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Assessment of Free Health Care Provision System in North Gondar Gondar Town, Ethiopia, 2011

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Abstract:

Equity is the requirement that individuals of unequal ability to pay make different payment (Vertical equity) or those of the same ability to pay make the similar contribution (Horizontal equity) To assess the effectiveness of waiver and exemption system and to compare the characteristics of households who are free health beneficiaries with households who are not free health beneficiaries, Gondar town, North West, Ethiopia -A cross sectional design was employed among free households health beneficiaries and households not free health beneficiaries in Gondar town from June, 1-30/2011. The sample size of 124 free health beneficiaries' households and 124 not free health beneficiaries households selected by stratified random sampling technique. The data were collected by using interview administered questionnaire consisting of major variables like, socio-demographic profile and knowledge about waiver and exemption system. Finally, analyzed using SPSS V. 16. only 8 (3.57)% of the households having free certificate and 11(4.91%) of households not having free certificate reported that leakage was a possibility while 30 (13.39%) for households having free certificate and 23(10.27%) households not having free certificate reported the possibility of under-coverage The results of this study showed that the current waiver mechanism is not very effective in screening the poor. Improved screening technique and creating awareness among keble officials on the financial impact of free health service is needed

Keywords – free health care, waiver and exemption

1. Introduction:

In Ethiopia there was a proclamation on the waiver mechanisms providing the authority of screening to Keble/farmer associations or city councils. There are no clear criteria and guidelines for granting waivers in the free health care system. The criteria for the provision of free health care are based mainly on the monthly income of individuals (16). The problems of under coverage and leakage render the exemption clause ineffective in meeting the financial access needs of the poor. The main reasons are not only lack of specification of criteria but also the following (17); Attitude of the facility managers to the needs of the poor, The large number of potential beneficiaries (the absolute poor, health workers themselves and the non-poor who have been made worse off by worsening economic conditions), The benefits of charging fees to

meet operational budget needs as government allocations decline and lack of monitoring of the policy by government.

Assessment of free health care provision system is important to determine the impact of fee, exemption and waiver policies. Comparing the characteristics of patients who receive and do not receive waivers is used to monitor the effectiveness of the waiver system, the impact of fee and system changes for appropriate selection. Describing the pattern of free health care provision system may generate information that might be helpful in understanding the important factors for the efficient functioning of the cost recovery and targeting mechanisms. It is important to periodically study how the fee waiver system is improving access to and use of health services by the poor so as to improve their overall health status.

2. Subjects and Methods

2.1. Study area and period

The study was conducted in Gondar town from June 30, 2011 to July 30, 2011. The city has 12 urban kebles and 12 rural kebles. The total population of the Gondar city in the year 2008 G.C is 222,749 of which 105,479 male and 117,270 females. The city has 1 teaching referral hospital, 8 health center, 13 health stations and 36 private clinics (21).

2.2. Study design

A Cross sectional study design that compares the characteristics of households who are free health beneficiaries with those households who are not free health beneficiaries was used.

2.3. Sample size and Sampling technique

The sample size was determined by power calculation on the basis of estimated proportion (the single proportion method) of free patients in the local health institutions.

Expected frequency of free health beneficiaries in the local health institutions is 17.7% and this is taken from study on free health care provision and its financial implication in Gondar town.

A total of 248 households were selected using stratified random sampling technique. The free health certificate is used to form strata due consideration of free health care privilege difference between free health beneficiaries and those who are not free health beneficiaries. Based on equal allocation in each stratum, 124 households from households who are free health beneficiaries and 124 households from households who are not free health beneficiaries were selected by using simple random sampling technique.

2.4. Study population

It consists of households 124 who are free health beneficiaries and 124 households who are not free health beneficiaries selected by stratified sampling technique and meet the inclusion criteria.

2.5. Inclusion and Exclusion criteria

2.6. Inclusion

In the selected households that are free health beneficiaries and households that are not free health beneficiaries if anyone in the households had been present during data collection time and is ill in the past one month were included in this study.

2.7. Exclusion criteria

In the selected households that are free health beneficiaries and households who are not free health beneficiaries; if anyone in the households had not been present during data collection time and not ill in the past one month, they were excluded from this study.

