



R728.5 Ei 2
blthr C.1
G365810



**COMMUNITY PERCEPTION OF EXEMPTION POLICY AND
IMPLEMENTATION OF THE POLICY IN ASSIN DISTRICT**

**A DISSERTATION SUBMITTED TO THE SCHOOL OF PUBLIC
HEALTH, UNIVERSITY OF GHANA, LEGON, IN PARTIAL
FULFILMENT OF THE REQUIREMENTS FOR A MASTERS
DEGREE IN PUBLIC HEALTH.**

DR JOHN BERTSON ELEEZA



September 2000

DECLARATION

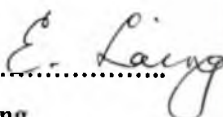
I hereby declare that this document is an original work produced by me under the supervision of Professor E. Laing, Dr K.A. Senah and Dr K. Sekyi-Appiah for the award of a Master of Public Health Degree.

This document has never on any previous occasion been presented in part or whole to any Institution or Board for the award of any Degree.

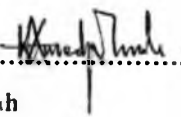
Signature: 

Dr. John Bertson Eleeza

SUPERVISORS

Signature..... 

Prof. E. Laing

Signature..... 

Dr K. A Senah



DEDICATION

This study is dedicated to Lydia Eleeza my wife and my children Ryan, John and Joan for sacrificing in diverse ways to see me through this one-year course.



ACKNOWLEDGEMENT

I wish to express my sincere gratitude to my Academic Supervisors Professor E. Laing and Dr.K. Senah as well as the field supervisor Dr. K. Sekyi Appiah for their inputs and guidance in the course of this study.

I wish to also acknowledge the contribution of the Assin District Health Administration, South Tongu District Health Administration, St. Francis Xavier Hospital the Assin Community and the staff of School of Public Health.

My course-mates at the School of Public Health have been a source of inspiration during the course especially my room mate Dr. Winfred Ofofu and Mr. Stephen Nkansah-Amankra my colleague during the Field Residency at Assin Fosu.

Once again my sincere gratitude to my wife and children for the sacrifices they made during the one-year course.

Finally, Ms Joan Gati and Ms Afua Dankwa deserve special thanks for the secretarial services they provided.

May the Lord Almighty bless all who assisted in diverse ways to the success of this study.

TABLE OF CONTENTS

	Page
DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
TABLE OF CONTENTS	iv
LIST OF TABLES	vi
ABSTRACT	vii
LIST OF ABBREVIATION	viii
 CHAPTER ONE: INTRODUCTION	 1
STATEMENT OF THE PROBLEM.....	5
FACTORS INFLUENCING PERCEPTIONS.....	7
OBJECTIVES	8
-MAIN OBJECTIVE.....	8
-SPECIFIC OBJECTIVES.....	8
RESEARCH METHODOLOGY.....	8
STUDY TYPE.....	8
STUDY UNITS.....	9
SAMPLING TECHNIQUES.....	9
DATA COLLECTION TECHNIQUES AND TOOLS.....	9
METHODS OF DATA ANALYSIS.....	10
ETHICAL CONSIDERATIONS.....	10
LIMITATIONS OF THE STUDY.....	10
 CHAPTER TWO: LITERATURE REVIEW.....	 11
CHAPTER THREE: THE STUDY ARE A	17
CHAPTER FOUR: RESULTS AND DISCUSSIONS.....	19
CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS.....	36
CONCLUSIONS	36
RECOMMENDATIONS.....	37
BIBLIOGRAPHY	38
APPENDICES.....	42

List of Tables

Table 1. Socio-demographic information of sample.....	19
Table 2. Sources of information	22
Table 3. Approval of existing exemption categories.....	25
Table 4. Definition of the ‘poor’	26
Table 5. Community suggested categories for exemption.....	27
Table 6. Services to be exempted.....	28
Table 7. Facilities to implement exemptions.....	29
Table 8. Who to decide beneficiaries of exemption.....	30
Table 9. Perception of quality.....	31
Table 10. Obstacles to exemption provisions.....	32
Table 11. Non-Hospital Illnesses.....	33
Table 12. Identifying the truly poor.....	35
Table 13. Financing health care.....	35

FIGURES

FIGURE 1: Awareness about exemption policy based on category of Respondents.....	20
FIGURE 2: Knowledge about exemption categories.....	23

ABSTRACT

This study examines the perceptions of the communities in Assin District with respect to exemption policy and its implementation.

A combination of interviews and discussion with community groups was used.

A total of 86 people were interviewed. This comprised mothers caring for children under 5 years, pregnant women, the Aged (70+years) and people not entitled to any exemptions. Three focus groups were organized.

This study was necessitated by the fact that most patients in the district still stayed off public health facilities on the basis of financial constraints despite the exemption policy and the high expenditure of the District Health Administration on exemption.

The level of awareness about the policy is high but the knowledge about policy statement is grossly inadequate and most of it erroneous. Only small proportion of respondents had information on exemption from Health workers. The community perceived anything given out free of charge as of poor quality. The community members could not provide an operational definition for “poor”

It was found that “financial constraint” as used by members of the community with respect to seeking health care does not necessarily imply inability to pay “user charges” but it also may mean cost of reaching the facility.

The community members were of very low self-esteem and could not imagine how they could make input into national policies or demand for a change in policy.

The study was carried out in a rural setting among people with basically low educational background. This is based on the fact that literacy rate in Ghana is just over 55%. It is believed that most of the illiterates live in the rural areas of the country.

LIST OF ABBREVIATIONS

31 DWM	December Women Movement
F G D	Focus Group Discussion
GPRTU	Ghana private road transport Union
M OH	Ministry of Health
N L C	National Liberation council
O P D	Outpatient Department
W H O	World Health Organisation

CHAPTER ONE

INTRODUCTION

The provision of adequate health care is a task that invariably involves the collective effort of both the government and the governed although decisions on financing health care are usually unilaterally taken by the government. Since the postcolonial era, the problem has been how much each party should contribute towards the realization and maintenance of a healthy society.

During the colonial era the local population never had free medical care. As far back as 1852 Governor Hill got the people to agree to a poll tax of one (1) shilling per head. Some of the proceeds were used for medical work.¹ When colonial administration sent Anti-malaria tablets to all health centres and postal agents these were to be sold cheaply to the local population and to be distributed free of charge to Europeans.²

Although the task of providing health care was partly shared by missionary bodies, mining companies and a few private individuals, the greater share of the responsibility fell on the colonial administration.

To reduce the financial burden of providing health care services, civil servants paid dispensary fees ranging between 6d and 5s but were entitled to free medical attention. All others, except paupers, paid professional fees in government hospitals. This was in addition to hospitalisation fee, dispensary fee and cost of drugs and x-rays³ given the poverty of the local population and the size and number of fees charged, many did not avail themselves of the facility. Between 1922 and 1932, for instance, not less than an average of 10 percent of total government expenditure went into public health financing.⁴

Although users of health facilities made some financial contribution towards the cost of health care, this was not enough.

Following the attainment of internal self-rule in 1951, the ministry of health was created and a commission was appointed to look into the colony's health system.

The commission recommended, among other things, that all public hospitals and health centres be placed under the control of the new ministry and that hospital fees be abolished.⁵

Immediately after independence, between 1959 and 1961, the Nkrumah government was confronted by the challenges of providing social services to most communities. Efforts to bring social services closer to the people did not stop at the expansion of physical facilities. The cost to users of health facilities was also drastically reduced; it was made free in some cases. On 9th October 1961, the government abolished private professional fees being charged by government doctors, dentists and specialists.

In May 1962, a further concession was granted to the populace:

- (a) Children of 16 years or less were to be treated free of charge except when treated in superior hospitals;
- (b) Government employees, employees of government corporations, members of the armed forces, worker brigadiers and the teaching services were to be treated free of charge at out-patient clinics;
- (c) For the rest of the population, a fee of 5s was to be charged for first attendance and 25s 6p for subsequent attendance; and
- (d) Mission hospitals (whose fees were high) were to be reimbursed by the Ministry of Health for treating the categories of people mentioned above. Thus for the first time Ghanaians were to pay a token fee for outpatient treatment. In addition, government employees who hitherto had to pay a fee for out-patient treatment were to be treated entirely free of charge.⁶

In 1966 when the Nkrumah government was overthrown by National Liberation Council (NLC), which was capitalist oriented, the Easmon Committee was appointed to revise the Nkrumah government's policy of involving the state deeply in a wide range of social and economic tasks. The committee recommended, among others, that hospital fees should be raised and their collection strictly enforced.⁷ The NLC on the 6th February 1968 introduced a statutory dispensing fee of 30np (new pesewas) in addition to the token hospital charges already in existence. The public outcry against the directive led to the quick withdrawal of the directive.

