Original article

An assessment of the free health care provision system in Jimma town, southwest Ethiopia

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Abstract

Background: Despite the fact that equity is the underlying principle of all major global health policies, difficulties have emerged in providing proper care for the poor with the introduction of user fees for health services. However, the criteria used to determine eligibility for free health services at public health facilities are either unclear or nonexistent in most sub-Saharan African countries.

Objective: To assess the free health care delivery system and the extent to which strict criteria are followed in granting free health care services in Jimma town, southwest Ethiopia.

Methods: A cross-sectional, exploratory study, employing both quantitative and qualitative study designs, was conducted from December 22 – 27, 2003.

Results: Fifty-eight percent of the respondents were found to be patients exempted from fees on the day of interview. There exist no clearly stated criteria in the free health care provision system of Jimma town. The presence of leakage and under-coverage were 36.9% and 43.6% respectively. The occupation and income category of the respondents showed a statistically significant association with their service category at the public health facilities (p=0.000).

Conclusion: The absence of clearly defined criteria for waiving user fees at public health facilities has made the free health care provision system difficult for both the providers and users. The system is also prone to the possibility of leakage and under-coverage. These findings imply the importance of a strict reconsideration of the exemption policy of the locality and the country with focus on efforts to produce clear criteria and guidelines in granting free health care.
[*Ethiop. J. Health Dev.* 2005;19(3):188-194]

Introduction

Equity is the underlying principle of major global health policies such as the Global Primary Health Care Strategy, the Health for All strategy, and recently, the health sector reforms spearheaded by the World Bank which are based on the assumption that everyone should have the opportunity to attain good health status (1, 2). The target of equity in health and equal access to health care is based on the principle that health care should be provided according to needs, not according to factors such as the ability to pay for care (3).

The role and effects of user fees for publicly provided health services in developing countries has evolved during the past ten years. Early proponents believed that fees could help to improve efficiency (through appropriate price signals), financial sustainability and also through targeted prices and exemptions (4).

However, the introduction of user-payments for health services is frequently followed by a concern about the impact it has on the equity of access for poor people. Governments often try to remedy these inequalities by putting in place safety nets in the form of exemptions and waivers in the user fee system (5). The central problems in the system of exemptions for the poor are: defining conditions for people in these category, working out an acceptable formula for providing subsidies, and effectively administering exemptions. A survey of official cost- recovery policies in 25 countries of sub-Saharan Africa revealed that exemptions due to poverty or inability to pay are remarkably uncommon (6).

In 1989, Uganda provided safety nets (granting of exemptions, waivers, and credits) to ensure equitable access to health care for individuals with limited financial resources. Exemption categories included children under the age of five, immunization, antenatal and postnatal care and family planning services. In addition, patients suffering from chronic illnesses such as AIDS, tuberculosis, cancer and poor individuals are exempted from fees by the local councils (5). Ghana's policies on fees, 1985, defined groups of patients to full or partial exemption in categories such as; 'paupers', health workers, patients with tuberculosis and leprosy, psychiatric patients and some services including immunization (4). As to the practice in Zimbabwe, patients with household incomes of less than Z$ 150 were provided free health care, and those who earned between Z$ 150 and 800/month could obtain reduced prices for some services at central and provincial hospitals (8).

In Ethiopia, the criteria for granting free health care services is mainly based on the real monthly income of the individual and setting the minimum wage for civil servants. In 1967, for example, any one with a monthly income of less than 50 Birr (US$ 25 back then) was eligible for free medical services. In 1977 the monthly income for eligibility was revised and changed to 105 Birr (US$ 52) in line with the increment in the minimum wage to that amount (9). As to the 1981 Proclamation the

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eligibility of an applicant was determined by the Kebele administration (10). A committee of people from the Kebele administration (by the former Ferd shengo or the present Mahberawi Ferd Bet) would examine the means of livelihood of an applicant and grant a certificate that allows the individual to get free health care from public facilities. This eligibility certificate would usually be valid for three to six months (7).