2.8.Data collection procedures

Data were collected by administering structured questionnaire for both free and not free households who are health beneficiaries as well as review of health facility record was done to assess free health care provision system in Gondar town. The questionnaire prepared in English and translated to Amharic for interview by other translator then reverse to English for data analysis. The questionnaire containing socio demographic variables, the respondents knowledge and experience of waiver and exemption system

2.9.Data quality assurance

The Quality of data was assured through pretesting of the questionnaire on 20 population Data were collected by trained interviewers who have completed grade 12. The interviewers conducted the structured interviews under the supervision of the investigator. Each day 5% of the questionnaire were randomly selected and checked for completeness and consistency. In addition meetings were held to discuss problems if any before the data collectors go back to their home

2.10. Data processing and analysis

Data were analyzed using SPSS V.16 software. Data frequencies and percentages were calculated. Bivariate and Multivariate analysis used to analyze date

2.11. Operational definition

Direct targeting: The provision of free or reduced-price services to the poor often used some form of means testing to determine how much people could afford to pay.

Exemption: A form of characteristic targeting where a free service is automatically provided based on medical condition, age, or other evidence. No means testing is required.

Leakage: Occurs when the non-poor receive benefits, such as a reduced fee or no fee, that were intended for the poor (charging users less than they can afford to pay).

Means testing: A process of determining a person's ability to pay for the purpose of providing free or reduced price services to those who can't pay the full price of the services

Under coverage: Occurs when the poor do not receive benefits intended for them because the rules covering waivers for user fees or the means testing procedures were too strictly applied or applied incorrectly.

Waiver: A form of direct targeting when a fee is eliminated or reduced for a person who cannot afford to pay a user fee for a service. Usually determined by the health facility or in the community using means testing .

2.12. Ethical considerations

Before the start of data collection process ethical clearance was secured from University of Gondar review board. After getting ethical clearance, official letters from university of Gondar were given to the Keble offices and Woreda health office then I obtained informed consent from the study participants and health education was given to the study subjects about the presence of free health care provision policy, The purpose of the study was informed to the study participants after getting informed consent from the respondents and assuring the confidential nature of the responses all the interviews with study subjects were made with strict privacy. Respondents have been told to have the right to give up or withdraw the interview at any time he /she wishes. All the household interviews have been held with an adult person.

3. Results

3.1.Characteristics of the interviewees

A total of 247 households interviewed and 50% were free health beneficiaries. From all, 151(67.4%) of them were females and 73(32.6%) were males.

3.2.1. Table 1 shows the socio-demographic characteristics of the study population Gondar town, December, 2010

Socio demographic Variable	No	%
Sex		
male	73	32.6
Female	151	67.4
Occupation		
Farmer	11	4.9
House wives		
Daily laborer	70	31.2
Government employees	18	8.0
No job	38	17.0
Student	64	28.6
Merchant	16	7.1
Monthly income	7	3.1
<425		
425-850	116	51.8
>850	63	28.1
	45	20.1
Family size		
1-2	49	21.9
3-5	95	42.4
>5	80	35.7
House ownership	105	46.9
rented	107	47.8
private	12	5.4
other		
Number of rooms		
1-2	169	75.4
>3	55	24.6

3.3.Characteristics of free health beneficiaries

Many, 95 (84.82%) had no problem of getting free paper from Kebele. The Household respondents who claimed the presence of difficulties in getting supporting letters stating that one as free patient are 17 (15.18%).Types of difficulties cited by these respondents include the process takes long time 14 (12.5%), difficulty to produce evidences 23 (20.53%), and uncooperative committee members of the kebele administrations 7 (6.25%). In line with, most of this free health beneficiaries 48 (42.86 %) were housewives and 37 (33.03%) were no job and 12 (10.71%) were daily laborers The frequency of visiting the health facilities varied .among the respondents 70(62.5%) reported to have benefited from free medical services once 25 (22.32%) two to three times and 17 (15.18%) four or more times a year. Some of the free health

beneficiaries, 11(9.82%), Including those earning low income, afford to visit private clinics on a regular basis. Few of the households having free certificate 8(7.14%) have also reported as knowing people who got the free service privilege when they did not deserve it. Reported conditions for such occurrences were being relatives to kebele officials and presenting false witnesses.