However the directive was gazetted as NLC Decree 360 to be effective from 1st October 1969 when the NLC would have safely handed over power to the newly elected civilian government of Dr. Kofi Busia.

The Busia administration appointed the Konotey-Ahulu Committee to investigate all matters relating to hospital fees. The Committee observed:

Considering the cost to the government that these drugs dispensed free must bring the committee recommended that for the generality of patients including civil servants, out-patient care and treatment (including ante-natal care) should no longer be free, and that something be paid towards the cost of drugs dispensed in government hospitals and clinics.⁸

Following the Committee's report an Act of Parliament⁹ was passed by which charges were instituted for various services and other categories of persons such as aliens and members of the diplomatic corps who hitherto had not been required to pay for health services at government hospitals. However, the legislative instrument,¹⁰ which detailed who was to pay for what services, made attendance at rural health centres and posts free. Also patients referred from urban health centres, district hospitals or general practitioners to regional or central hospitals were to pay 100 cedis for the first attendance and 50p for subsequent attendance. Private patients were to pay 10 cedis per attendance. Charges for in-patient services were also raised.

The Provisional National Defence Council (PNDC), which seized power from the Limann administration in 1981 in its efforts to save the public health system from imminent collapse, raised fees for all kinds of hospital services.¹¹ Consequently, outpatient consultation, which had been free in certain areas, attracted a flat rate of 5 cedis per visit. For the first time also non-Ghanaians were discriminated against in the payment of hospital fees; they were required to pay anything ranging between 100 and 200 per cent of what Ghanaians were to pay. The argument for those increases was that the state could no longer bear the full cost of health delivery services.

In 1985 a comprehensive cost sharing policy was instituted by enacting the Hospital Fee Regulations¹² as part of the economic reform programme of the government. The Hospital Fees Regulation specified fees to be charged for consultation, laboratory and other diagnostic procedures, medical, surgical and dental services, medical examination and hospital accommodation. The law, however, indicated that full cost of drugs should be recovered through user fees.

The law provides for full user fee exemption for 'paupers,' (not defined), health workers and students in health institutions, patients with tuberculosis (TB), leprosy and psychiatric patients and some services like immunization, antenatal and postnatal services and child welfare clinics.

Interestingly despite the above exemption provisions since 1961 to 1985, the Ministry of Health (MOH) in 1996 identified financial constraint as one major factor militating against service utilization among most vulnerable groups in the country¹³

The government in response to the Medium Term Health Strategy decided to reduce the financial burden and increase financial access of most vulnerable groups to health care by announcing user fee exemption for the following sub-populations:

- (a) Children under 5 years of age;
- (b) Pregnant women for 4 antenatal visits;
- (c) Elderly (70 years and above);

Although this facility already exist in the 1971 and 1985 Acts for hospital fees.

Although the president announced this during a session with parliament in January 1997, the guidelines for its implementation were made available eight months later. These guidelines were full of ambiguities and different interpretations were given to it in various parts of the country. Like the other two previous acts no public education concerning the policy was given to the implementers or the beneficiaries. As the World Bank Report (1995) emphasized, when exemptions are provided at health facilities, both staff and clients should be well informed about the exemption policies, and there should be a clear community consensus on who qualifies as "poor" ¹⁴

The exemption policies in this country since 1961 have all been of a “top-down” approach. Communities’ views have never been sought. The current exemption policy is difficult to implement because the implementers cannot define who is a “pauper” and even tell the real ages of beneficiaries.

The communities may not want to pay for certain services not because they do not have money but because they feel the quality of the service is not worth the amount charged. It may also be that the expenditure involved in reaching the facility outweighs the cost of service to be exempted.

The community may have a completely different view about the type of services and category of people that must be exempted and even suggest very practical criteria for category identification.

It will be recalled that when the family planning project was first introduced in the northern part of Ghana the patronage was abysmally low, this was a programme the implementers were imposing on the communities without finding out their views. At a focus group discussion with the community members, the project implementers were told, “Let our children survive first and then we can talk about controlling or spacing births” The communities’ acceptance of family planning improved when the project introduced immunization schedule and treatment of minor ailments of their children. This study is to seek the communities’ views about exemption policies and their implementation.

PROBLEM STATEMENT

There has been in place exemption policy to cater for the vulnerable in our society since 1961. In 1997 the government introduced some other categories to enjoy exemption. Despite the existence of this exemption provisions a study in the Assin district to unveil the reasons for low utilization of the public health facilities in 1998 concluded as follows:

”Most people in the communities studied preferred to seek health care from public health facilities but were deterred from doing so due to financial constraint.”¹⁵

On the other hand the DHA had spent ₵59million on exemption from 1997– 1999 and had an outstanding bill of ₵20million to pay to facilities, which exempted people during the last quarter of 1999.¹⁶

The questions then to answer are:

1. Who defines the “poor”---the community or the health providers?
2. Is user fee the only constraint limiting access to health or other expenditures?
3. What factors influence the community members’ decision on utilization of exemption provisions?

FACTORS INFLUENCING PERCEPTIONS

There are several factors, which influence the utilization of exemption in any society. For anybody to utilize service there must be knowledge about the existence of such facilities. The knowledge about exemption policy is crucial if people are to take advantage of the facilities.

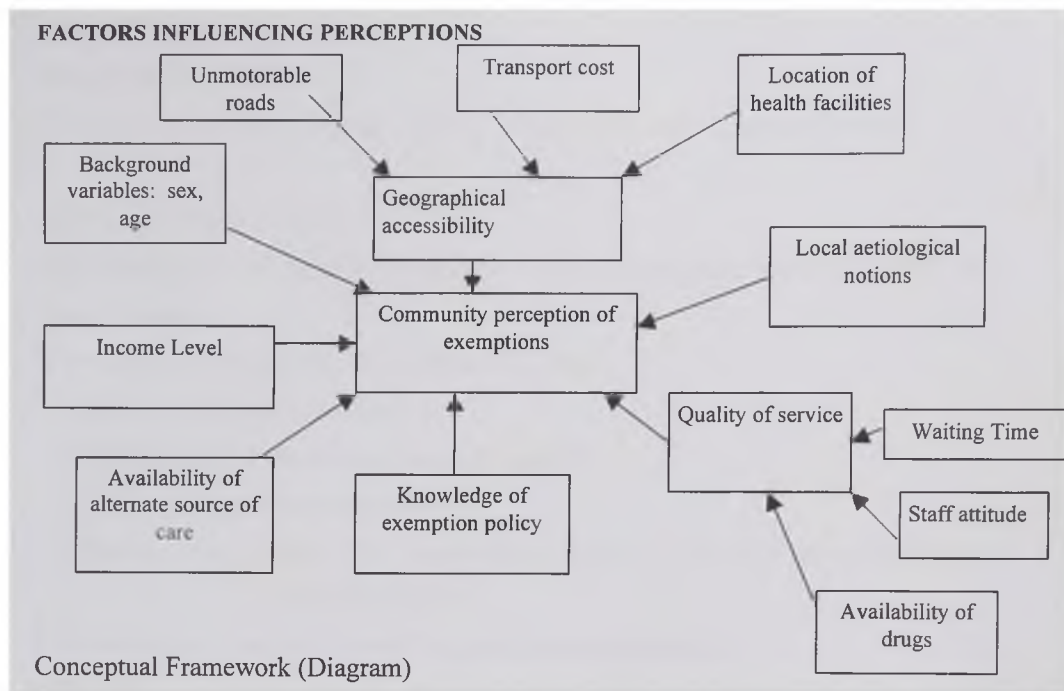
The perceptions of the quality of the services is important, if people perceive quality of services as good then they would patronize then but if perceived as poor then even if given free they may not use the services.

The geographical accessibility of the health facilities plays a role when patients want to seek care. If a patient thinks the cost of travelling to a facility exceeds the user charge exemption he may not make use of the exemption provision because it is uneconomical.

He will therefore use alternate health care services even if he has to pay for them.

Also patients are not likely to utilize exemption facilities if the perceived cause of illness is attributed to factors which they believe cannot be treated by orthodox medicine. They may resort to seeking care in facilities not having exemptions.

