Hospital in the night. He paid for treatment for the child, but then another client at the hospital told him that treatment for under fives was free, so he claimed his money back.

None of the interviewed had received a waiver due to poverty status and none were over 60 years old. General procedures for waivers due to poverty status often involve a letter from a street chairperson, explaining the circumstances which prevent the individual concerned from paying for medical treatment. The Medical Officer at Vingunguti explained that they receive many more requests for free treatment, but the clients come straight to the dispensary, where they are judged on their individual merit by dispensary staff. In other small dispensaries, clients explained that the dispensary staff know who is poor in the area and thus provide them with free services.

In the case of older people, there appears to be two main ways of obtaining a waiver. In some instances, older people said that they had received letters from their street chairman explaining that they had no means of supporting themselves and thus no way of paying for health care. Others said that they just turned up at the health centre, told them their age and they were automatically given an exemption card. People are not clear as to whether the waiver applies for poor older people or for all people over 60. For example, there were cases of elderly people interviewed at Kigamboni Health Centre, Illala District Hospital and Mnazi Mmoja Health Centre, some of whom had already paid for treatment. They were told that they would not be given free care until they got a

letter from their Street Leader, explaining they are too poor to pay for health care. In other cases, patients were issued with a waiver card immediately on arriving at the facility (e.g. Kinondoni District Hospital, Vingunguti dispensary). At Vingunguti dispensary, there were copies of letters that had been written by street chairpersons to request waivers – there were ten letters in the file, dating from December 2003. Three were standard printed forms for older people, two were for men from the local military, and the others were for temporary waivers for poor people who had been sick for some time and who were not able to pay. One of the sick people was also blind. An interviewee at Mnazi Mmoja Health Centre said that when her mother visits from another part of the country, she brings her exemption card and gets free health care wherever she goes.

In the interviews, the respondents were asked what would happen if a person turned up at the health facility with no money, sick or having had an accident. There was a variety of opinions from the 43 respondents asked this question, 27 said that the health staff would treat the client, 10 that the health staff would not treat the client, 5 did not know, and 1 said it depends on who is on duty at the time. Many of those who said that the client would be treated added that they would probably have to wait until those who had paid had been seen to. A woman at Kinondoni District Hospital said 'You sometimes see people who have been waiting for hours and are the last ones to be seen, even though they arrived before everyone else, and you know that those are the ones with no money'. Most of them said that the client would be expected to find the money and come back with it at a later date. Those who said that the client wouldn't be treated explained that they would be told to go home and come back with money, then they could be seen to. Some patients expressed strong views about the way that poor people were treated by health staff. However, there were also some stories of poor patients with no letter being treated free of charge.

The social welfare officer at Illala District Hospital said that street children are also treated for free – if they have to be admitted to the hospital they are given food and a bed, with all medical treatment necessary until they are well again.

No standard systems for waivers seems to exist in Dar es Salaam. Some people are required to bring letters, others (older people) should be waived but have to have letters, while some are given waivers at health facility level, depending on their financial situation at the time. Thus whether a person gets a waiver at the health facility may depend on who is on duty at the time, how busy they are, or even what mood they are in at the moment of the waiver being requested. There are no criteria to define who is poor – it is down to the opinion of the person who is making the decision about the waiver to judge themselves. Even the municipal administrator at Illala District Council didn't perceive this as a problem, saying, 'There's no problem identifying the poor - it's obvious if someone is poor.' When questioned about the quality of care, most patients suggested that the standard of service they received was just as good as if they were paying for it.

Seventeen of the respondents were asked about whether those with exemption or waiver status ever felt the necessity to make extra payments to medical staff to ensure better service. The general opinion was that this sort of demand for payment was much reduced compared with the past when it was all pervasive, but that it still existed. Nine respondents felt that this sort of payment no longer existed, while eight out of the 17 mentioned that some payments were still made, the main function of which is to assist in queue jumping or hurrying along procedures rather than it affecting the quality of service

6.3 What does 'free medical care' mean?

A point which gradually became clear in the course of the patient interviews was that the concept of free medical service varies greatly from one health facility to another, and even possibly within one health facility. Those with exemptions explained that in general they received the services, tests and drugs connected with their condition free of charge. However, it became clear that there are many anomalies between what is paid for and what is free. In all health facilities, those with exemption status were not required to pay the fee to see the medical staff (usually about 100 Tsh at

dispensaries and 300 Tsh at health centres). In some facilities, everything else was free, including laboratory tests and drugs. One older man at Mnazi Mmoja said, 'Even if I need an ambulance to take me somewhere, it'd be free'. However, in other facilities there were variations:

- A pregnant woman of 23 at Illala District Hospital said that she paid 500 Tsh for her clinic card and 2,000 Tsh for a blood test. 'They say it's free, but you end up paying for all sorts .
- A pregnant woman at Tabata Dispensary said that the blood test for STDs cost 2,000 Tsh, but testing for other conditions and AIDS testing and counselling was free.
- Women in Magomeni Health Centre said that pregnant women get free service, but they had to pay 100 Tsh for any syringe that might be used. Another woman in the same facility said that women have to pay for gloves, thread for stitches and cotton wool used during delivery.

Similar examples emerged about treatment for children:

- In Vingunguti dispensary, women said that MCH services were free for children, but testing services and drugs had to be paid for.
- In Rangitatu dispensary, women said that children are seen free and can be tested free, but they have to pay for any drugs prescribed.

Another issue which came up over the course of the study was confusion about drugs and payment. It seems that those who have exemption and waiver status are entitled to free drugs from the hospitals. But some drugs are charged for in the health facilities. For example, a woman in Vingunguti Dispensary said that there were certain types of drugs that are charged for whether a client has exemption status or not, and at Magomeni Health Centre, an older man with exemption status said that cheap drugs like paracetamol were provided free of charge, but more expensive ones had to be paid for. Another problem is that on many occasions the drugs prescribed are not available at the hospital, since the drug kits often run out of certain types of drugs, as the indent system is not operating everywhere yet. Unless drug stocks have been replenished by health facilities buying direct from the medical stores department, clients therefore have to go to the local privately run pharmacies to buy them. In most of the facilities, people said that they should receive the drugs free of charge except that the facility had usually run out of them, so they had to go and buy them from a local pharmacy. One older man with exemption status said that he would often be prescribed with four types of drugs and on average two would be available (free of charge) from the hospital, and two would have to be purchased from the pharmacy because they were not available at the hospital. However, the health administrator at Illala District Council made it clear to us that everything for those with exemption and waiver status should be free, including testing, syringes, drugs and all the other items and services that people had mentioned paying for.

6.4 Conclusions

The user fee system is appreciated and the presence of the exemption and waiver mechanism accepted as being necessary and desirable for the categories of people who need to be granted free health care. The main points which have come out of the client interviews are as follows:

- The system of exemptions functions well when the condition is clear, such as pregnancy or children under five years of age.
- The system of waivers functions to an extent, but is incoherent. For example, some people get letters from their street chairpersons, while others go directly to the dispensaries. Also, there are no criteria to define who is poor.
- It is not clear whether older people are exempt upon reaching a certain age, or whether they only qualify for waivers if they are old and poor.
- It is not clear whether other conditions, apart from the one for which the client has an exemption, should be treated free of charge
- Many clients are not able to demand exemptions or waivers because they don't have enough information about who is eligible.

- Individual health facilities make their own decisions on what to charge those with exemption and waiver status. There seems to be no standardised system, even within one municipality.
- Although government policy dictates that drugs are free to those with exemption and waiver status, the reality of the drug supply situation at health facilities ensures that many people are forced to buy drugs from private shops.
- Exemption and waiver status has little effect on the quality of service provided
- Bribery is not a serious issue, and barely affects those with exemption and waiver status.

7. Conclusions and recommendations

7.1 Conclusions

The general understanding of those to be exempted or waived is the same across all health system levels, with some minor variations in understanding. The highest level of agreement was for children under five and pregnant women. However, certain chronic diseases (tuberculosis, HIV/AIDS) were mentioned more than others (diabetes, asthma, hypertension). Emergency cases and prisoners are generally treated free at the point of service and there seems to be some variation for poor and elderly people.

Despite some concerns about understanding of exemptions and waivers among both health providers and the population at large, the numbers and proportion of exempt patients in most facilities is quite impressive. In the year 2004, roughly 580,000 exemptions and waivers were given in Dar es Salaam, which for a population of 4 million equals roughly 0.15 visits per capita. On a total of 1.4 million health service contacts per year (from cost sharing information), roughly 40% of these are exempted or waiver cases. The value of exemptions and waivers is at least 800 million Tsh (US\$1,000,000), giving roughly 1300 Tsh per health service contact.