3.2.2. Table 2: Table shows the distribution of free health beneficiaries based on their monthly income and house ownership in Gondar Town, 2010 (N = 112)

	No	(%)
Monthly Income		
<or equal to 425	83	74.11%
425 850	23	20.54%
>850	6	5.35%
Housing		
Rented from private	21	18.75%
Rented from keble houses	48	42.86%
Own house	35	31.25%
Other	8	7.14%

3.4. Bivariate analysis

The service category of the respondents and knowledge about the exemption of delivery service showed a statistically significant association ($\chi^2 = 4.291$; $P = .038$) (Table). However, the usual place of health care seeking in times of health problems showed no statistically significant association with their knowledge about the possibility of free health care ($\chi^2 = 3.789$; $P = .150$). The chi square showed that the place people seek care during illness and service category of the respondents have statistically significant association ($\chi^2 = 17.924$, $p = .000$)

Comparing the service categories of respondents with their socio demographic characteristics have statistically significant association while sex, marital status and family size are not significantly associated with service categories of the respondents

There is significant difference between free health beneficiaries and non free health beneficiaries in the place they seek care on a regular basis during illness , source of information about waiver, source of information about exemption and knowledge about the exemption of u5 ,delivery and leprosy service

3.3.3. Table 3: Bivariate analysis comparison of the characteristics of households who are free health beneficiaries with households who are not free health beneficiaries (household survey, N=224, July, 2011)

Variable	Service category		Crude OR(95% CI)
	Waiver	Pay	
Age			
18-27			
28-37	8	26	1.00
38-47	24	26	.333(.127, .877)
48-57	25	23	.283(.107, .750)

>58	22 33	21 16	.294(.109, .793) .149(.055, .402)
Educational status			
illiterate	84	42	.053(.012, .237)
read and write	16	18	.118(.024, .590)
grade1-8	07	18	.271(.050, 1.480)
grade9-10	03	15	.526(.078, 3.565)
grade 10 and college	02	19	
Occupational status			
Farmer	3	8	.500(.102, 2.446)
housewives	48	22	.086(.031, .235)
merchant	1	6	1.125(.114,11.104)
daily labor	12	6	.094(.025, .348)
no job	37	27	.137(.050, .373)
student	5	11	.413(.105, 1.624)
government employee	6	32	
monthly income			.061(.024, .158)
<or equal to 425	83	33	.268(.098, .728)
425-850	23	40	
>850	6	39	
House ownership			.
Rented	69	36	1.043(.294, 3.701)
Private	35	72	4.114(1.160,14.597)
Other	8	4	
Number of rooms			
1-2	94	75	.388(.205, .736)
>3	18	37	
Where do you seek care on a regular basis when you are sick			
Government HC			
Private clinic	101 11	75 37	.221(.106, .461)

Where did you heard about this			
friends /acquaintances	40	61	2.007(.979, 4.112)
health institution staff	22	17	1.017(.426, .426)
kebele leaders	25	15	.789(.329, 1.894)
I do not know	25	19	
Child <5 not pay			
yes			
no	30	48	2.050(1.170, 3.593)
	82	64	
delivery not pay			
yes	32	19	.511(.269, .970)
no	80	93	
leprosy patients not pay			
yes	37	64	2.703(1.570, .653)
no	75	48	
Source of information about exemption system			
from health staff	31	40	
word of mouth	54	47	
media ,newspaper ,radio ,TV	10	19	3.656(1.289, 10.366)
I do not know	17	6	2.466(.899, 6.767)
			5.383(1.613, 17.967)

3.5.Multivariate analysis

In multivariate analysis: The socio demographic characteristics; age, educational status, monthly income, house ownership and number of rooms have statistically significant association with service categories of the respondents. There is significant difference between free health beneficiaries and non free health beneficiaries in the place they seek care on a regular basis during illness and knowledge about the exemption of delivery service

3.3.4. Table 4: Multivariate analysis, comparison of the characteristics of households who are free health beneficiaries with households who are not free health beneficiaries (household survey, N=224, July, 2011)