SEE DIAGRAM ON NEXT PAGE



OBJECTIVES

MAIN OBJECTIVE:

To explore community perception of exemption policy and its implementation

SPECIFIC OBJECTIVES

- 1.To determine the level of awareness of the community members about the exemption policy.
- 2.To determine community views on the following:
 - (a) Who qualifies for exemptions?
 - (b) What services should exemption be granted?
 - (c) Who should be the implementer?
 - (d)What role should the communities play in policy formulation and implementation?
- 3.To determine if people are benefiting from the current policy.
- 4.To determine if the community members have alternative arrangement for increasing financial access to health care other than exemption.

RESEARCH METHODOLOGY

Study Type

It is a descriptive and exploratory study, of community perception of exemption policy and its implementation in Assin District. A combination of qualitative and quantitative method was used but mostly qualitative.

Qualitative method could provide more information about policy practice, policy effectiveness and the constraints facing policy and the weaknesses of the policy⁴⁴.

Study Units

- (a) Caretakers of children less than 5 years of age
- (b) Pregnant women
- (c) Aged 70 years and above (men & women)
- (d) Those not entitled to any specific exemption (men & women)

The above groups were chosen with the intention of finding out differences if any between those entitled to exemption and the non-exemption group perceptions.

Sampling Techniques

- Assin district has eight-[8] sub-districts four [4] each in Assin South and Assin North.
- The study was carried out in four sub-districts two from South and other two from North Assin.
- The two sub-districts in the South Assin were selected randomly from the four [4].
- The same was done for North Assin.
- In all nine [9] communities were studied.
- Two communities were randomly selected from the respective sub-district except Foso sub-district from which three communities were selected randomly because of its large size.
- Respondents in the study were randomly selected.

DATA COLLECTION TECHNIQUES AND TOOLS.

1. **Interview:** Using structured questionnaires for;
 - (a) Care takers of children under 5 years of age
 - (b) Pregnant women/nursing mothers
 - (c) Elderly 70 years and above
 - (d) Those not entitled to any specific exemption.
2. **Focus group discussion** with:
 - (a.) Elderly ≥ 70 years
 - (b.) Pregnant women/caretakers of under 5 years.
 - (c.) None exemption group

In all three [3] focus groups were organized

Sample Size Calculation

Computer programme called EPI-Info stat-cal was used

A sample size of 86 was used

See Appendix for details.

METHODS OF DATA ANALYSIS

Descriptive statistics were mostly used to analyse the information collected from the field since most of the information is qualitative. The conclusions drawn were based on the percentages of respondents who expressed a particular view and the frequency of some issues mentioned by respondents.

ETHICAL CONSIDERATIONS

Confidentiality was ensured; names of respondents were not recorded.

Only willing respondents were interviewed.

LIMITATIONS OF THE STUDY

Assin District is predominantly rural population (85%) and with a high illiterate population and therefore their opinions may not reflect that of those in urban and highly literate population with respect to the exemption policy. The qualitative findings cannot be statistically generalized, though it can provide the decision-makers with valuable information.

CHAPTER TWO

LITERATURE REVIEW

Many studies have been carried out to find out how the poor or certain vulnerable groups are catered for by the various health systems. Other studies focused on the problems with exemption or the effectiveness of exemption schemes. Most of these studies focused on the health providers, the implementers of exemption to get solutions to the problems associated with exemption or to improve the exemption schemes. The beneficiaries/community members, most often than not are left out. Only few people have seen the need to consider the views of the communities with respect to exemptions policy and its implementation and request them to make inputs into policies for improvement of exemption scheme to suit realities.

Survey of official cost-recovery policies for health Care Systems in African countries suggests that exemptions are remarkably uncommon.¹⁷ crude classification of twenty-one African countries by exemption policy showed that of the twenty-one, only one has an official income ceiling below which people are exempted. Twelve countries reported that their national health policy provides for exemption but have no clear criteria for determining who qualifies for them. The remaining eight countries provide exemptions only as part of local projects or facilities with criteria determined on an ad hoc or community basis¹⁸

Targeting for free health care can be done by using general characteristics of group of people such as services provided for children, and pregnant women, and other communicable diseases like TB, AIDS and leprosy.¹⁹

Occupational status is also considered in some characteristic targeting schemes, such as the unemployed, or people who do work but have a low wage or civil servants and health workers²⁰

There is preference of the characteristic targeting in most developing countries because it has fewer informational and administrative constraints than direct targeting scheme. Direct targeting requires measurement of the personal income, which becomes difficult when most of the population is working in the informal market²¹

Although some difficulties do exist in determining the employment status in some countries where the formal labour market is not well developed, targeting by occupational status like unemployed or people with low income can also be a means of reaching the poor.

The main disadvantage of the characteristic target is the leakage of subsidizing of health care to the non-poor. If eligibility for exemption is given to the people within a rural area, some of the households that are granted exemptions may be able to afford the fee.²²

Direct targeting is exemption or subsidizing of Health Care that is based on the socio-economic status of the patients and the objective is to discriminate between the household that can pay and unable to pay the cost of the health care.

The Ghanaian exemption policy combines both characteristic targeting and direct targeting.

A Survey of International cost recovery in 18 countries, which have a policy to exempt, the poor households are means tested and divided into two payment categories: able to pay (full cost of the treatment) or unable to pay (total exemption).

In countries with two income bands, quantitative and qualitative criteria define who is eligible for the exemption. In other countries with a stated exemption policy, qualitative descriptive criteria were used. However it was recommended to these countries that, although the survey described the mechanism used to determine eligible to exemption in those countries, attention be paid to the fact that what is stated in the policies does not reflect the actual implementation of the policy²³

Four main procedures have been identified to reach the beneficiaries of exemption or subsidise.

The first procedure is the community leader referral or certificates. In Lesotho, relatively strict criteria have been used to distinguish between the poor and the non-poor. Exemptions are awarded only to people with no income and no land, or livestock. These individuals must be certified by village chiefs and district officer as being “pauper”,²⁴ only about 200 people had received their certification.

The low figure suggest that other hardships cases, such as members of poor households headed by women who cannot afford to pay for health care, might be denied treatment.

The second procedure is objective assessment using developed criteria. This is found in Thailand and Zimbabwe where quantified income criteria are used.

The third procedure is self-selection for exemptions with voluntary payment systems.

Fourth procedure is the subjective assessment by health facility personnel²⁵

In Ghana the exemption depends on the subjective assessment of the health workers and they consider the appearance as a method to identify the poor²⁶

In the Volta region the heads of health facilities were to use their discretion to decide who qualifies as “pauper.”²⁷

When the government of Malawi was introducing cost recovery in her health facilities she recognised the need to exempt the ‘core poor’ from the Ministry of Health cost- sharing scheme. It therefore examined the structure of land holding to determine such households.²⁸ Core poor were defined as families farming less than 0.5 hectares and had been estimated to comprise 50,000 households, or 18 to 20 percent of all households in Malawi.

In working out a lower and affordable schedule of fees the government of Malawi did this in collaboration with the communities served. She concluded that community involvement is particularly worthwhile in this task, because community representatives are in a far better position to determine who can and cannot pay than say, a central government official removed from such realities.

In Kenya the ability to pay is determined by conducting health care expenditure survey. If the health expenditure exceeds 5% of the total income then the households are eligible for the stamps, which are issued by the in-charge of the health facility. Patients who carry stamps are granted exempted.²⁹

It is believed that the limited capacity to administer exemption in most African countries may well be most important explanation for their infrequency and ineffectiveness in reaching the truly poor³⁰

There are many factors or constraints, which influence the effectiveness of the exemption in developing countries. Some of the important factors identified include the following:

The Lack or limited information necessary to determine the eligibility for exemption, made health workers to apply their subjective criteria.

Although relevant information is available, income criteria may not be enough to accurately determine the ability to pay.³¹

Due to scarce information about the income in low-income countries, because most of the population works in the informal sector, it is difficult to locate the household above or below the poverty line³² Gilson cited evidence from other authors to support her argument.

The interaction between the providers and the claimant and sometimes third actors such as social workers, will affect the decision to seek eligibility or to provide it. Attitude of all these groups is critical to the effectiveness of the exemption.³³

Cost recovery and exemption are constrained by low levels of revenue, thus making it difficult to reach the objectives of improving quality and increase coverage.

