Health care at crossroads

Jackson Mbogela

Thesis for MSc for Public Health and Society

The impact of cost sharing policy on accessing hospital-based health care services in rural Tanzania

A case study of the Makete District

Jackson Mbogela

Reg No: 740716548130

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Supervisors

Prof. Dr. A. Niehof

Dr. J. A.C. Van Ophem

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“For I know the plans I have for you”, declares the LORD, “plans for welfare and not for evil to give you a future and a hope”.

— Jeremiah 29:11(ESV)

Abstract

Health is one of the necessary rights to everyone. People have to attain health without discrimination of any form. Factors that can make people fail to have access to proper health care should be identified and addressed. This research aimed at developing knowledge on the impact of cost sharing policy to access health. The study assessed the effect user fee paid as out-of-pocket on access to hospital based health care.

Data were collected qualitative and quantitative methods that included interviews, surveys and from key informants. The analysis was done by using a Statistical Package for Social Science (SPSS) by giving out descriptive, correlation and a linear regression outputs. The results from this study suggest that government hospital attracts people because it is cheap, private hospital because of quality and dispensaries because of their closeness. Also the study indicates that income is positively correlated to quality. At the same time income had a no significant impact on willingness to pay for hospital-based health care. However when a hospital based health care service becomes cheap, expensive and of good quality or satisfaction were positively had a positive impact on willingness to pay (WTP). Other variables like gender, HIV status of the head of the household or spouse, the size of the household and the position in the household has no impact on willingness to pay.

Key words: Hospital-based, Willingness to pay, Care,

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List of acronyms

AIDS	Acquired immune deficiency syndrome
AMREF	African Medical and Research Foundation
ARV	antiretroviral
BLH	Bulongwa Lutheran Hospital
CBHIF	Community based Insurance Fund
CTC	Care and Treatment Centre
EAWM	Evangelical Association for the world mission
FBO	Faith Based Organization
HAART	Highly Active antiretroviral Therapy
HBC	Home-based Care
HIV	Human immunodeficiency virus
MASUPHA	Makete Suppor for Self Support
MDH	Makete District hospital
MOSH	Ministry of social welfare and health
NACP	National AIDS Control Program
NBS	Tanzania National bureau of statistics
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NHS	Nation Health Service
OECD	Organization for Economic Cooperation and Development
PHI	Private Health Insurance
PIUMA	Pima Uishi kwa matumaini
PLHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child-transmission (PMTCT)
SCD	South Central Diocese
SD	Social Demand curve
SPSS	Software Package for Statistics and Simulation
STI	Sexual transimmited Diseases
SUMASESU	Support makete for self suppot
TACAIDS	Tanzania Commision for AIDS
WHO	World Health organisation
WTP	Willingness to Pay

Chapter 1

1.1 Motivation

For three years I worked as a coordinator for *Pima Uishi kwa Matumaini* (PIUMA), a self-support NGO for People Living with HIV/AIDS (PLHA) based in Makete district in the western southern part of Tanzania. PIUMA, a registered NGO is involved with provision of voluntary counselling and testing for HIV/AIDS by its mobile clinic, provision of Education on HIV seminars and workshop, peer education on HIV and other health related issues.

PIUMA provided an education that covered prevention, counselling and testing, Prevention of transmission from mother to child (PMTCT) as well as treatment with antiretroviral drugs (ARV). We also supported the care and treatment clinic of the Bulongwa Lutheran Hospital which was financially and technically supported by the Evangelical Association for the World Mission (EAWM) based in Vienna, Austria.

During this period I heard from Dr. Rainer Brandl, the leading doctor in charge of the Bulongwa HIV/AIDS Care and Treatment Clinic saying "*It is a pity that there are many people living in villages very close to the hospital dying in their huts as they cannot come to the hospital for medical care"* I was touched by the statement as it referred to hundreds of men and women who were very well known to me. I was motivated to investigate the reason behind this observed pattern.

I believe that health including hospital-based health care is a basic and compulsory human right for everyone and therefore it was supposed to be unconditionally provided and available to everyone. According to WHO Constitution: *"the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..."*

Looking at the statement by Dr. Rainer it I started developing some doubts on the possibility on the feasibility of realizing the WHO constitution in the rural area in Africa. I was wondering why people would come to lock themselves in their houses to die, although the hospital was within a nearby distance. I wondered if the user fee which patient have to pay at different points to access the hospital-based health care, plays a role in deciding whether to seek health care or not.

I was interested to learn if the patients who were sleeping in their house waiting to die were in that situation for the reason that they could not afford to pay the user fees. Was it because they did not want to? Was there any other hidden reason, such as members of the household not being willing to invest in the health of person living with HIV/AIDS (PLHA), a woman or a child?