Variable	Service category		Crude OR(95%CI)	Adjusted OR(95%CI)
	Waiver	Pay		
Age				
18-27	8	26	1.00	
28-37	24	26	.333(.127, .877)	13.190(1.861,9.54)
38-47	25	23	.283(.107, .750)	8.565(1.864,3.351)
48-57	22	21	.294(.109, .793)	1.767(.352,8.871)

>58	33	16	.149(.055, .402)	3.81(.680,11.889)
Educational status				
illiterate	84	42	.053(.012, .237)	.206(.024, 1.758)
read and write grade1-8	16	18	.118(.024, .590)	1.432(.135, 8.177)
grade9-10	7	18	.271(.050, 1.480)	1.909(.177,2.530)
grade 10 and college	3	15	.526(.078, 3.565)	5.950(.443,7.918)
	2	19	1.00	
monthly income				
<or equal to 425	83	33	.061(.024, .158)	.031(.006,.170)
425-850	23	40	.268(.098, .728)	.117(.019,.714)
>850	6	39	1.00	
House ownership				
rented	69	36	1.043(.294, 3.701)	.209(.027,1.602)
Private	35	72	4.114(1.160,14.571.00	5.400(.680,4.878)
Other	8	4		
Number of rooms			.388(.205, .736)	
1-2	94	75	1.00	
>3	18	37		.050(.012,.215)
Place seek care on a regular basis during illness				
Government HF			.221(.106, .461)	
Private clinic	101	75	1.00	
delivery not pay	11	37		.233(.055,.993)
yes			.511(.269, .970)	
no		19	1.00	
	32	93		
	80			.052(.012,.216)
	24.			

3.6.Experiences Of The Households With Targeting Mechanisms:

Due to the prescreening of those all the households had someone who had been sick in the last month. 97.8% of these households who reported sickness sought care. Surprisingly, the proportion of free health beneficiaries (97.32%) and non free health beneficiaries (98.21%) who sought care is identical, which is coincidentally the same as the overall percentage of households seeking care(97.77%). Eighty one point sixty nine percent (81.69%) of all respondents who sought care went to a government facility, indicating that government facilities are often the only available sources of care for the population. Of these, 45.09% % are free health beneficiaries and 36.61% non- free health beneficiaries. 38(16.96%) of all households undertook treatment program by going to private clinic, however, within this group, 11(4.91) were free health beneficiaries.

For those households who choose not to go to a formal health care facility, they were asked why. 26.82% of all those who responded were free health beneficiaries. 28(68.3%) responded that they did not go because of the lack of drugs, and 13(31.7%) cited lack of money.

Households were asked if they knew anyone who did not seek health care because they could not pay. Overall, 53(23.66%) percent of all respondents stated they knew someone who could not go for care because they could not pay and among this group, 30 (13.39%) were households having free certificate. In addition to inability to pay, 68(30.36%), of the respondents stated there were other access barriers, such as distance, waiting time, and quality of care, which prevented someone they knew from seeking care. 180(80.36%) of all respondents believe the poor have not to pay for services at government health facilities, and among this

group, 85(47.22%) were free health beneficiaries. Only 17(7.59%) were not aware of the waiver policy and stated that poor have to pay and 27(12.05%) were either not sure or had not heard of waivers. More people knew about waivers than an overall exemption policy, with 122 (54.46%) responding overall that people with certain conditions did not have to pay for health services, regardless of their ability to pay. Of this group, more free health beneficiaries were aware of exemptions than non-free health beneficiaries (30.36% to 24.11 % respectively). Only 102(45.53%) stated that they were not sure or not aware of an exemption policy overall.

To assess knowledge about exemption, households were asked if they knew that certain categories of patients or people with specific diseases were exempted from paying for health services. The proportion of those aware about the exemption policy was higher in those who have got waiver than who did not get waiver. Again majority of the respondents 68 (60.71%) of those who got waiver and 54 (48.21%) of those who did not get the waiver know about exemption system. Of those who know about the exemption system 101(82.79 %) informed from word of mouth while only 71(58.19%) respondents were informed about exemption by health institution staff.

The source of information about exemption services at public health facilities were word of mouth for 54 (48.21%) of the respondents who have free certificate

To determine whether the public was familiar with the existence and policy on waiver, respondents were asked whether they knew about the presence of this privilege. Most of 180 (80.4%) respondents reported as having knowledge of this fact. Of those who were aware of the privilege, 85 (37.95%) are households having free certificate and 95 (42.41%) are households not having free certificate.