The problems of Low levels of revenue are exaggerated by the additional administrative cost of the exemption and revenue lost on exemptions of non-poor such as Ministry of health staff. Gilson stressed that in the poor areas if most of the population is eligible for the exemption the cost will be more. In addition, due to low household income and limited cost sharing capacity of the systems in these areas the revenue will be even less. In these areas allocation of more resources from the central level is essential for protection of equity goals, but most of the time this is unlikely to happen.³⁴

In Ghana the recently announced exemption policy in 1997, the guidelines were so ambiguous that the interpretation of the policy varied in all the regions. Most health facilities were therefore not implementing the exemption because criteria for identify beneficiaries was lacking. Besides the public, which is to benefit from the exemption provisions was not educated about the policy.

Most African country governments not only exclude communities, i.e. potential beneficiaries from participation in formulation of policies but also do not involve implementers.

In 1994 the President of South Africa announced a revision of the exemption policy. The groups to have free services included: children under six years, pregnant women and nursing mothers, elderly people, disabled people and certain categories of the chronically ill³⁵

Although popular support for these provisions was overwhelmingly positive, many health care providers objected to the inadequate preparation time and the lack of consultation preceding the decision to implement what had been seen as policy suggestions available for these new services.

A survey carried out in Cape Town to seek public opinion on the categories announced for exemptions, revealed that the respondents recommended that the following categories of patients, regardless of the nature of the service should receive 'Free Care' Percentage of respondents: Elderly 67%, Indigent 57%, disabled 54%, children < 6 years 41%, unemployed 37% and pregnant women 24%. The relatively low proportion of respondents who felt that children and pregnant women need exemption is worth nothing³⁶.

This survey also indicated that administrative personnel and skills, especially for the implementation of exemption mechanisms are often inadequate, while many patients are unaware of the details of exemption procedures.

The utilisation of any exemption provision or any measure in place to protect the poor will depend on how the potential beneficiaries perceive such a mechanism.

A review of the Cash and Carry experience in two facilities in Ashanti Region, found that exemption was granted mostly for the health staff and paupers. The exempted patients received "less value drugs."³⁷

This implies if there are two drugs which can perform the same functions, but at different rates, the exempted will be given the cheaper of the two and the less effective.

"A free treatment could be, but when you report and you are given free medication, it is not likely to be of high quality. For example, when the doctors see the patients is not wealthy, he does not give him a very sound treatment" These were the words a trader during a Focus group discussion in 1997 in Ho district.³⁸

The WHO Director-General, Dr. Gro Harlem Brundtland is quoted as saying in The World Health Report 2000 - Health Systems Improving performance.

“The poor are treated with less respect, given less choice of service providers and offered lower-quality amenities.”³⁹

An experimental study conducted in the Cameroun to test the effects of introduction of user fees with improvement of the quality of care. The rate of the facilities utilisation by the poor was specifically assessed. The result showed an increase in the utilisation, especially by the poor, which contradicted many of the studies that were conducted on the impact of the charging of health care.⁴⁰

Even when someone who is eligible for exemption could be identified, there are several factors, which can influence the targeting effectiveness. The stigma of being poor and the behaviour of the providers towards the poor make them reluctant to request the exemption.

In Indonesia, the people refused the free exemption cards due to the stigma to be identified as poor.⁴¹ Jordanians criticised the procedure of defining people as ‘poor’ to enable them get exemption, because the word ‘poor’ carries a stigma and therefore refuse to seek help if it involves being called ‘poor’.⁴²

It is not always that the truly poor come forward to be helped. The assessment of Thai Free Medical Care Project, which sought to concentration government assistance on the poorest groups, suggested that “the major draw back of this type of approach occurs if the poor are unwilling to draw attention to their state by opting for special assistance, thus large numbers who qualify for special assistance do not request it.”⁴³

In some studies the community has described or defined a pauper as a person with dirty clothes, blind, disabled or mad, and who says that he cannot afford the cost of the health care.

CONCLUSION

From the literature review it can be said that granting user fee exemption does not necessarily make health services accessible to the deprived, because they may decide not to take advantage of such provision.

The perceptions of the community members with respect to, the quality of exemption services and the criteria for exemption can have significant influence on acceptability and utilization of exemption.

CHAPTER THREE

THE STUDY AREA

LOCATION

The study was conducted in Assin District of the Central Region. Assin District is bounded by Adansi East District (Ashanti Region) in the north, Birim South District (Eastern Region), Asikuma-Odoben-Brakwa and Ajumako-Essiam in the east, Upper Denkyira and Twifo-Hemang in the west and Abura-Asebu-Kwamankese and Mfantseman in the south.

Assin is the largest among the 12 districts in the region with a land surface area of 2375 square kilometres.

DEMOGRAPHIC BACKGROUND

The district has a population of 193888, (2000 census). This is the second highest population in the region; Gomomo District being the highest with a population of 196756. The large surface area has made the Assin District the least densely populated district in the region. The sparse distribution of the population poses a great challenge to the health care delivery. The district is predominantly rural (85%). Assin Foso, the administrative capital of the district is the largest town with about 14,000 inhabitants. About 85% of the population live in villages with less than 1000 inhabitants.

MAIN ECONOMIC ACTIVITIES

Most people are farmers engaged mainly in Cocoa and Palm nut cultivation.

Many women are engaged in selling food products and trading activities.

There are few small-scale industrial activities such as mining, lumbering and saw milling taking place in the district.

COMMUNICATION/ UTILITIES

The major transportation network is the Cape Coast-Bekwai-Kumasi asphalt road which passes through the capital, but most parts of the district are served by feeder roads. The Accra-Takoradi Railway line also passes through Foso, the district capital and some other smaller settlements in the district.

Telecommunication facilities are provided by Ghana Telecom and three private communication centres at Foso.

A number of decentralised government departments are also linked to other parts of the country motorolar radio.

EDUCATION

Educational institutions include: 21Nursery schools, 64 Kindergartens, 157 primary schools, 86 junior secondary schools, 7 senior secondary schools, 1 Teacher Training college and 2 Vocational Training Institutions

HEALTH SERVICES

Health care services are provided by the Catholic Hospital, St Francis Xavier Hospital at Foso and seven other health centres and twenty-five community clinics.

There are two private maternity homes, three hundred traditional birth attendance and six Homeopathic clinics operating in the district. Only one hundred and fifty of these birth attendance were trained by the District Health Administration.

There are seventy chemical shops and one pharmacy shop, which is located at Foso.

For administrative purposes the district is divided into eight sub-districts

CHAPTER FOUR

RESULTS AND DISCUSSIONS

SOCIO-DEMOGRAPHIC INFORMATION

The study was carried out in nine [9] communities in four sub-districts in Assin Foso district. A total of 86 respondents were interviewed, 52 of which were women and 34 males. Out of the 60.5% females interviewed 51.2% are either pregnant or had a child under five years of age. There is a preponderance of female in the sample because one of the categories for exemption is restricted to women, that is pregnant women, and also it was the females who were responsible for the care of children especially when are ill.

Majority of the respondents (45.3 %) had only elementary education; only 4.7% of the respondents went further beyond Secondary level. More than a quarter (29.0%) of the respondents had no formal education. Therefore they would have to depend on people for the interpretation of the policy.

Mothers with children aged less than five formed 22.1% of the respondents. Pregnant women were 27.9% whilst the aged represented 18.6%. The majority of 31% were community members who are below 70 years who do not belong to any exemption category. The table below (Table 1) shows the details of the distribution.

Table I Socio-demographic Information of Sample

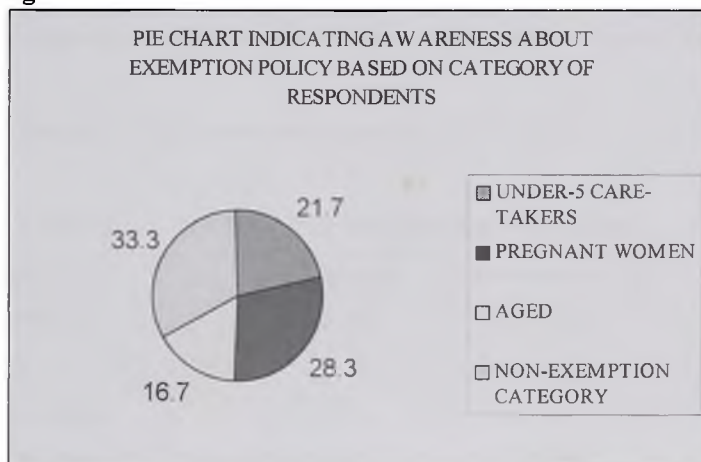
Characteristic of Respondents	Frequency	Percentage [%]
<u>Sex distribution</u>		
Male	34	39.5
Female	52	60.5
Total	86	100
<u>Respondents Status</u>		
Mothers of Child <5yrs	19	22.1
Pregnant women	24	27.9
Aged (70+)	16	18.6
Non-Exemption group	27	31.4
<u>Educational Level</u>		
None	23	26.7
Elementary	39	45.3
Secondary/Vocational	18	20.9
Tertiary	4	4.7
Non-formal (Adult Education)	2	2.3

Awareness and Knowledge about Exemption Policy

Awareness about existence of exemption is very high in the district. As many as 74.4% of the respondents knew of the existence of some kind of exemption such as exemption for the aged, pregnant women, children and the poor. Awareness was highest among the non-exemption category of respondents and least among the Aged. However not much details about the policy are known. Majority of the respondents were aware of exemption of the aged, whilst only few knew about other categories such as children less than five years and the poor.