The majority (70-80%) of exemptions and waivers are provided to children under the age of five. After children in importance were pregnant women (10-20% of waivers), chronic diseases, emergency cases, police cases, and the poor (variable, but each constitute less than 5% of exempted cases). Again, there is considerable variation between the health facilities in the sample. The apparently low level of waivers granted for poor people should be a concern for the Government of Tanzania. Only 2.4% and 3.0% of this group has access to formal or informal savings, respectively. Only 0.5% have a bank loan. Therefore, the access of poor people to cash to pay for health services is extremely limited making it a challenge for the public health system.

Knowledge about the exemption and waiver mechanism was found to be variable among the selected sample of health staff and community members. While there appears to be no systematic means of keeping health staff updated on exemptions and waivers, several information channels are used and appear to be quite effective. The average level of knowledge of the community was considerably lower than the health staff. Again, there is no systematic means of communicating information on the exemption and waiver mechanism to patients and the community at-large. The most important channel is to the patient at the point of registration during his or her visit to a health facility. However, few patients knew anything about the function of Health Boards, the community representatives, and their role with regards to exemption and waiver policy.

The process of obtaining an exemption or waiver was also highly variable, in terms of ease, timeliness, and consistency between health facilities. For categories, such as children under five, pregnant women, emergencies, police cases, and some chronic diseases, there was generally no problem in being granted an exemption. In general, the documentation in form of a health card of the individual, was enough. For categories such as the poor, the elderly, and some chronic diseases, patients are not guaranteed free health services if the relevant documentation is not presented. All poor cases and some elderly people are required to produce evidence of status from

community leaders. When this is not possible, the decision is left to the discretion of a senior member of staff at the health facility. However, criteria are not defined for identifying who is poor. And if resources for the service are not available (e.g. drug kits) the quality of care for the exempted or waived case is likely to be compromised.

The financial procedures were, in general, found to be appropriate for the context of the public health system of Dar es Salaam – not too burdensome, but with a paper trail that promotes accountability and reduces possible fraud. The recording of information on exempted and waived patients and monetary values, was highly variable between health facilities and municipalities.

7.2 Recommendations

The following recommendations should be integrated into the ongoing and new activities planned for 2005 and beyond, as stated in the three Municipal Council plans of operation.

1. Further refine exemption and waiver policies.

- Exemption and waiver categories should be better defined. Those eligible to receive a waiver on account of being poor should be further clarified, with explicit criteria defined.
- Specify which services each group of exempt and waiver patients have free access to.
- Set targets at ward level for the numbers of poor people who should be given waivers, based on the local poverty rates.
- Examine whether the exemption/waiver categories chosen exclude any specific vulnerable group, e.g. HIV-affected households or households with a high dependency ratio.

2. Communicate the new policy clearly to the health staff and population.

- Staff should receive further training on exemption and waiver guidelines, particularly as they relate to waivers. This is especially the case for night staff
- Community representatives should also receive training, in order to develop a common understanding about exemption and waiver.
- Strengthen social welfare units in hospitals, ensure representation at lower level facilities.
- Strengthen communication channels for reaching target groups in the community.
- Improved functioning of Health Boards in terms of two-way flow of information.

3. Ensure access to all free services for exempt and waiver categories

- In particular, increase the budget for drug kits, or where this is not possible it is necessary to prioritise among exempt cases (thus reducing eligibility).
- The drug distribution system could be made more efficient by adopting the indent system, which ensures that the drugs delivered are tailored to the community needs. Capacity building should be provided to implement the indent system.
- Reduce the red tape for poor people to obtain waivers, so that the waiver comes to them, rather than the poor person having to seek out a waiver.
- Granting of waivers should not be left to the discretion of health workers. In the absence of routine household data on income (e.g. for tax forms), a community-based solution is necessary, not far removed from the concept of the Tencell or Street Leader being authorized to grant waivers. However, some further objective assessment criteria should be added to reduce the subjectivity and variability of the current assessment
- The government could design a special “identity card for the poor”, with photo attached, and valid for a longer period to reduce administrative costs. At present, the letter from the community leader is only valid in one specific area.
- The exemption system could include home visiting, where medically justified.

4. Standardisation of approach for better outcomes.

- Conduct studies to examine inter-health facility differences in practices and outcomes related to exemptions and waivers.
- Provide regular feedback to health facilities, showing cross-facility comparisons, and requesting missing information.
- Ensure that health facilities are using the same template for recording information on exemptions and waivers, and compiling summary information for reporting to MMOH. Practices should be standardised at least within each municipality and at City level.