The proportion of those aware about the waiver policy was higher in those who did not get the waiver than waiver granted. Of those people who were aware of waivers, they were asked how they knew they existed. Table 8 indicates that most people 101 (45.09%) learned from friends /acquaintances followed by kebele leaders 40(17.86%) and discussion with health institution staff 39 (17.41%).

The main information source as regards the availability of free health services was information from friends /acquaintances 101 (45.1%) followed by Kebele offices 40 (17.9%) and health professionals 39 (17.4%) and 44 (19.6%) did not know about waiver system. With regard to level of awareness and source of information, 22 (19.64%) of those who got the waiver and 17(15.18%) of those who did not get the waiver knew about waiver privileges in the utilization of health services.

Interviewees were asked how long they waited before they sought care. Specifically, they were asked if they sought care immediately, waited less than one week or waited more than one week. Overall, 85(37.94%) of all respondents stated they waited more than one week before seeking care, though 46(20.53%) of the free health beneficiaries waited more than a week compared to 39(17.41%) of the non-free health beneficiaries.

For the remaining 62.06% of households who responded, 65(29.02%) sought care immediately and the remaining 71(31.69%) sought care within a week of the onset of their illness (see Table)

Since the survey did not provide any information regarding the patient's clinical condition, it is not possible to draw concrete conclusions, but a possible explanation for the delay of the poor to seek care may be attributed to the need for the poor to obtain money from family, friends or through the sale of personal belongings to pay for transport and health facility fees. These individuals were asked whether they deserved free health care or not. A majority of them, 45(40.18 %) replied that they do deserve free health care services. The only reason mentioned by these respondents is being poor. On the other hand, only 8 (3.57)% of the households having free certificate and 11(4.91%) of households not having free certificate reported

that leakage was a possibility while 30 (13.39%) for households having free certificate and 23(10.27%) households not having free certificate reported the possibility of under-coverage

3.7.Record review

The MOH guideline existed for reporting monthly revenue collections from fees and the value of exemptions and waivers granted at health center and hospital level. Neither facilities collected information on waivers and exemptions or calculated the cost of those services. The only consistent report produced at all facilities was revenues generated each month

4. Discussion and Conclusion

This study assessed the effectiveness of waiver and exemption system and compares the characteristics of households who are free health beneficiaries with those households who are not free health beneficiaries. One hundred twelve 112 (50%) in this study were free patients which approximates to the finding of a similar study in northern Ethiopia (7).

As this result indicates, the main beneficiaries of free health care were females 81(72.32%), showing the burden of disease (as related to maternal diseases) is higher in women and the income status of women is lower than men. The fact that most of the free care users are in the economically active age group and the dependency on government resources is not explained by dependency resulting from old age (above 65 years) . This might indicate that, waiver is used for public health importance such as tuberculosis, and for high priority services such as MCH and FP. Similarly, the majority of free health service users were illiterate 84 (75%) indicating that, the better the educational status of people the higher their income. But out of the respondents who were paying, 45(40.18 %) claimed that they deserve free health care, the justification for all of them being low income. In addition, out of all the respondents who have free certificate, 17 (15.18%) mentioned the presence of difficulties in getting supporting letters-stating one as a free patient. This is higher as compared with the finding registered in the study done at Bahir Dar town which is 26 (12.4%) (7).

Among households not having free certificate 33(29.46%) would in reality be below the cut of point used for poverty, even higher proportion of people as not getting free service privilege when they should have. This may imply the failure of the system to serve the genuinely disadvantaged group of the population Despite this fact, people having high income (i.e.>Birr 850 per month) were not excluded from benefiting the free health care provision. In multivariate analysis the socio-demographic variables such as monthly income, educational status, house ownership, number of rooms and age were found to have a statistically significant association with waiver grants which are comparable to the case of urban exit respondents of a study conducted in the northern part of Ethiopia (7).