The percentage awareness among the various categories of respondents is shown in the pie chart.

Figure 1.



SOURCES OF INFORMATION ON EXEMPTION

The major sources of information about exemption in the district are Radio and Television communication 29.2%, Friends 26.2% and Health workers 24.6%.

Quite a significant number of respondents had information from relatives (13.9%). Only 7.7% had information from newspapers this is not surprising since we were dealing with a rural setting where most people are expected to have low educational background.

It is important to note that most of the respondents had information from sources other than health workers. This explains the perception of the community members, as

revealed during all the Focus group discussions, that the health workers are not implementing the exemption the way the President announced the policy recently.

They said the government said all children under five years, elderly and all pregnant women are to have free medical care, but when you go to our clinics/hospitals the health providers charge our children under five years and pregnant women are asked to pay for some services. The elderly are made to pay for some services and even some elderly are denied free care on the ground, that they are not 70 years.

This revelation implies that not enough public education on the exemption policy has come from the health providers. It also implies that the health workers have not made the government guidelines for implementation of policy known to the public.

Majority of the respondents (41%) have heard of the exemption policy 7-12 month before the interview. Twenty-seven percent (27.9%) had the information only six month before the interview.

Only 16.4% of respondents have heard of policy 25 and above months before the interview time.

Details about sources of information are shown in Table 2 below.

Table 2: Sources of Information On Exemption

Source (n=65)	Frequency	Percentage (%)
Radio/TV	19	29.2
Friends	17	26.2
Health workers	16	24.6
Other Relatives	9	13.9
Newspaper	5	7.7
Community leaders	2	3.1
Beneficiaries	2	3.1
Duration in months (n = 61)		
6 months	17	27.9
7 – 12 months	25	41.0
13 – 18 months	3	4.9
19 - 24 months	6	9.8
25+	10	16.4

Knowledge about Exemption Categories

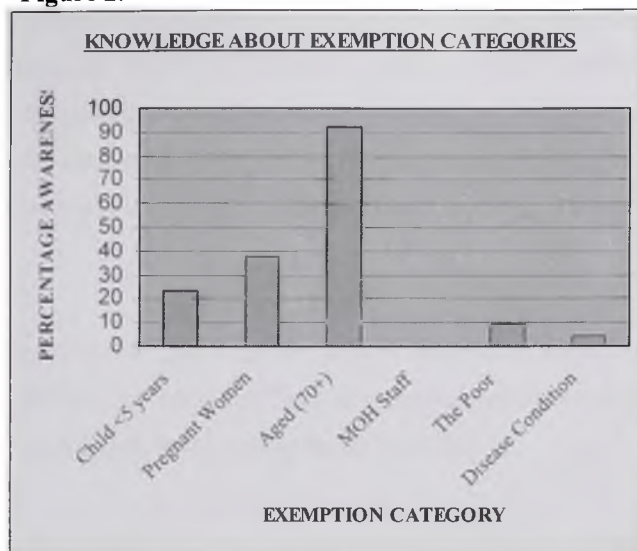
Knowledge about exemption categories was very low generally. But significantly most respondents (92.2) were aware that aged were to enjoy free care, however most did not know about the minimum age limit of 70 years for exempting the elderly. This could be a source of confusion between health care providers and the public; since the community members think once you are elderly you can enjoy exemption.

None of the respondents knew of any exemption for the Ministry of Health staff.

It was very surprising that only 9.4% of respondents knew the poor were entitled to free health care and 4.7% were aware that certain disease conditions like tuberculosis, buruli ulcer etc are treated free of charge. All those aware of exemption disease conditions were males engaged by the District Health Administration as community base disease surveillance volunteers. This is evidence that if the communities are involved in health activities there would be more cooperation because they would be well informed.

Only 37.5% of respondents are aware of exemption for pregnancy women and 23.4% for children under five years. All the pregnant women knew they were entitled to exemption but only three out of twenty four knew they were to enjoy partial exemption. Interestingly all the three were lady teachers.

Almost all the respondents thought all those entitled to exemption are to have every service free. They had no idea that some categories were to have partial exemption. This actually is a reflection of their source of information Radio/Television and from friends which is actually referring to pronouncements the president made during his sessional address to parliament in 1997. A male participant during a focus group discussion said *my pregnant paid during her last visit to the clinic according to the nurse that was the cost of malaria treatment*. The inadequate detailed knowledge of the exemption provisions is a major source of the limited utilization of the exemption provisions.

Figure 2.

Approval of Existing Exemption Categories

Although majority of the respondents endorsed the various categories being exempted presently, they varied markedly with respect to the type of exemptions the various categories should enjoy.

From the table it is clear that as high as 72.9% of respondents think the aged should enjoy full exemption while 25.9% think it should be only partial exemption. Interestingly, none of the respondents said no to the exemption of the aged. Most of the respondents and the discussants felt the aged have contributed enough towards the development the nation and therefore it is the turn of the nation to care for them. This feeling was summed up by a young male discussant when he interrupted an elderly who was pleading for full exemption for the aged. He queried, *why is the minimum age for elders to qualify for exemption not pegged at 60 years to allow pensioners who have serve this nation to benefit?* He concluded with a proverb, which literally goes like this, *if your parents care for you to grow your teeth it is your duty to care for them to lose their teeth.*

In the case of pregnant women 32.9% of respondents wanted full exemption but 48.2% almost half of the respondents think pregnant women should be given partial exemption. However 14.1% said “No” to exemption for pregnant women. This stance was further buttressed during focus group discussion when people queried why the government should take responsibility of somebody’s pregnant wife? One elderly lady during focus group discussion said *it is good the government is caring for the*

pregnant women this will ensure that all give birth to healthy babies, but their husbands should pay the delivery fee except when the delivery involves operation should it attract exemption, since you require a deposit of three hundred thousand cedis at the hospital before operation is done.

A young male discussant queried why should the government look after someone's pregnant wife? What becomes of the family planning promotion campaign of the health providers?

Almost half (49.4%) of respondents want the poor to have full exemption whilst 28% think it should be partial, only 9.8% said “no” to exemption of the poor, 12.9% were indifferent about what happens to the poor at health facilities.

For children under five years 44.7% of the respondents think they should enjoy full exemption whilst 35.3% think they should only have partial exemption. A significant 14.1% of respondents said no to exemption of children less than five years of age.

The disease condition had 30.9% of respondents agreeing to full exemption but 9.8% of respondents said no to disease condition and 24.7% are indifferent. The MOH staff had the highest number of respondents (20%) saying no to their exemption. However 35.3% respondents think they must have full exemption whilst 30.6% think they must have only partial exemption.

Contrary to expectation there is a significant number who felt, children less than 5 years, pregnant women, disease conditions and especially MOH staff should not enjoy exemption. This finding is similar to that in a survey in Cape Town, South Africa where only few people favoured exemption for pregnant women 24% and 41% for children less than 6 years. See Table 3 for details.

TABLE 3: Approvals of Existing Exemption Categories (n = 85)

Category	Full exemption		Partial		No – Exemption		DNK	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Child < 5 years	38	44.7	30	35.3	12	14.1	5	5.9
Pregnant women	28	32.9	41	48.2	12	14.1	4	4.7
Aged (70+)	62	72.9	22	25.9			1	1.2
Disease Condition	25	30.9	20	24.7	16	19.8	20	24.7
The Poor	42	49.4	24	28.2	8	9.8	11	12.9
MOH staff	30	35.3	26	30.6	17	20.0	12	14.1

Who the community classified as “poor”

Majority of the respondents (71.8%) consider anyone who cannot afford basic needs as poor. One who cannot afford health care followed this and unemployed persons as indicated by 17.9% of respondents respectively. Only 6.4% considered Disabled as poor. It was the expectation of this study that the community members would provide an operational definition of the “poor” but this expectation was not met. In Lesotho the poor were those with no income and no land, livestock or other belongings.(Shaw P.R. and Griffin C.C 1995). Generally it is difficult to define the poor because of the associated stigma. During a focus group discussion when participants were asked if there were any poor people in the community a woman queried *how could I say somebody is poor?* Other person said *there are people in the community who do not pay any community levies yet they get offended when you say they are poor.* This implies that people are likely to refuse utilization of exemptions if beneficiaries are to be classified as poor. In Indonesia, the people refused the free exemption cards due to the stigma of being identified as poor, Abel-smith,B., and Dua, A.(1988).According to Longford et al (1980)the Jordanians criticized the procedure of defining people as “poor” to enable them get exemption.