It is not clear whether patients who accumulated debts at the hospital would be willing to visit the hospital when they become sick again before they have settled their previous bills. The debts were carried forward because many of them went home and were still sick as they were PLHA and therefore they could not get enough time to work to raise enough money to pay.

Sometimes back there was a purposeful initiative to improve access to hospital-based health care and make it affordable for everyone: the initiative to start the community based health insurance fund, the poor patient fund of BLH. It is not clear if the population in the rural area recognizes and appreciates the presence of these initiatives and if they are willing o join and use the schemes.

At the time when I was living and studying in the Netherlands I learned more and gained new insight and experience on how health care system is organized in the Netherlands. The type of health care organization in the Netherlands makes almost everyone to be entitled to health care. The health care system in the Netherlands is based on a private insurance (PI) system. The system motivates the population to pays the premium in equal amounts but spent and is reimbursed according to the needs(McPake and Normand, 2008a). It is challenging and interesting to try establishing ways whereby the community in the rural areas of Makete will mechanism to learn from this approach. This study tried to answer some of the concerns raised.

1.2 Problem Statement

The problem was related to the theory of McPake, et al, (2008a) from which cost associated with health care services are described. Health unlike other goods and commodities cannot be traded, one cannot buy or sell health and it is closely attached to individuals. Apart from the fact that health can neither be sold nor traded, another factor that differentiates health from other goods is the fact that it is associated with uncertainty. It is not possible for one to predict illness. Since health is very different from other commodities and goods, it is then evident that the expenditure on health will be considered in different ways from other goods. In places where a consumer has to pay some fee to access health service, willingness to pay becomes an important item to be considered. The willingness to pay is the consumers' self-assessment whether the commodity or goods purchased are worth of the amount to be paid. Although willingness to pay is associated with benefits, there are limitations associated with it. Lack of ability to pay is one of the limitations of willingness to pay. Willingness to pay (WTP) measures if the consumer is satisfied with what is offered by the goods or services one pays for, in relation to the amount is spent on the product. However, in the market that functions very well and it is controlled by the market hands, willingness to pay is determined by the benefit the consumer gains from the goods or services. Consumers spent income on services or goods so that they can benefit in a maximum way from it. However it becomes more difficult for a person who spends on health to say that he will benefit as much as he would like, because the benefits derived from health care services are uncertain. This means that it is not certain that spending on health care will lead to health improvement, as sometimes it may lead even lead to health deterioration.

According to Munishi (2003) since the mid-1990s Tanzania has introduced a health reform policy which aims at improving efficiency, effectiveness, equity and accountability. Before the introduction of the health sector reform the government of Tanzania was the sole financer of the health care. However, following the collapse of the economy the government, failed to continue to provide health care service to her citizens for free. The reform included the introduction of user fee, which was inevitable.

Following the collapse of the economy the government was faced with pressure to improve quality which was deteriorating. Quality deteriorated because there was lack of important supplies such as equipment and medications in the hospitals. Apart from improving the service the government was also under pressure to ensure that hospital-based health care

becomes available and easily accessible by everyone. The two pressure factors were caused by rise in demand which was due to emergency of diseases related to HIV/AIDS pandemic. There were many people who needed treatment at the same time the cost for care and treatment increased. Following the inability of the government to continue providing free health care in the year 1993, the government sought of means to solve the problem by initiating a cost sharing policy for health users. The cost sharing policy demanded the user to share the cost of care. The users would share the cost by paying a user fee. Although the money raised from the fee does not make a significant contribution to the total health expenditure, it is believed that the money paid helps Tanzanians to see the importance of contribution for their own health (MUNISHI, 2003).

There is literature on the introduction of cost sharing policy on health but little is known about effect of user fees on accessing hospital-based health care. In rural Tanzania where the resources are limited, cost sharing for health care must have a great impact on people access to hospital-based health care. It is necessary to study the effects that have been associated with a policy of cost sharing.

Spending on health care relates not only to the willingness to pay but also to income which determine the ability to pay (Morris et al., 2007, McPake and Normand, 2008a). Users of hospital-based health care have limited resources and income at the same time they are faced with spending their income on either health care or other social obligations such as the supply of basic needs for the members of the household. Then the question will be to what extent the household will be willing to spend the last resources available to support one member of the family to get care at the health care centre, perhaps at the expense of care for other members of the household.

For one reason or another it is very likely that not all groups of people are treated equally although they may belong to the same household. There might be some differences on the grounds of age or sex. For example, older people may be given less priority as compared to young persons, or there might be some disadvantages to other groups of people who seem to have brought on the problems to themselves such as AIDS patients and other sexually transmitted diseases. It is also likely that that those who can work are treated different by those who are dependents.