Among households having free certificate 29(25.89%)would in reality be above the cut-off point used for poverty, indicating even higher proportion of people as getting free service privilege when they should not have. A significant number of the free patients live in their own houses, this shows that assets like a house are not given due consideration in selecting patients that should be given free medical services. That is, wealth as a flow concept rather than a stock concept is given more emphasis to support the poor to get free health services. Having assets like a house is an important indicator to distinguish the real poor or in other words government resources are misallocated in the form of paying the health care expenses of those who can afford to pay The financial burden on the government could have been reduced had better screening

technique been used. This implies that, although the majority of free medical service users are poor, there are also the haves who benefit from free health care indicating the inefficiency of the free health care system to select the needy. This is supposed to be the outcome of the very low awareness of both the Kebele officials and the patients about the financial implications of free health care In granting waivers. Similar study has also shown that those who could afford were given free care (18). This may be the result of false pretence, subjective waiver criteria and informal identification and verification procedure. In addition, as free certificates are granted at kebele level, social pressure on leaders to accept bribe or waive fees for acquaintance might make it difficult to prevent leakage (17-19). 53(23.66%) of the household survey reported the possibility of under coverage while 19 (8.48 %) claimed a possible leakage in the free health care system. This finding is lower in terms of reported possibility of under coverage and reported possibility of leakage as compared with that was seen in the study in Bahir Dar area where 36% and 14.7% were findings for possible under-coverage and leakage respectively and the study in Jimma town. Of the entire facility exit respondents, where 144(43.6%) and 122(36.9%) were findings for possible under-coverage and leakage respectively. This could imply the failure of equity goals, which are the primary aims of exemption policies. This is problem that could possibly be alleviated by setting up a transparent and organized free health care provision system.

The house hold survey show that having witnesses ,income level and being a resident in a certain kebele are consistently required evidences similar with the finding of an earlier research in the northern part of the country which is mentioned as criteria for eligibility by both groups of the respondents (7). The minimum amount of monthly income required turned out to be different in different years according to minimum wage The inconsistently considered criteria currently used by the MFB are highly liable for leakage and under coverage. This implies that a proper and well-organized means of testing is lacking in the system. 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 (4, 5, 6, and 7).. This may lead to an agreement with a statement by a Ugandan study that stated: "Guidelines to regulate exemptions are non-existent or ignored, or selectively applied in Uganda at the lower unit level"(5). The free patient rate in the Amhara region is very high reaching up to 85% (16). Therefore, this region is considering proposing the municipality to cover the costs of free patients through its annual budget (17). If health service has to improve in this region, better screening technique or users fee must be introduced. The results of this study showed that the current waiver mechanism is not very effective in screening the poor. Therefore groundwork must be done in the implementation of effective waiver mechanisms to protect the poorest from the burden of payment. Establishment of community decision -making bodies that effectively represent the interest of all groups may be more effective than the present system.

Place seek care on a regular basis during illness and knowledge about exemption of delivery service were found to have a statistically significant association with waiver grants. For normal goods, such as quality curative health care demand by the non-poor is greater on a per capita basis than demand by the poor. The higher demand by the non-poor responds to their higher income. It also reflects their greater education and the higher associated awareness about the benefits of timely quality health care (7). Wealthier and better educated individuals are more likely to use health services and to use private health services rather than public providers and drug vendors. Health facilities and providers are more often locally available to wealthier individuals. Affordability is also an important factor. The price of a medical consultation has a significant negative effect on both adults' and children's probability of obtaining medical treatment. Among

those using poverty certificate some patients in our study used to visit private clinics. This occasional visit of private clinics by some of the free patients is another justification to the problem of the system. In this study there is no significant difference between free health beneficiaries and non free health beneficiaries in seeking care at times of illness ($\chi^2 = .205, p = .651$). An earlier study showed that cost-sharing group was one third less likely than the free care group to see a physician when they had minor symptoms, but did not differ significantly in seeking care for serious symptoms (18). This shows that cost sharing creates a sense of ownership, which leads to greater responsibility on part of the users and more accountability on part of providers (19).

Many studies have also shown that users are willing to pay when the quality of health care improves (6, 19). Obviously, beneficiary input may result in increased revenue to enhance quality. Considering the existing level of development of the country, there is less hope for the introduction of health insurance in the short term. However, it could possibly be introduced at the community level through community health insurance scheme and gradually develop to full fledged insurance particularly in the urban areas. This system worked well at least in some African countries (17-19). According to the findings of the present study, there is leakage of free health service benefits to those who actually are able to pay. Therefore, improved screening technique and creating awareness among kebele officials on the financial impact of free health service is needed.