Table 4: Definition of the “Poor”

Definition	Frequency	Percentage (%)
One who cannot afford basic needs (clothing, food, shelter)	56	71.8
One who cannot afford health care	14	17.9
Unemployed person	14	17.9
Disabled	5	6.4
DNK	2	2.6

Suggested Categories

The relatively small numbers of respondents who think some categories must be added to the existing ones suggest the adequacy of the existing categories.

However a significant number(21.7%) think the disabled should be exempted for some services. The accident victims, chronically ill patient, and pensioners appear to enjoy the same concerns of the respondents (13%).

The suggested categories need some considerations, since these categories abound in our society especially disabled, pensioners and accident victims. Mujinja and Mabala (1992) found in Tanzania that the proportion of hospitals and dispensaries exempting disabled people were 90 and 75 percent, respectively and retired workers 9 and 10 percent.

The exemption of pupil and students had 8% of the respondents supporting it. This desire to have pupil and students exempted for all kind of services featured prominently during the focus group discussion with the aged. They referred to the Nkrumah era when this category had full exemption and suggested it should be re-introduced. Table 5 shows details of suggested categories.

Table 5: Community Suggested categories for Exemption (n = 23)

Category	Percentage (%)
1. Disabled (Blind, deaf, cripples)	21.7
2. Pensioners	13
3. Accident Victims	13
4. Chronic illness	13
5. Unemployed	8.7
6. Pupil & students	8
7. Orphans	4

Services for Exemption

The respondents were not familiar with most of the services available at the health facilities. The services mentioned appear to be limited to those they have encountered personally or by a friend or relative. However, well over half (58%) of the respondents want major operations to be included in the services to be exempted.

This supports the revelation during all the focus group discussion, that the operation charges at the district hospital are too high and that the situation is made worse by the insistence of payment of deposit before the operation is carried out on the patient irrespective of the condition of the patient. Investigations at the district hospital revealed that a deposit three hundred thousands cedis for caesarean section and two hundred thousand cedis deposit for herniorrhaphy are paid before operation.

Another striking finding was the fact that 39.2% of respondents thought only antenatal services should be exempted as against 34.2% who are advocating for both antenatal services and delivery. Only 6.3% of them think all services should be given free of charge.

A significant percentage (44.3%) of respondents want child welfare services to be considered for exemption. This implies that some illegal user charges are collected at the child welfare clinics, which are, suppose to be free. Only 8.9% of respondents felt consultation fee and OPD card should be exempted. The table also indicates that 34.2% of the respondents want acute illnesses exempted. Almost all did not think it was important to exempt accident victims.

TABLE 6: Suggested Services for Exemption

Services	Frequency	Percentage (%)
Antenatal only	31	39.2
Antenatal & Delivery	27	34.2
Acute Illness	27	24.2
Major operations	46	58.2
Child Welfare Services	35	44.3
Malnutrition Management	17	21.5
Consultation Fee/OPD Card	7	8.9
Accident Victims	1	1.3
All conditions	5	6.3

Facilities to Implement Exemption

Some of the respondents (40.5%) will prefer only government facilities to implement the exemption as indicated in the table below.

However another 44% will want both government and mission to implement the exemption; but only 9.5% favoured only mission facility.

Almost 9.5% favoured only mission facility. Almost all did not favour the involvement of Private Clinics in the exemptions. Surprisingly not because of mistrust but the reason being that the private clinic person cannot afford to give free services since his/her primary motive is to make profit.

This implies that the community members do not know that the government pays for the services granted free in the public and mission facilities. About nine percent (9.5%) of respondents favoured the District Assembly as implementer of exemption. Maternity homes/clinics had 4.8% respondents wanting them to be implementers of exemptions.

Only 10.7% of respondents felt all health facilities must be allowed to implement exemption.

Table 7: Facilities to Implement Exemption (n = 84)

Facility	Frequency	Percentage (%)
Only Government facility	34	40.5
Mission facility	8	9.5
Private Clinics	1	1.2
Maternity Homes/Clinics	4	4.8
District Assembly	8	9.5
Government & Mission facilities	37	44.0
All Health Facilities	9	10.7

Who decide beneficiaries

From the table, majority of the respondents (69.9%) favoured the doctor to decide on the beneficiaries of exemption. Most of the discussants said *it is the doctor who examines the sick and so he knows the problem of the patient and therefore he can decide better who should benefit*. This is followed by the nursing sister in-charge with 18% of respondents. Formation of Community Exemption Committee to decide on who benefits from exemption was favoured by 13.1% of respondents. Only 10.1% and 10.8% favoured hospital management and social worker respectively. It was clear that most respondents do not know the role of social worker. There is none in the only hospital in the district.

It requires more than an individual to decide beneficiaries, a doctor may be useful if exemption involving disease condition but exemption for a pauper would require the skills of a social worker.

Table 8: Who to decide beneficiaries of Exemption (n = 83)

Category	Frequency	Percentage (%)
Doctor	58	69.9
Nursing sister in-charge	15	18.1
Community Exemption Committee	11	13.1
Hospital management	9	10.8
Social worker	9	10.8
Others	1	1.2

Quality of exemption services

The table below shows that almost half (47%) of the respondents think free services are poor. Only 10.8% consider free services as very good. The remaining 42.2% think free services are good. This gives credence to what was found in the literature review. The above finding confirmed the general notion that anything given out free is of poor quality. However this perception of the community is confirmed by the comment of the WHO Director-General, Dr Gro Harlem Brundtland, Ghanaian Times (28th June 2000), that *The poor are treated with less respect, given less choice of service providers and offered lower-quality amenities.*

Knauth, C.J. (1990) in the review of cash and Carry system concluded that the exempted patients received “*less value drugs*”

This means that exempted patients are given low cost and less effective drugs even when more effective but expensive drugs are available for the treatment of their illness.

Table 9: Perception of Quality of Free Service (n = 83)

Category	Frequency	Percentage (%)
Very Good	9	10.8
Good	35	42.2
Poor	39	47.0

Effect of specific quality factors on utilization of exemption

Over half of the respondents said they will be prevented from utilization of exemption provision because of the cost of reaching health facilities and negative staff attitude as indicated by 54.9% and 51.2% respondents respectively in Table 10 below. From the above it implies that the financial cost of reaching health facility is what the community members may be referring to when they say “financial constraint” rather than user charges.

Aniteye, A. (1998) in her unpublished work found that 30 of her respondents were victims of negative staff attitude. Twenty-one out of the 30 have decided not to utilize certain health facilities for fear of being mishandled by health care providers. A study by Dovlo, D. et al. (1992) to determine the factors contributing to client dissatisfaction

with services in government health facilities, however found that 92.2% respondents were content with staff attitude.

The distance of facility from patient is not of much influence only 9.8% respondents. Waiting time at facility will deter 31.7% of respondents from using exemption facilities. A mother of child less than 5 years during focus group discussion said *I prefer going to chemical shop because there I don't waste time and nobody shouts at me. I get medicine for my child and can go and sell at the market to get money to feed the sick child.* Only one person said nothing would prevent him from using exemption services.

Table 10: Obstacles to Exemption provisions (n = 82)

Factors	Frequency	Percentage (%)
Cost of reaching facility	45	54.9
Negative staff attitude	42	51.2
Waiting time at facility	26	31.7
Distance of facility	8	9.8
Others (nothing will prevent me)	1	1.2

Where to treat illnesses

As high as 75% of the respondents said not all illnesses could be treated in the orthodox health facilities examples of such illnesses included mental illness and illnesses due to 'juju'. This has serious implication on the utilization of the public health facilities and the services they provide. However the remaining 25% of the respondents said all illnesses could be managed in the orthodox health facilities.