It is known there is a fee for every service that is undertaken in the hospital but we do not know to whom the poor patients turn to when they are in need of hospital-based health care. Do the patients turn to the traditional healers and if they do so, is it for financial reasons?

The aim of this research is to collect data which will help in establishing the effect of the cost sharing policy on consumers in need of hospital-based health care. This research will investigate whether user fees paid for hospital-based health care as a result of the cost sharing policy affects the willingness of consumers to access hospital-based care.

The study aims at establishing if at any point consumers who need health care were not able or allowed to access hospital care for reasons based on their HIV status, gender or position in the household. Data from this research answers whether there is discriminations on spending for health by HIV status, Gender, position in the household and age. Furthermore this study will answer an important question whether cost sharing policy has effects to access hospital-based health care.

The combination of the described factors necessitated this study to be carried out. First the increase demand for health care because of the high HIV/AIDS prevalence and therefore many people that have acquired HIV need to be cared and treated. The people from the villages are subsistence farmers with small gains from their farms. The cost sharing policy changed the traditional custom of free hospital-based health care and pay system whereby users had to pay user fee. The combination of these factors lead to the following objectives and the research questions as described below.

1.3 Objective

This study has an objective of acquiring knowledge on the impact health cost sharing policy on access to hospital-based health care services in rural Tanzania

1.4 Specific objective

To study the effect of user fee paid as out-of-pocket on consumer to access to hospital-based health care services in the Makete district in Tanzania.

1.5 Research questions

1. Is fee paid as cost sharing a determining factor for accessing hospital-based health care?

2. What are the factors affecting willingness to pay for hospital-based health care?
3. What are the alternatives to hospital-based health care?
4. What is the perception for HIV+ people?

1.6 Description of the study area

Makete district is located in the southern Highlands of Tanzania in the Livingstone ranges. Although the place is rich of fertile land still its inhabitants are poor with a majority of them living below poverty line of less than a dollar per day.

The district is of mountains and heavy rainfall that makes roads not passable easily in most parts of the year. Because of the problems in the transportation infrastructures the people living in this district have difficulties ways to generate income and therefore remain poor.

Data for this study were collected from Iniho, Bulongwa, Kipagalo and Iwawa wards. In these four wards there are two hospitals which are separated by a distance of twenty kilometres from each other. The four mentioned wards were sampled because they are close to two hospital services. The population of the four wards was estimated at 25,025 people from 28 villages in 2005, according to Tanzania Bureau of Statistics (NBS, 2005).

The four wards are served by two hospitals, Bulongwa Lutheran Hospital (BLH) and Makete district hospital (MDH) which are twenty kilometers apart from each other. The villages within a radius of ten kilometers from the hospital were involved to eliminate the walking distance factor.

1.6.1 The Bulongwa Lutheran Hospital (BLH)

The Bulongwa Mission hospital is the oldest hospital in place. It was established in 1968 by the Evangelical Lutheran church. However the Ministry of Health and Social Welfare MHSW) is responsible for supervising and monitoring the quality of treatment and care offered. The Bulongwa Lutheran Hospital apart from the donations from charity organizations, and small subsidies it receives from the government, has to cover all the cost of the patients. Therefore the patient's fee is very important for the well-functioning of the hospital.

The hospital also receives patients from nearby towns like Mbeya and Njombe. The patients from other places visit the hospital because of the specialized services, such as the orthopedic department (Brandl, 2003). Some of the patients come to be treated at these hospitals because they originated from the villages around the hospital and therefore coming back they will have a relative to care for them when they fell sick as they would have no relatives to care for them in big cities they live.

In every department a patient is seen the services given will be associated with service fee. There is a fee for each stage of service, registration, seeing a doctor, laboratory, x-ray, surgery and bed as shown in the table below.

Table 1-1 The price for the care services given at Bulongwa Lutheran Hospital

Service	Price (Tsh)
Registration	1000
Occupation fee	500
Delivery	10,000
Caesarean section	30,000
Laboratory	4000
Medication	1000
Doctor	4000
Teeth	4500
Teeth	6000

Note: € 1 = Tsh 1,900 (2010)

Source: Observed in the field

Patients who are to be admitted have to pay a deposit of 10,000 shillings before they are given a bed. Later on other cost incurred during period spent in hospital will be incorporated. When the patient is discharged, the down payment will be deducted from the total cost and the patient will have to pay the remaining amount.

When it happens a patient has failed to pay the required amount at the time of discharge, she or he is held within the hospital premises. The hospital administration will not allow the patient to go home after his discharge from the hospital. During the times the patient is held

within the hospital premises either of two scenarios can happen. The first scenarios necessitate the patient to wait until members of the household raises enough money to pay the expenses incurred. The members of the household can raise money by either borrowing from relatives and friends or finding a paying job work. Sometimes a patient has no family member that is capable to raise the required amount enough to cover the expenses incurred in the hospital. It can happen when the healthy members of the household are either children or very old people. In such a situation the sick person will stay at the hospital until she or he has recovered and gained a good health to work. Then after being healthier enough the patient will be given a job at the hospital, jobs like cleaning the hospital or planting trees. The hospital's vision was derived from the biblical parable of a Good Samaritan. The hospital was determined to offer treatment to every patient without discrimination of any kind, such as according to gender, sex, religion, race, ethnicity, political orientation or income.