The criterion for granting free health care service privilege hasn't been critically revised since its adoption. There were only minor changes that accompanied redefinitions of the minimum wage in the country. In the urban areas, it is only a small proportion of the population that is in formal employment. Therefore, the use of monthly salary as a criterion for comparing socio-economic status needs serious reconsideration. Even though the fact that the targeting system uses local (Kebele level) structure for determining eligibility is an encouraging attribute. There should also be some mechanism to improve the record keeping and management capability of kebele and health institution officials at the local level. Record keeping was found to be poorly practiced by health centers compared to the hospital. This lack of records might make it difficult to evaluate the waiver system for the poor since the effectiveness and the cost of the system cannot be known without such information. Lack of records has also been shown to make it difficult for the Ministry of Health in Tanzania to evaluate the waiver and exemption system (12). Few facilities collected data and reported information on the numbers and types of patients that received full or partial eligible for exemptions and the value of the fees not collected. Hence, the cost of waivers for the poor was not known (7). The proportion of respondents that were aware of the presence of exemption was also higher in those households having free certificate 68 (60.71%) than households not having free certificate 54 (48.21%). In contrast to hospitals, exemption schemes at health centers are generally well publicized and exemptions are provided quite readily. Exemption rates at health centers ranged from 8 percent to 50 percent, with a median value of 25 percent. However, Exemptions are provided more readily at health centers. Available information on the use of maternal services shows that, those from richer households have more probability of accessing skilled assistance at delivery and use of modern contraception compared to women from poor households. However, there are no disparities in access to other public services like vaccines between the poor and the rich (15). The proportion of respondents that are aware of the presence of free health care for the poor was 85(75.89%) and 95(84.82%) for those who have got waiver and those who did not get waiver respectively and from the total respondents it is 180(80.36%), a finding lower than the study in Bahir Dar area (north Ethiopia) where 93% of respondents were aware of privilege(7). The sources of information about waiver for the majority of both waiver granted and those who did not get waiver were friends /acquaintances and the sources of information about exemption for the majority of both waiver granted and

those who did not get waiver were word of mouth(friends /acquaintances) as was found in the household survey of the study in Bahir Dar area.(5) This indicates that there is no health facility that strongly considers the importance of disseminating the information to the needy. In the Kenyan study information from health staff was the most important source (11). This shows that there is no active communication between health facilities and patients on the existence of the waiver system and the process of obtaining waivers and exemptions. Even though their schedule is very busy, it should not be impossible for health workers to disseminate information about waivers and exemptions during health education sessions to individual patients or groups. The fact that most of the exempted disease categories are those with “public good nature” makes this activity worth the additional effort. The proportion of respondents that reported as knowing cases of under-coverage was 30 (13.39%) of those who have got waiver and 23(10.27%) those who did not get waiver. With regard to leakage, it was 8 (3.57%)for households having free certificate and 11(4.91%) those who did not get waiver. Similarly, studies in other African countries have found minimizing under-coverage as being poorly handled than preventing leakage (13). In view of the fact that the main objective of health financing options is maintaining equity, mechanisms should be created for addressing the problems of under-coverage. among households having free certificate 29(25.89%)would in reality be above the cut-off point used for poverty, indicating even higher proportion of people as getting free service privilege when they should not have. However, according to our findings, comparison of average income of those who have got waivers with those who did not get waivers showed that there was statistically significant association between the designated low income and free health services utilization in the study area. However, those who got waivers had a statistically significantly lower average income than those who were paying. This may be because those who could afford to pay in urban areas might have alternative options of visiting private practitioners. In addition, urban officials might be relatively strict in enforcing the rules and regulations for granting the waiver privilege.(5) The practice of proper registration and recording, which was seen to be more prevalent in the urban areas, might also have helped in this regard.(5) It is known that eliciting information on household income is a sensitive issue and getting accurate response would usually be difficult. Even though this can be considered as a limitation for studies like ours in Ethiopia, it would not have affected our main finding on the issue of interest for the present study. The expected direction of information bias in this regard would be towards under report of monthly income.