Although there are no clear criteria and guidelines for granting waivers in the free health care system only a few studies have been conducted on this issue. Therefore, this study is aimed at assessing the free health care delivery system in Jimma town and the extent to which the criteria are adhered to in granting free health care services by the responsible authorities in Jimma Town.

Methods

A cross sectional exploratory study using both quantitative and qualitative study designs was conducted from December 22 - 27, 2003 in Jimma town. Jimma Town is located 335kms southwest of Addis Ababa. The town has 21 kebeles, which are organized under three weredas. The total population of Jimma Town projected to date is 144,232. The Town has one hospital, one health center, and one MCH clinic as public facilities. The study included patients visiting Jimma University Hospital and Jimma Health center, kebele leaders, administrators of both health facilities and the head of environmental affairs at the municipality. For the quantitative study design a cross-sectional exploratory study with structured questionnaires was used while a design interview with semi-structured questionnaires was carried out for the qualitative study.

A total of 329 respondents were drawn from all the out-patient departments excluding the services provided for free MCH/FP, tuberculosis, leprosy, diabetes mellitus, hypertension, asthma and seizure clinics. Admitted patients were excluded as they necessarily pass through the out-patient departments. Sixty percent of the facility exit respondents were from Jimma University Hospital. This over sampling was purposely made in order to include the large number of patients visiting the health facility.

The respondents were identified using a systematic random sampling technique where the first respondent was selected by lottery method and every twelfth person was taken. In cases of non-voluntary respondents, the next patient was interviewed. A total of 27 key informants including Kebele leaders, Hospital and Health center administrators, and head of environmental health department at the municipality were identified using purposive sampling technique and were then interviewed using semi-structured questionnaires.

Data were collected by trained interviewers who have completed grade 12. A semi-structured questionnaire was used to describe the presence of criteria in determining eligibility for exemptions from payment at a public health facility. A structured questionnaire was used to assess the awareness of exit respondents about the existing free health care provision system with their perceived presence and extent of leakage and under coverage. The quantitative data was cleaned, edited, and analyzed using SPSS for windows version 11.0. Statistical tests were employed wherever appropriate at the level of significance of 5%. Qualitative data was also cleaned, edited and analyzed using the thematic framework approach where familiarization with the transcripts was followed by theme identification according to the objectives of the study, which are, coding, mapping and interpretation.

Result

Socio-demographic characteristics of the respondents

The study covered a total of 329 facility exit respondents making the coverage of the study 85.7%. Out of the 329 respondents, 214 (65%) were found to be females and 64% (212) of the facility exit respondents are from urban areas. Ninety nine (30.1%) of the respondents are housewives followed by farmers which number 89 (27.1%). The mean monthly income for the respondents was 265.5 (US $31) birr per month. One hundred twenty four (38.1%) of the respondents had a monthly income of less than 100 birr (US$ 12) per month. Of the total respondents 214 (65%) had private houses, 108 (32.8%) rented houses, and 7 (2.2%) don't have a house at all. A total of 27 individuals including 11 kebele chairmen, 10 members of the *Mahberawi Ferd Bet*, five health facility administrators, and one secretary at the environmental health department of the municipality were the key informants for the qualitative study (Table 1).

Waiver granting to exit respondents

One hundred ninety six (59.5%) of the exit respondents had been served for free whenever they came to public health facilities and 128 (38.9%) claimed that they got services free of payment. Partial exemption and credit services were mentioned only by five (1.5%) of the respondents who were required to bring a letter from their work place.

Comparing the service categories of respondents with their socio demographic characteristics; family size, occupation, monthly income, and numbers of rooms of the houses of respondents have statistically significant association, while age, sex, address, and house ownership are not significantly associated with service categories of the respondents (Table 2).