Since 1987 the hospital established a community-based health fund, which showed a tendency of declining membership as shown in the table below. The community fund was the initiative of the church and the hospital to increase access to hospital health care in the community around it. The fund was expected to help individuals and households in the community to share the risk and the cost that are associated with the health care.

Table 1-2 The community based health care insurance fund of Bulongwa Lutheran Hospital

Year	1998/1999	2000	2001	2002
Members	334	414	380	150
Income (Tsh)	4,554,177	2,141,443	737,820	639,966
Expenditure	2,493,500	1,441,800	403,300	877,200

Source: Brandl, R (2004),

By the year 2002 the Bulongwa Lutheran hospital was invited by the Tanzania ministry of health to participate in implementing the National Health Insurance Fund (NHIF) scheme. The scheme required the hospital to give care and treatment to patients that have been enrolled with NHIF. Most of the people that were registered with the NHIF were government employees. A big part of the village population was not covered. The villagers were not included because the monthly contribution that was supposed to be paid by the beneficiary was too big by many villagers. Therefore in this area NHIF was not a solution to help people meet their hospital-based health care needs, which forced health providers to think for

another solution. By the year 2003 another initiative was taken to help the poor household in the area. The initiative involved starting a new scheme "The poor patient fund of the Bulongwa Lutheran hospital". The fund was re-established in corroboration with the Evangelical Association for the World Mission (EAWM) an organization based in Vienna, Austria. The fund was targeting people who could not afford to cover bills related to the hospital-based health care. The fund was expected to source its income from local donation which would make it operate sustainably. Through this fund it was expected that there would be more enrolment of patients from the poor household. The fund was not in operation for many years as described in case of poor patient fund.

1.6.2 Makete District Hospital (MDH)

The Makete District Hospital is a newly established hospital owned by the government.
All its running costs are covered by the government. However patients have to share some cost through user fees as part of implementing the cost sharing policy.

As the District Hospital is heavily subsidized by the government and the Bulongwa Lutheran Hospital is not, there is difference in user fees. The district hospital charges lower user fees than the Bulongwa Mission Hospital.

Table 1-3 Price list for care and treatment at the Makete District Hospital

Service	Price (Tsh)
Registration	500
Occupation fee	500
Delivery	Free
Caesarean section	Free
Laboratory	1000
Medication	500
Teeth	1000
Teeth	2500
Circumcision	10,000
Under 5 years	Free
Above 60	Free

Note: € 1 = Tsh 1,900 (2010)

Source: Observation from the field

Apart from the two hospitals in the area there are four medical dispensaries, the Iniho Utanziwa, Luwumbu and Iyoka dispensaries. Utanziwa and Iniho dispensaries are owned by the BLH and therefore have the same fee structure as BLH. The other two dispensaries, Luwumbu and Iyoka are government-owned facilities and their fee structure is accordingly. There are two voluntary and counselling centres that are attached to BLH and MDH respectively and two NGOs, PIUMA and AMREF owns one each in Bulongwa and Iwawa Village respectively.

1.6.3 HIV/AIDS in Makete

Makete is among the most HIV/AIDS affected districts in Tanzania, with a prevalence estimated nearly between 12-13% (Brandl, 2006). However Nombo (2007a) makes an observation that at national level the number might have been underestimated as stated by the National AIDS control Program (NACP). The reason for underestimating would be due to the underutilization of the testing facilities available, including the voluntary counselling and testing centres.

In his study Joseph (2005) realized that large part of the children population in the district was orphaned. He further observed that in a school almost one third or half of the pupils were orphans. And every household has lost at least one person from the disease.

AIDS related diseases have not only been killing the people of low education and income. Educated people who are important for the professional services in the community also died from AIDS related diseases. For example from 1999 to 2004 the death toll of the civil servants was 8 agricultural extension officers, 74 teachers and 27 health staff who died and were not replaced (Brandl, 2003).

Joseph (2005) says that during his study the voluntary counselling and testing (VCT) and anti-retroviral (ARV) services were very limited and absent in many areas. The educational program and home-based care mainly were offered by a few NGOs which were operating in the district. Some simple programs such as a nutritional program and sexual transmitted diseases a STI clinic was very weak.