These recommendations should be integrated into the ongoing and new activities planned for 2005 and beyond, as stated in the three Municipal Council plans of operation.

References

Abel-Smith B and Rawal P (1992). Report on user charges. Health Sector Financing Study for the Government of Tanzania.

Bitran R and Giedion U (2003). Waivers and exemptions for health services in developing countries. Social Protection Discussion Paper Series No. 308. World Bank.

Bonu S, Rani M, Bishai D (2003). Using willingness to pay to investigate regressiveness of user fees in health facilities in Tanzania. *Health Policy and Planning* 18(4): 370-382.

Dar es Salaam City Council (1994). Implementation guidelines for cost sharing in health services. June 1994.

Dar es Salaam City Council (2003). Minimum Package of Health and related Management Activities. 216 pages.

Gilson L, Russell S and Buse K (1995). "The political economy of user fees with targeting: developing equitable health financing policy." *Journal of International Development* 7(3): 369-401.

Gilson L (1997). The lessons of user fee experience in Africa. *Health Policy and Planning* 12(4): 273-285.

Hausmann M, Mushi A, Muela Ribera J (2000). The paradox of the cost and affordability of traditional and government health services in Tanzania. *Health Policy and Planning* 15(3): 296-302.

Hussein, A and Mujinja P (1997). Impact of user charges on government health facilities in Tanzania. *East African Medical Journal* 74(12): p. 749-50.

Hutton G (2004). Charting the path to the World Bank's WDR 2004 "No blanket policy on user fees". A look over the past 25 years at the shifting support for user fees in health and education in Africa, and reflections on the future. DFID Health Systems Resource Centre. June 2004.

Kivumbi G and Kintu F (2002). Exemptions and waivers from cost sharing: ineffective safety nets in decentralised districts in Uganda. *Health Policy and Planning* 17 Supplement: 64-71.

Levaque L (1999). Role, organization and functioning of the Health Boards within the Dar es Salaam Public Health Delivery System. Dar es Salaam Urban Health Project. August, 1999.

Levine R, Griffin CC and Brown T (1992). Means testing in cost recovery: a review of experiences. Health Financing and Sustainability Project, Abt Associates.

Litvack JI and Bodart C (1993). User fees plus quality improve access to health care: results of a field experiment in Cameroon. *Social Science and Medicine* 37(3): 369-383.

Manzi F, Mbuyita S, Urassa H (2004). Development of a standardised exemption mechanism for Kilombero district. Ifakara Health Research and Development Centre. March 2004.

Matee M, Simon E (2000). Utilisation of dental services in Tanzania before and after the introduction of cost sharing. *International Dentistry Journal* 50(2): p. 69-72.

Mujinja P, Msangi S, Kagaruki G, Kamugisha J (1993). Cost recovery in the Dar es Salaam

Region. A proposed fee policy and operation manual. Dar es Salaam Urban Health Project. December 1993.

Munyetti L, Mmbuji P, Nswilla A (1999). Evaluation of the cost sharing programme: implementation of health services user fees in the public hospitals in Tanzania. Ministry of Health, Tanzania.

Musau S (1996). Evaluation of cost sharing implementation and Bamako Initiative study. Dar es Salaam Urban Health Project.

National Bureau of Statistics (2002). Household budget survey 2000/01. Government of Tanzania.

Newbrander W and Sacca S (1996). Cost sharing and access to health care for the poor: equity experiences in Tanzania. Management Sciences for Health, Boston.

Oester E (1998). Exemption policy and costs of exempt services, for the Public Health Delivery System in Dar es Salaam. Dar es Salaam Urban Health Project.

Swai G (1998). Cost recovery exemption policy for the poor and its implementation procedures. Dar es Salaam City Council. Dar es Salaam Urban Health Project. June 1998.

Tibaijuka A, Kaijage F, Rugemalira P, Kajumulo B, Züst D, Wolff M (1993). The implications of cost sharing measures announced in the 1993/4 budget in Tanzania. The case of the Dar es Salaam City Council. Dar es Salaam Urban Health Project. October 1993.

Walraven, G (1996). Willingness to pay for district hospital services in rural Tanzania. Health Policy and Planning 11(4): 428-37.

Willis C and Leighton C (1995). Protecting the poor under cost recovery: the role of means testing. Health Policy and Planning 10(3): 241-256.