Table 1: **The socio demographic characteristics of the study population, Jimma town, December 2003**

Socio- demographic Variables	No	%
Sex		
Female	214	65
Male	115	35
Total	329	100
Age		
15-24	99	30.1
25-34	114	39.7
35-44	60	18.2
45-54	32	9.7
≥ 55	24	7.3
Total	329	100
Address		
Urban	212	64.4
Rural	117	35.6
Total	329	100
Marital status		
Married	236	71.7
Single	60	18.2
Widowed	22	6.7
Divorced	8	2.4
Separated	3	0.9
Total	329	100
Educational status		
Illiterate	135	41
Gr.1-6	66	20.1
Gr. 7-8	38	11.8
Gr. 9-12	67	20.4
> Gr. 12	23	7
Total	329	100
Occupation		
Farmers	89	27.1
Housewives	99	30.1
Daily Laborers	24	7.3
Merchants	23	7
Government employees	39	11.9
No job	19	5.8
Students	36	10.9
Total	329	100
Monthly income		
<100 Birr	124	38.1
100-385 Birr	122	37.1
>385 Birr	83	24.8
Total	329	100
Family size		
1-2	52	15.8
3-5	174	52.9
>5	103	31.3
Total	329	100
House ownership		
Rented	108	32.8
Private	214	65
Do not have	7	2.1
Total	329	100
Number of rooms		
1-2	240	74.3
3 and above	82	25.7
Total	322	100

Out of the total, 313 (95.1%) respondents were aware of the presence of a possibility for poor patients to receive free health care at a public health facility. The address of the respondents and their knowledge about the possibility of getting free health care at public health facilities showed a statistically significant association (x^2 =5.326; P=0.021) (Table 3). However, the usual place of first health care seeking in times of health problems showed no statistically significant association with their knowledge about the possibility of free health care (x^2 = 0.231; P= 0.630). Out of all the respondents that have this knowledge, 242 (77.3%) said they have heard about it some years back, while 33 (10.5%) of them said they heard about it recently and the rest did not remember when they had the information. The source of information about exemption services at public health facilities were friends and acquaintances for 205 (65.5%) of the respondents (Table 4). Groups of individuals suggested to be served for free at public health facilities were people who can't afford to pay 281 (85.4%), every citizen 30 (9.1%), and people who pay tax for 16 (4.9%) of all the respondents.

Presence and use of criteria for user fee exemption

All the 27 key informants replied that there are no clear documented criteria for granting waivers at public health facilities.

Respondents from all Kebeles stated;
"The responsibility of granting user-fee exemption is given to the 'Mahberawi Ferd Bet' (MFB) and the 3 members of this committee are expected to know most, if not all, of the Kebele residents together with information on their economic backgrounds."

A total of 190 (57.8%) exit respondents said they were served for free on the day of the interview. Of these 154 (81.9%) have applied at their respective kebele administration offices with the remaining percentage of respondents having a health facility, missionary of charity, municipality and others as a place of application for free health care.

According to the key informants the most common prerequisite required by the MFB in granting waivers was being a resident of the respective Kebele and being unable to pay for health care as witnessed by three residents of that Kebele who are responsible for any inappropriate suggestions they may give. Similarly, of all the respondents who were free patients on the day of interview 151 (79.7%) exit respondents claimed that the evidence required to be eligible for free health care is having three witnesses who should be the kebele's residents. Others include producing a letter from a work place, or from a government office, and at times no evidence was required. A chi-square test showed that the place of application for granting free health care for the respondents has a statistically significant association with the evidences required for eligibility (Table 5).

Table 2: **Comparison of socio-demographic variables with waiver granted and pay categories of services at public health facility, Jimma Town, Southwest Ethiopia, December 2003**

Socio-demographic	Service categories			
	Granted waiver	Pay	Total	P-value
Sex				
Male	75	37	115	0.12
Female	121	91	214	
Age				
15-24	54	45	99	
25-34	72	43	115	
35-44	36	24	60	0.796
45-54	19	11	30	
>55	14	11	25	
Address				
Urban	108	99	211	
Rural	88	29	118	0.080
Family size				
1-2	36	16	52	
3-5	110	60	174	0.036
>5	50	52	103	
Marital Status				
Married	114	84	232	
Divorced	6	6	12	
Widowed	15	6	21	
Single	30	30	60	
Separated	2	2	4	
Occupation				
Farmers	75	14	89	
Housewives	58	41	99	
Merchants	19	18	23	
Government employees	5	24	39	0.000
No Job	14	5	19	
Student	15	24	36	
Daily laborers	19	5	24	
Monthly Income				
< 100 Birr	103	21	124	
100-385 birr	68	53	121	0.000
>385 birr	24	57	81	
House Ownership				
Rented	57	51	108	0.820
Private	134	80	214	
Number of Rooms				
1-2	159	79	240	0.000
>3	31	49	83	

According to the respondents from the kebele administrations, an individual who cannot prove to be a resident of a certain kebele or who lives on the street should apply at the town municipality where there is a department set up for this purpose.