Households that have been affected by the diseases either by losing someone who died of HIV/AIDS or by taking care of the patient for a long time, showed the same level of poverty as their counterpart households that were not affected. The affected family could not own even basic wealth items such as bicycle, a hurricane lamp, and a sponge mattress (Gillespie et al., 2007b).

Brandl (2003) says almost everyone in the villages around Bulongwa Lutheran hospital either knew someone who is HIV positive or died from the diseases. This phenomenon showed that the scale was very large. Joseph (2005) sums up that in Makete district family that had to foster orphans for the period 1999 – 2004, or had lost a relative or had to take care of a sick relative for a period of about two years were subjected to reduced wealth generally.

1.7 Methodology

This section of the chapter techniques used to generate data will be explained. How the sampling was conducted and how the tools for data collection were made is explained and will explain how the analysis was conducted.

1.7.1. Research design

This study used a cross-sectional and mixed method design, combining quantitative and qualitative methods of data collection. The mixed method design was chosen so that the information from the qualitative study could be further explained by figures that were obtained by quantitative research. It was intended that the two types of methods would complement each other. The qualitative methods helped to give the numbers a meaning and gaining an in depth understanding of the subject.

1.7.2 Sampling

Makete was sampled because it is one of the districts hardest hit by HIV/AIDS, which raises the demand for hospital-based health care. As described above, a large part of the district is a rural area. The research involved four wards in the catchment area of the hospitals, namely Iniho, Kipagalo, Bulongwa and Iwawa, which were sampled purposively.

From the four wards around the hospitals within a radius of about 10 kilometers a random sample was taken. The radius of 10 kilometers from the hospital is assumed to be a walking distance, to eliminate the influence of walking distance factor. The household was the unit of analysis. From the village the households were sampled systematically. The number of households in each village were determined and the sample size of each village was calculated and a formula was established how to get the representative sample. The reasons for using households as unit of analysis are explained in Chapter 3.

The head of the household and the spouse of the household filled in questionnaires on behalf of every member of the household. The survey results were also used to select household for the in-depth interviews in the case studies. The households selected would have experience with the effect of the introduction of the cost sharing policy.

The group of health care providers was split into two subgroups. The first group was composed of professionals who are working in the hospitals. The second group was made up of the community members who were trained to provide home-based care service.

At the hospital also purposive sampling was conducted; one expert from each of the departments that works directly with patients and departments that are cost centers of each hospital were requested to participate in the research. The professionals came from the

following departments: VCT and CTCs, male wards, female wards, the dental unit, and the paediatric ward. This study also included doctors for inpatients and outpatients, and the hospital home-based care coordinator, the pharmacist and the financial cashier. The experts were selected because of their involvement in activities of their respective departments. They are working very closely with the patients and understand the situation patients' face at the hospital and the cost sharing policy.

Most of the community health care providers are attached to either a nongovernmental organization or a faith based organization. The list of the organizations that provide health care was obtained from the office of the district home-based care coordinator. From the list a number of providers were drawn randomly. The home-based care providers included in the interviews were from the following nongovernmental organizations, PIUMA, TUNAJALI, and SUMASESU. The interviews helped to broaden the concept as health care providers have met different patients with different backgrounds. Following handling different backgrounds the health providers could provide more in-depth information.

1.7.3 Data collection

Different means of data collecting primary and secondary data were involved. Data that had been used for this study were gathered from the literatures, interviews, documents, and survey.

1.7.3.1 Literature review

The literature describes the health care systems and the cost sharing policy. Understanding the health system helped in determining the key areas to settle research questions. The literature also provides the theoretical solutions for research questions which will be tested if they had ever been implemented on the ground. The theoretical background includes information on the cost sharing of health and funds or insurances that have been established to improve the burden of cost to consumers.

From the literature facts that were documented by other researchers were collected and henceforth presented in this study. The literature was collected from PubMed, Medline, Science direct, Scopus, the website of Ministry of Health of Tanzania and the Wageningen University library. The literature helped in fine-tuning the other tools for data collection.

1.7.3.2 Secondary Data

The research area profile, the prevalence rate, the population, demographic information, awareness of HIV/AIDS, prevalence rates and pricing list were obtained from the statics offices, bureau website, local government offices, such as office of the district medical officer and from unpublished work reports of different departments of the BLH and MDH.

1.7.3.3 Survey

Information from the sample of health care users at household level was collected by means of a questionnaire. The questionnaire with closed end questions was developed, tested and later on administered. A small pilot study was conducted to test the questionnaire. During the survey the head of the household and the spouse were involved in answering the questions. The questionnaires were administered face-to-face to give room for further probing. Data on demographic information, ability and willingness to pay and alternatives to hospital-based health care were collected.