Aetiology and choice of where to seek care

Majority of respondents 44.3% who believe not all illness must be sent to hospital think that spiritual illness or illness due to 'juju' falls in this category. Mental illness or epilepsy was also considered by 23.0% of respondents as not hospital illness. Rheumatism (Sasabro) (13.1%) is a kind of migratory joint pain common among the elderly. Since these illnesses could be treated only at spiritual or prayer camps irrespective of exemption provisions at the public facilities, it implies these people

deny themselves access to exemption and yet they complain of financial constraint because they pay huge sums of monies at the camps.

It is not surprising the 6.6% of respondents share the belief that boil and piles are not hospital illness because this belief appears to be universal in all communities in the country. See Table 11 below for other non-hospital illnesses.

Table 11. Non-Hospital Illnesses

Disease	Frequency	Percentage (%)
Spiritual Illness/Juju illness	27	44.3
Mental Illness/Epilepsy	14	23.0
Sasabro(migratory joint pain)	8	13.1
Boil	4	6.6
Piles (Kooko)	4	6.6
Stroke	3	4.9
STD's (Gono, Syphilis, AIDS}	3	4.9
Chronic Chest illness	2	3.3
Guinea Worm	1	1.6
Diabetes	1	1.6

Where non- hospital illnesses are treated.

Majority of the respondents (60%) think non-hospital illness should be treated at spiritualist or prayer camp. Whilst 36.7% think it should be at home, only 3.3% will go to traditionalist shrine.

Suggested ways of identifying the “poor”

About half of the respondents (50.7%) believe that the truly poor can be identify when community committees are tasked to do so, this is feasible if linked to the unit committees which cater for a maximum of 500 individuals. This has the advantage of allowing the committees to tailor the exemption criteria to suit the peculiar situation of their community. There is however the tendency of abuse of the exemption because of the close relationship among members of small communities. However 30.4% of respondents think including community members in hospital management will help identify the poor.

About 7.3% have no idea about how to identify the truly poor.

The above is indication of the communities' willingness to get involved in the implementation of exemptions since the majority favoured community exemption committees as indicated in Table 13 below.

The above finding is similar to the practice in Lesotho where an individual must be certified by the village chief and district officer as a 'pauper' to qualify him for exemption. Shaw P.R and Griffin C.C (1995)

According to Ferster, G., P.H. et al (1991) in Malawi the 'core poor' were defined as families farming less than 0.5 hectares. This was estimated to comprise 50,000 households, or 18 to 20 percent of all households in Malawi. Ownership of land is so poorly registered in Ghana that this would not be practicable.

Huber, J. (1993) indicated that in Kenya the ability to pay is determined by conducting health care expenditure survey. If the health expenditure exceeds 5% of the total income then the households are eligible for exemption.

Table 12: Identifying the truly poor

Method	Frequency	Percentage (%)
1. Community Exemption Committee to submit list to Health workers	35	50.7
2. Hospital management to include community representatives	21	30.4
3. Community bound to review list of exempted	8	11.6
4.DNK	5	7.3

Funding health of the poor

Most of the respondents (45.6%) think that families should support their sick. This view was supported by an elderly man during focus group discussion when he asked me: *my son have you ever seen or heard of a family that has refuse to bury their member? Look at the monies we spend on funerals of supposed paupers.* However significant number 43% felt there was the need to have a community based health insurance scheme. To demonstrate their willingness to fund their health care a female discussant said *some of us belong groups which contribute one thousand cedis monthly we give a token to members when they admitted to the hospital.*

The community members should be encouraged to form larger groups and pay bigger dues, this reduce the dependency on government.

Most of those suggesting that families should take responsibility of their sick poor lost sight of the fact that the entire family could qualify as poor.

Table 13: Financing Health care (n=69)

Method	Frequency	Percentage (%)
1.Contributions from family members	36	45.6
2.Community based health insurance scheme	34	43.0
3.Wealthy members of community to support	8	10.1
4.Government to provide job opportunities	1	1.3

Effectiveness of the current exemption

The study found that 65.3% of the respondents do not know or had heard of any beneficiary of exemption. Only 34.7% are aware of some beneficiaries.

The exemption policy does not seem to be effective. As high as 65% of the respondents did not know of any beneficiary despite the high expenditure on exemption by the District Health Administration. Could it be that most of the beneficiaries are health workers? It will be recalled that work done by Waddington and Enyimayew,(1990) revealed that in Ghana in 1986, most statutory exemptions from user fees were granted to employees of the Ministry of Health and their dependents.

In conclusion, the findings point to a strong desire by community members to be involved in taking decisions that affect them.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Generally awareness about Exemption Policy is very high in the district, however, not much detail about category and types of exemption is known.

Knowledge about exemption for the aged is highest and this is more among the non-exemption category. The aged have the least knowledge.

Most of the people in the district obtain information about exemption from television and radio, and friends. Health Care providers did very little public education. Although the current exemption was introduced three years ago most of the people had information barely a year ago.

This study has established that Is not always that “financial constraint” used by communities with respect to seeking health care, imply “inability to pay “user charges” at the facilities, but it may mean cost of reaching facility.

Complain of financial constraint may not necessarily be due to lack of exemption facilities but may be due to the fact that health care is obtained from prayer camps or shrines.

The Local aetiological notion of patient about illness will lead to self-denial of exemption. Most rural dwellers are victims of this situation.

Staff attitude towards patient plays a very significant role in the decision on where to seek health care. A significant number of the patients would stay away from health facility even if they know of the benefits of exemption.

There is the general perception that free health care services are not of poor quality, this notion is so strong that patients prefer to go to chemical shops for medication.

The study was disappointed because Community members could not provide operational definition for “poor”

They considered anyone who cannot afford basic needs, of food, shelter and clothing as poor.

The most of the community members were of low self-esteem and could not imagine how they could make input in national policy or demand for a change in policy.

However, they said formation of community exemption committees would help identify the truly poor in the community.

The exemption policy and its implementation are not effective because only 33.2% of the respondents were aware of beneficiaries of the present exemptions. It implies therefore that most people are not benefiting from the exemptions.

The community members indicated at various forum, (FGD, interpersonal interview) that the government alone cannot support the health care expenditure and that everybody need to pay something for health care and for the seek of the poor formation of either family health insurance scheme or community base health insurance will go a long way to minimize financial constraint during emergency situations.

RECOMMENDATIONS

1. There is the need to educate the public about Exemption Policy.
This could be done by organizing community durbars or by reaching out to various organized bodies e.g.
 - 31st DWM
 - GPRTU
 - Churches
 - Association of Teachers
2. Health workers in the district should be given regular refresher course on communication skill and patient-health provider relationship.
3. It came up strongly at FGD and in almost all the communities studied that the user charges at the District hospital (Mission Hospital) are too high.
I suggest a Committee be set up to investigate this and the necessary action taken.

BIBLIOGRAPHY

1. Medical Report in 1867. Blue Book. P. 154.
2. Senah K. Problems of the Health Care Delivery System. In: Hansen E.K., Ninisin A.K., Eds; The State Development and Politics in Ghana. London: Codesria Book Series, 1989: 243-267.
3. Report of the Committee Appointed to investigate hospital fees (Reference as the Konotey-Ahulu Committee).
4. Patterson, D.K. – Health in Colonial Ghana: Disease, Medical and Socio-Economic Change (1900 – 1956) Waltham, Mass: Cross Roads Press 1981. P. 112.
5. Report of the Commission Appointed under Sir John Maude. 1952 to look into Colony's health system. Accra, Government Printer 1952.
6. Ibid.
7. The Easmon Committee Report P. 81.
8. Konotey-Ahulu Committee Report.
9. Hospital Fees act, 1971, (ACT 387).
10. Hospital Fees Regulation. 1971. Legislative Instrument 706.
11. Hospital Fees Regulations 1983: Legislative Instrument 1277.
12. Hospital Fees Regulations, 1985: Legislative Instrument 1313.
13. Medium Term Health Strategy MOH 1996.
14. World Bank Report (1995).