In conclusion, the effectiveness of targeting mechanisms in the study area seemed to have been compromised by problems that are amenable to corrective measures. Improving the registration and recording systems at health facilities is the most important measure that can be taken. In addition, health workers should play active role in raising the awareness of the public about the presence of and the mechanisms for properly utilizing these measures. Periodic monitoring of the functioning and effectiveness of targeting mechanisms by regional and district officials is also necessary. As mentioned above, revising the current guideline for the urban areas should be an undertaking that needs policy level attention.

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References

1. G, Mulligan. J, et.al. An assessment of the health financing system in Tanzania Journal of Ifakara Health Research and Development Centre; MAY 2007 .
2. Delali Margaret badasu, Implementation of Ghana's health user fee policy and the exemption of the poor problems and prospects, African Population Studies Supplement institute of African studies university of Ghana,1990, Vol 19
3. David Collins, William new brander, guidelines for achieving equity ensuring access of the poor to health services under user fee systems, Office of Sustainable Development Bureau for Africa, U.S. Agency for International Development 2000.
4. Mirkuzie Woldie, Chali Jirra, Ayalew Tegegn ,An assessment of the free health care provision system in Jimma town, Ethiopian Journal of Health Development 2003,vol 19 ;150-152.
5. Engida E., Haile Mariam D. Assessment of the free health care provision system in Bahir Dar Area, northern Ethiopia. Ethiopian Journal of Health Development, 2002; 16(2):173-182.
6. Araoyinbo, idowu d.a ataguba, john e. user fees in Africa: from theory and evidence, what next? b an essay submitted to the African health economics and policy association (afhea) April 2008
7. Morgan, R Targeting Human Development Priorities an Evaluation of Progress and Potential Impact. Dar es Salaam Ministry of Health 1993.
8. Levine RE, Griffin CC and Brown, T. Means Testing in Cost Recovery: A Review of Experiences. Health Financing and Sustain-ability (HFS) Project. Technical Note 1992, No.
9. Adams, I., D. Darko and S. Accorsi. 2001. "Utilization of Outpatient Services: User Profile and Disease Pattern". Bulletin of Health Information July to September. 1(1): 18-22
- 10 The World Bank. The Poor and Cost sharing in the Social Sectors of sub-Saharan Africa. 1996
- 11 Newbrander W and Collins D. Methodology for Equity and Coverage of health Care Provision Study. The BASICS Project, Management Sciences for Health, 1995.
- 12 Agyepong, I.A.. "Reforming Service Delivery at District Level: The Perspective of a Ghanaian District Medical Officer". Health Policy and Planning 1999;14(1): 59-69.
- 13 Audibert, M. and J. Mathonnat. "Cost Recovery in Mauritania: Initial Lessons" Health Policy and Planning 2000;15(1): 66-75.
- 14 Avura, F.B, Hague. Bjorkman , The Policy Ambiguities of Primary Enrolments. M.A.Dissertation, Educational Reform in Ghana: Institute of Social Studies, "Implementation and Development Policy: Large Problems, Small Steps". Public Enterprise 1995;14: 368-378.
- 15 Mmbuji, P.K.L., P.A. Ilomo and A.L. Nswilla, Implementation of Health Services
- 16 Willis CY. Means Testing in Cost Recovery of Health Services in Developing Countries: Phase I: Review of Concepts and Literature, and Preliminary Field Work Design. Health Financing and Sustainability (HFS) Project. Major Applied Research Paper 1993 No. 7.
- 17 Gizachew Ashagrie, et.al. Free health care provision and its financial implications in Gondar town, northwest Ethiopia Ethiop. J. Health Dev. 2005;19(3):188-194
- 18 Reddy S et.al. User Financing of Basic Social Services: A Review of Theoretical Arguments and Empirical Evidence: UNICEF Working Paper, 1996.
- 19 User Fees in Tanzania, Ministry of Health, Ghana. Health Sector 5-Year Programme of Work 1996.
- 20 Amhara national regional state Gondar city administration finance and local economic development office statistical bulletin for the budget year 2006-2010.pp,1-30.