1.7.3.4 Interviews

A number of interviews were conducted with health professionals and consumers at household level. The health care professionals came from the NGOs and FBOs that are providing care to patients, as well as members of the staff of the BLH and MDH. The in-depth interview was intended to provide additional information and to clarify information that has been collected from the survey. The interviewing guide contained semi-structured questions which were developed during the survey. The respondents were free to give as much information as possible. The interviews gave an in-depth understanding of the subject and helped in establishing the magnitude of the effects caused by cost sharing policy from the providers' point of view. The interviews were tape recorded.

1.7.3.5 Cases

During the survey some household had interesting stories to tell. The researcher documented their stories as they were told and they are here in presented as cases. The cases are from the individuals and households that had significant testimonies related to the topic in question. Also cases on initiative that had been taken either by the hospital or community to reduce the burden of cost of patients were documented. The initiatives taken by the Lutheran church and BLH by creating the Poor Patients Fund is incorporated in this report.

1.7.4 Analysis

Data from the questionnaires were analysed statistically by SPSS. The results were included in the descriptive part and a linear regression analysis was done. Information obtained by qualitative methods including all the interviews was transcribed manually.

Table 1-4 Summary on data collected that produced the results.

Key Informants	5
In depth Interviews	
HBC Volunteers	10
Doctors and Nurses	10
Cases	5
Total	30

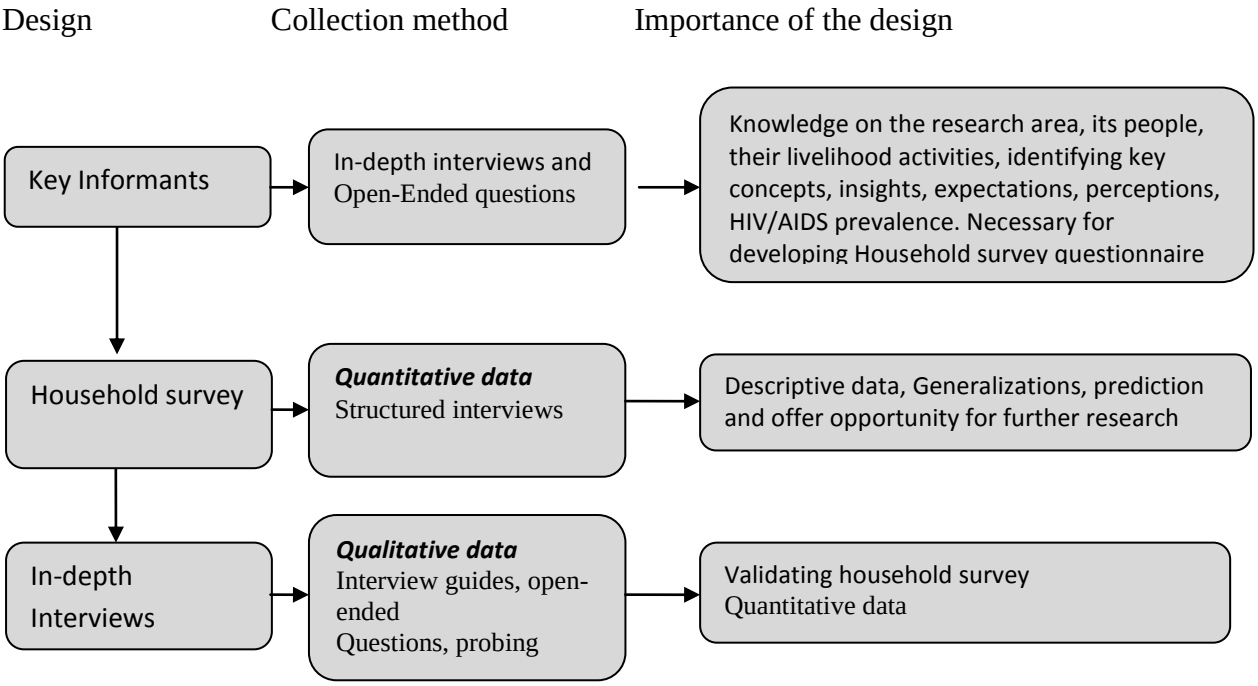

Figure 1-1 Research methodology used in this study adopted from Nguthi (2007)

1.8 Ethical Matters

A number of ethical issues were put into consideration when conducting this study. The issue of incentive was raised several times by the respondents. The researcher and researcher assistant tried to refrain from giving incentives as it would have been not feasible to give everyone an incentive, whether in kind or in cash. However, at some point the research gave some clothing and bought food for some orphans who were desperate. The respondents were informed in advance that there would be no incentives attached with their participation and that the research was aimed at acquiring knowledge that would be useful for helping the policy makers to work on in improving the situation.