Due to the absence of clear criteria for granting waivers at public health facilities the provision of certificates at the municipality is even more vulnerable for leakage.

A respondent from the environmental health department of the municipality explained:

"No formal written application or witnesses are required and a free health care certificate is provided after a one time assessment of the applicant's situation by the responsible individuals at the environmental health affairs department of the municipality."

But there are occasions where an actually poor individual takes a free health care certificate and hands the certificate of others in exchange for money. This is because most individuals who apply at the municipality have no identification cards and are not registered on any formal records.

She concluded, *"A better system is, thus, mandatory."*

Table 3: **Awareness about the presence of free health care for the poor with the educational status and address of the respondents, Jimma town, December 2003**

Characteristics	Awareness			
	Aware No (%)	**Not aware** No (%)	**Total** No (%)	P-Value
Address				
Urban	206 (97%)	6 (3)	212	0.012
Rural	107 (91.4)	10 (8.6)	117	
Total	313	16	329	
Educational Status				
Illiterate	127(94%)	8 (6%)	135	
Gr. 1-6	64 (97%)	2 (3%)	66	
Gr.7-8	37 (97.4%)	1 (2.6%)	38	
Gr. 9-12	64 (95.5)	3 (4.5%)	67	
Gr. 12	20 (87)	3 (4.5%)	23	
Total	312	17	329	

Out of the entire facility exit respondents 139 (42.2%) were not served for free on the day of the interview. These individuals were asked whether they deserved free health care or not. A majority of them, 76 (54.7%), replied that they do deserve free health care services. Two reasons mentioned by these respondents are being poor (82.9%) and assuming it as an individual's right (17.1%).

Facility exit respondents who claimed the presence of difficulties in getting supporting letters stating that one as free patient are 123 (37.3%). Types of difficulties cited by these respondents include the process takes long time 59 (17.9%), difficulty to produce evidences 35 (10.6%), and uncooperative committee members of the kebele administrations 29 (8.7%).

According to the health facility key informants, parts of the population that are served for free at public health facilities other than the poor include; prisoners, members of the police and defence forces. Groups of patients exempted from payment because of the type of disease they have are; leprosy, tuberculosis, and HIV/AIDS patients. Promotive and preventive services such as antenatal care, family planning and immunization are also provided for free. On the other hand, all government employees are expected to make half of the required payment at public health facilities. This also applies to under 18 years old children and the spouses of government employees.

Leakage and under coverage

According to the respondents from the health facilities there is a way to check whether a free paper is right by revising its protocol number and the kebele's stamp. But there is no mechanism to prove that a paper is appropriate because it is not possible to assess the background of each and every patient visiting the facilities.

Table 4: **Source of information about free health care and address of respondents, Jimma town, December 2003**

Source Of Information	Address			
	Urban No (%)	Rural No (%)	Total No	P-value
Friends	142 (69.3)	63 (30.7)	205	0.270
Health institution staff	40 (58)	29 (42)	69	
Community leaders	19 (61.3)	12 (38.7)	31	
Cannot remember	6 (54.5)	5 (45.5)	11	
Total	207	109	316	

Of the entire facility exit respondents, 122 (36.9%) indicated that there is a possibility of leakage (people who don't deserve waivers get them) in the free health care provision system of the town. Some of the reasons for this possibility are being relatives or acquaintances of committee members 92 (75%), relatives of health facility workers 15 (12.1%) and in exchange to money 15 (12.9%). Similarly, 144 (43.6%) claimed the possibility of under coverage (failure to provide free health care for those who are eligible). And the reasons mentioned are problems in the system (63.4%), lack of awareness (28.2%), inaccessibility of health facilities (5.6%) and having no money (2.8%).