15. Aniteye PA: A Survey of Health Facility Utilization in Assin District. (Unpublished) Legon: School of Public Health, University of Ghana. 1998.
16. Assin District Health Annual Report 1999.
17. Senah K. Problems of the Health Care Delivery System. In: Hansen E.K., Ninisin A.K., Eds; The State Development and Politics in Ghana. London: Codesria Book Series, 1989: 243-267.
18. Shaw P.R. and Griffin C.C.: Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance. World Bank, Africa Technical Department, Washington D.C. 1995.
19. Waddington, C., & Enyimayew, K. A. (1989). A price to pay: the impact of user charges in Ashanti-Akim District, Ghana, International Journal of Health Planning and Management 4: 17 – 47
20. Gilson, L., Russel, S., and Buse, K. (1995) The political Economy of User Fees with Targeting in developing equitable health financing policy, Journal of International Development 7 (3): 369-401.
21. Sen, A. (1992). The political economy of targeting. Text of Keynote speech at conference of public expenditure and the poor: Incidence and targeting. at the World Bank, Washington D.C., 17-19.
22. Russel, S., Gilson, L. (1995). User Fees at governmental health services: Is equity being considered? London EPC Publication No. 15.
23. Russel, S., Gilson, L. (1995). User Fees at governmental health services: Is equity being considered? London EPC Publication No. 15.
24. Shaw P.R. and Griffin C.C.: Financing Health Care in sub-Sahara Africa Through User Fees and Insurance. World Bank, Africa Technical Department, Washington D.C. 1995.

25. Abel-Smith, B., and Dua, A. (1988). Community-Financing in Developing countries: The potential for health sector, Health Policy and Planning 3, 95-108.
26. Waddington, C., & Enyimayew, K. A. (1990). A price to pay, Part 2: The impact of user charges in Ashanti-Akim of Ghana, International Journal of Health Planning and Management 4, 17 – 47
27. Nyonator et al. Caring For the Health of the Poor in the Volta Region, unpublished. Regional Health Administration, Volta Region, 1998.
28. Ferster, G., P.H. Van Kessel, Y. Abu-Bohene, and F.R. Mavambaghe. 1991. Strategic Framework for the Cost-Sharing System for the Malawi government Health Services. Volume 1 and 2, Government of Malawi, LLongwe.
29. Huber, J. (1993). Ensuring access to health care with introduction of user fees: A Kenyan example, Social Science and Medicine 36 (4): 485-491.
30. Nalon, Brain, and Vincent Turbat, 1993. Cost Recovery in Public Health Services in Sub-Sahara Africa. World Bank, Economic Development Institute, Washington D.C. Processed.
31. Mills, A. (1991). Exempting the poor: the experience of Thailand, Social Science and Medicine 33, 1241-52.
32. Gilson, L., Russel, S., and Buse, K. (1995) The political Economy of User Fees with Targeting in developing equitable health financing policy. Journal of International Development 7 (3): 369-401.
33. Huber, J. (1993). Ensuring access to health care with introduction of user fees: A Kenyan example, Social Science and Medicine 36 (4): 485-494.
34. Gilson, L., Russel, S., and Buse, K. (1995) The political Economy of User Fees with Targeting in developing equitable health financing policy. Journal of International Development 7 (3): 369-401.

35. South African Health Review 1995, published jointly by the Health Trust and the Henry I. Kaiser Family Foundation. P. 165-166.
36. Health Economic Unit: Public Sector Health Services, University of Cape Town. 1995
37. Knauth, C.J. (1990). Experience with Revolving Drug Fund at two health centers in Kumasi, Ghana, up to the introduction of the “The Cash and Carry” System: A case study on two self-initiated revolving drug fund and their impact on patients in two government health facilities in the Ashanti region of Ghana. Dissertation of McommH, Liverpool school of tropical Medicine.
38. AlHibshi, S.A. Is there a Future for the exemption to protect equity within the user fees and Cash and Carry scheme in Volta region (Unpublished) International Health Division, Liverpool School of Tropical Medicine, U. K. 1997
39. WHO assesses the world’s health systems, Ghanaian Times, 28th June, 2000, No. 13262, Issue 0855-1502 Pg. 14.
40. Litvack, J., Bodart, C. (1993). User fees plus quality equals improved access to health care: results of a field experiment in Cameroon, Social Science and Medicine 37(3):369-383
41. Abel-Smith, B., and Dua, A. (1988). Community-Financing in Developing countries: The potential for health sector, Health Policy and Planning 3, 95-108.
42. Longford et al 1980.
43. Walker, R. (1985). Applied qualitative research, Aldershot: Gower

Appendix 1

Calculation of Sample Size

Population size	-	200,176
Expected Frequency		20%
Worst Acceptable		5.00%

Confidence Level	Sample Size
80%	12
90%	19
95%	27
99%	47
99.9%	77
99.99%	108

Ref: Kish & Leslie survey sampling, John Wiley & Sons, NY 1965

Though I selected confidence level of 99 I decided o sample size of 86

Study Communities

1.	Assin Foso	}		
2.	Gangan	}	Assin Foso	
3.	Basofiningo	}	Sub district	
		}		
4.	Kushea	}	Kushea	
5.	Achiano	}	Sub district	
		}		
6.	Fantinyakomasi	}	FNK	
7.	Juaben	}	Sub district	
		}		
		}		ASSIN SOUTH
8.	Anyinabrim	}	Anyinabrim	
9.	Dawomako	}	Sub district	

Appendix II

QUESTIONNAIRES TO BE ADMINISTERED TO COMMUNITY MEMBERS

PERCEPTIONS OF COMMUNITY ABOUT EXEMPTION POLICY AND ITS IMPLEMENTATION IN ASSIN DISTRICT

Name of community:..... Sub-District.....

Date:.....

Code of respondent:.....Sex [] 1 = male 2 = female

Age of respondent:.....

Status of respondent [] 1 = mother of child <5 years. 2 = Pregnant woman
3 = Aged 70 years 4 = Members of non-exemption
category

1. Educational level [] 1 =None 2 =Elementary 3 =Secondary/vocational
4 =Tertiary 5 =Adult education (non formal)

2. Have you heard about any exemption policy for health care? []
1 = Yes 2 = No If No, skip to question 7

3. How long ago (in months) did you hear of the policy?
.....

4. From where did you hear it (many options accepted)
- | | |
|-------------------|----------------------|
| 1. Radio/TV | 5. Community leaders |
| 2. Health workers | 6. Church |
| 3. News paper | 7. School children |
| 4. Friends | 8. Others |
- (specify).....

5. Which groups of people are to benefit from the policy.
- | | |
|---------------------------|---------------|
| 1. children under 5 years | 6. Poor |
| 2. pregnant women | 7. Disabled |
| 3. Aged (70 yrs) | 8. Pensioners |
| 4. Disease groups | 9. Others |
- (specify).....
5. MOH staff

6. What type of exemptions are they entitled to?

Full Partial DNK

1. Children <5 yrs
2. Pregnant women
3. Disease groups
4. MOH staff
5. Poor
6. Disabled
7. Pensioners
8. Others
9. Aged.

7. Which facilities are to provide the free services to the groups mentioned (many options accepted)
- | | 1 | 2 | 3 | 4 | 5 |
|--------------------|---|---|---|---|---|
| 1. Children <5 yrs | | | | | |
| 2. Pregnant women | | | | | |
| 3. Aged (70yrs) | | | | | |
| 4. Disease groups | | | | | |
| 5. MOH staff | | | | | |
| 6. Poor | | | | | |
| 7. Pensioners | | | | | |
| 10. Disabled | | | | | |
- 1 = Govt. facility 2 = mission 3 = Private 4 = others 5 = DNK
8. Are there categories/groups that you think should be given free medical care who are ignored? (Many options accepted)
-
 -
 -
9. Do you think all these groups deserve exemption?
- | | Yes | No | DNK |
|-----------------------|-----|----|-----|
| 1. Children <5 yrs | | | |
| 2. Pregnant women | | | |
| 3. Aged (70yrs) | | | |
| 4. Disease conditions | | | |
| 5. The Poor | | | |
| 6. MOH staff | | | |
10. For what services should exemptions be granted?
- | | |
|---------------------------|---------------------------|
| 1. antenatal only | 5. Child welfare services |
| 2. antenatal and delivery | 6. malnutrition |
| 3. acute illness | 7. Others (specify).... |
| 4. major operations | 8. All conditions |
11. Which facilities should implement exemptions
- | | |
|-------------------------------|------------------------------------|
| 1. only government facilities | 5. District assemblies |
| 2. mission hospital | 6. Government & mission facilities |
| 3. private clinics | 7. All health facilities |
| 4. maternity homes/clinics | |
12. Who in the facility should decide on what services should be exempted?
- Doctor in-charge
 - Social workers
 - Sister in-charge
 - Hospital management
 - Community exemption committee
 - Others (specify).....
13. What is your view about the quality of services given free of charge: []
- 1 = very good 2 = good 3 = poor 4 = very poor
14. You know you are entitled to exemption, which of these will prevent you from seeking free care from a facility.
- Distance of facility
 - Staff attitude
 - Cost of reaching the facilities
 - Waiting time at the facility

- 3