Confidentiality was another serious issue considered during when conducting this study. The respondents of the survey volunteers to give their names and the names of all the members of the household. They were assured that their information would be kept confidential. However, PLHA were willing to disclose their status. In the study a total of 70 PLHA told the researcher that they are HIV+. The disclosure might have been possible, perhaps because of the work done by NGOs and FBOs, in creating awareness. Also it may be because of the higher prevalence in the place where everyone knows someone who is HIV positive and the level of stigma is very low. Although the sampling was random, the participation in the survey was purely voluntary.

1.9 Problems

The researcher encountered a number of problems. The researcher was expecting to sample the household for the survey from the household list. All the villages did not have the list for the household. The villages had only the number of households which was divided in groups, female, male, children, people who are capable of working and those who are not.

In the village of Idende from the Bulongwa ward the researcher was not allowed by the local village leader to conduct a study unless he had a letter to authorise the study to be conducted in this place from the immediate boss of the village leader, the ward executive secretary. When the ward executive officer was asked for an authorisation letter, he could not give it immediately for the reason that he also needed a letter from the district officer such as the district commissioner or the district director. The researcher made an official request for all these permissions. It took some few weeks before all the letters were there and the bureaucracy was cleared. The same problem occurred in the village of Ivalalila from the Iwawa ward.

On the other side the Bulongwa Lutheran administration could not give permission to interview its staff and have access to its records. The BLH administration asked the researcher to send his request to interview members of the staff to the Bishop. The researcher did so and the bishop declined. However a handful members of staff volunteered to participate in the study on the condition of being kept anonymous

Supply of necessary requirements was one of the challenges in the field. Stationary such as papers, ink, printing cartridges and photocopying were not available in the village and when available, were expensive. Transport was another challenging problem, this study was conducted during the rainy season when the roads were not passable. Even if there would have been no rain, there are still many villages that are not accessible by road. In that case the researcher had to walk a number of kilometres every day to be able to reach the respondent and complete this work.

1.10 Thesis outline

This thesis is arranged in the following manner, chapter one is containing the motivational for conducting this study, the description of the study area and the methodology. Chapter 2 contains literatures overview and describes global health systems and the Tanzania health system. In Chapter 3 the ability and willingness to pay for health care are addressed. Chapter 4 gives the alternatives to hospital based health care and Chapter 5 contains the conclusions and recommendations.

Chapter 2

Literature review

This chapter covers the theorretical back ground of the subject studied. The chapter adresses th theoretical frame that was used in working on the subject. Further more it explains the global and the tanzania helath systems. The theories that addressses mechanism to reduce costs related to health care are addressed.

2.1 Theoretical framework

The study framework was adopted from McPake et al., (2008a). From MacPacke could be deduced that the own valuation of customers shows that individuals' willingness to pay follows demand curve. This means that those that value the benefit and the outcome most are willing to pay more. However demand is not only depend on willingness to pay, it is also affected by the ability to pay. This means that there will be difference on the demand of rich people as compared to the demand of poor people. The demand of the rich people weighs more than the demand of the poor.

Own valuation of consumers also depends on number of other factors such as access to information. Individuals that lack information may place higher value on interventions with only limited effects. They tend to value intervention with limited effects high due to lack of information. The valuation is represented graphically in terms of the demand curve which measures the marginal valuation. The nature of the curve is sloping downwards, because of individuals' point of view we are expecting "diminishing marginal utility" therefore the sum of many individual demands gives a downward sloping demand curve.

Since individual makes society, therefore the demand curves of the individuals make the demand curve of the society. The social demand curves when graphically represented produce a demand curve with the same patterns as the individual demand curve. The social demand curve will represent a social marginal valuation and therefore diminishing social marginal value. For health interventions, individuals are very likely to value the intervention very lower than the private market demand. In the graph below it is represented by graph D.