Table 5: **Evidences required to be eligible for free health care with address and place of application of the respondents, Jimma town, December 2003**

Characteristics	Evidences required to be eligible				
	Witnesses	Letter from work place	Letter from government office	None	Total
Address					
Urban	74	9	6	17	106
Rural	79	3	2	2	86
Total	153	12	8	19	192
Place of application					
Kebele Office	138	5	6	6	155
Health Facility	4	5	1	1	11
Municipality and Missionary of Charity	8	1	1	12	22
Total	150	11	8	19	188

Discussion

This study assessed the presence of criteria, the way they are applied in determining eligibility for granting waivers and users' knowledge and attitude towards the existing free health care provision system.

Though all key informants have agreed on the importance of user-fees at public health facilities, most have agreed on the idea of granting free health care to the poor. However, as it has been seen in other studies the problem lies on the absence of clearly stated criteria and means testing while granting waivers (4, 5, 6, and 7).

In granting waivers both the key informant and facility exit interviews show that having witnesses and being a resident in a certain kebele are consistently required evidences. But unlike the finding of an earlier research in the northern part of the country income level is rarely mentioned as criteria for eligibility by both groups of the respondents (7). Even when income level is considered, the minimum amount of monthly income required turned out to be different in different Kebeles.

The inconsistently considered criteria currently used by the MFB are highly liable for leakage and under coverage. The shortcomings include the idea that all members of the MFB know that every resident in their respective kebele is not reliable and should be a heavy burden for the committee members. Only a few of the respondents mentioned monthly income, family size and being elderly as a measure for eligibility. This implies that a proper and well-organized means of testing is lacking in the system. The situation at the municipality of the town is even more vulnerable for leakage. Because applicants do not have identification cards or they are not registered in any formal record, it is even very difficult to for the provider to be certain on whether he/she is registering an indigents' genuine name or not.

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).*

One hundred ninety (57.8%) in this study were free patients which approximates to the finding of a similar study in northern Ethiopia (7). But out of the respondents who were paying, 76 (54.7%) claimed that they deserve free health care, the justification for most (82.9%) being low income. This may imply the failure of the system to serve the genuinely disadvantaged group of the population. Inaddition, out of all the respondents, 123 (37.3%) mentioned the presence of difficulties in getting supporting letters-stating one as a free patient. This is more than twice the finding registered in the study mentioned earlier (7).

The proportion of respondents that are aware of the presence of free health care for the poor was 97% and 91.4% for urban and rural areas respectively, a finding similar to the study in Bahir Dar area (north Ethiopia) (7). The sources of information for the majority of both rural and urban respondents were friends and acquaintances as was found in the household survey of the study in Bahir Dar area. This indicates that there is no governmental body that strongly considers the importance of disseminating the information to the needy.

Forty four percent of the exit respondents reported the possibility of under coverage while 37% claimed a possible leakage in the free health care system. This finding is even worse than was seen in the study in Bahir Dar area where 36% and 14.7% 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.

In this study the socio-demographic variables such as monthly income, occupation, educational status, family size and others 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). This may show that despite the absence of clear criteria, people who deserve it have got the service.

In conclusion, this study shows that the absence of clearly documented criteria for granting waivers at public health facilities has made the free health care provision system difficult for both providers and users. The effect of inconsistently applied criteria on the equity goals of the government is also undeniable. The high proportion of respondents that suspect the possibility of leakage and under-coverage could be an indication that the community is not confident about the system. This could also be attributed to the absence of clearly stated criteria and guidelines for granting waivers in the system. The free health care provision system should hence be revised and clear criteria and guidelines for granting waivers need to be developed to improve the efficiency of the system. While the provision of the certificates at local levels is something that should be encouraged, a better system that can be clearly monitored for leakage and under- coverage is important.

Acknowledgement
The authors are grateful to Jimma University for its financial support and all the respondents who have participated in the study for their cooperation.

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