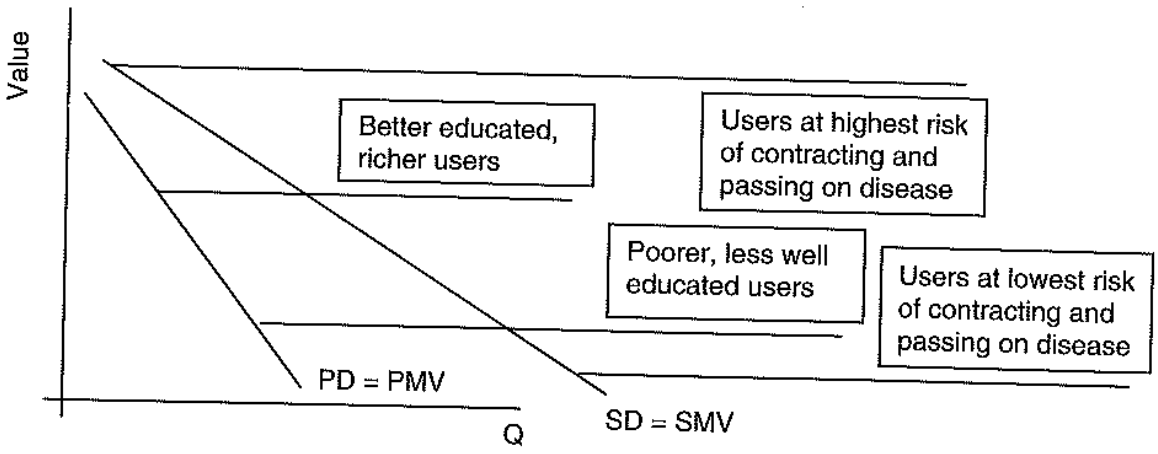

Figure 2-1 Demand and Social value of health intervention

Source: McPake and Normand (2008a)

The higher value on the left part may describe the situation that is concerned with the rich and the educated. The two groups place higher values on the left side of the graph it may be because they can afford to pay or they understand the meaning and the importance of the intervention and can pay for it. Their higher level of willingness to pay can be due to their ability to afford the cost of health and have enough information.

The social demand curve (SD) will sum up the demand curves of the individuals and therefore the social demand curve will lay on the right of the private demand. This is because the society puts more emphasis on intervention for individuals at the highest risk and it will slope downward. Due to that the demand for the poor who are most risk will be placed higher than that of the rich.

The graphical representation of social demand shows that the social demand has quite different priorities from the private demand curve. The private demand curve will lie left because individuals may undermine the importance of the intervention due to lack of information, poorest who suffers most from the communicable may not afford to pay and therefore express low demand.

People in rural remote areas of Tanzania, in this case Makete district, presumably belong to the category of the poor. Less-well-educated users who can apart from being controlled by

demand but their income and ability to pay may be contributing factors on willingness to pay and henceforth affects their access to hospital-based health care

2.2 Health systems

The OECD report (1992, 1994) describes that the health care system is made of three categories based on stakeholders, the providers, financers and users. In many countries the government plays the role of provider and financer. On certain occasions, health care services are shared between public and private providers. There is no country in which the health system is fully private.

Even in the presence of the private health system the government regulates health care by setting rules and regulations and also it subsidies in some cases. Countries that practices pure public financed and provided by the state system which is sometimes is called as “semashko” their hospital-based health care services are free of charge to the patients. The system represents the extremely public dominated system.

The other health care system whereby hospital-based care is public financed and provided by the government. The systems allow and include the user fee for some areas like the dental services, the optical services and the prescription. Such a system is practiced in the UK by the British national health services (NHS).

The British system ensures that most of the resources that are used in health care are owned publicly with some private firm and individuals allowed to participate. For example the contribution of the private sector in the British health system it is in a such a way that the primary care doctor (General practitioner) is contracted, in Denmark non hospital activities is provided under public by contract to the private practitioner and the co-payment exist. In Sweden private practice is only possible for occupational health and dentistry.

The Bismarck system which was founded in German puts many people from the population under compulsory insurances and the few that remain under voluntarily with either sick fund or privately. The same system operates in Belgium and the Netherlands. In some countries there is a payment at the time of use which will later on be reimbursed by the insurances companies.

In some countries especially in the developed world, use of the insurance system is most developed. The health system of the most of the remaining countries in the west is run and organized by the social insurances. Health insurances have helped consumers sharing the risk between the rich and the poor and eliminate inequalities that arise due to income. This process eliminates the possibility of one family, household or individual to fail to access health care at time of need due to lack of capacities and abilities.

2.3 The Tanzania health system

Tanzania is among of low income countries with maternal mortality ratio of 950 per 100,000 live births and life expectancy at birth of 50 years (WHO, 2008). The per capita income of Tanzanians is estimated to be $100 which is very small as compared to $ 640 estimated for sub Saharan countries.

Table 2-1 Some Selected Indicators for Tanzanian Healthcare System

Indicator	Value
Total expenditure on health as % of GDP	4.4
Per capita total expenditure on health at average exchange rate (US$)	12
Per capita government expenditure on health at average exchange rate (US$)	5
General government expenditure on health as % of total expenditure on health	46.7
Private expenditure on health as % of total expenditure on health *Sources of public health expenditure:*	53.3
Social security expenditure on health as % of general government expenditure on health	0
External resources for health as % of total expenditure on health *Sources of private health expenditure*:	29.5
Prepaid plans as% of private expenditure on health	4.4
Out-of-pocket expenditure on health as % of private expenditure on health	83.1

Source: (WHO, 2008)

Many of the poor countries in the developing world are either practicing the Semashko or British system model (McPake et al., 2002). According to Shiner (2003)The Tanzanian health system was dominated public since the time when Tanzania obtained its independence the

government was a sole financer and provider of health care. After the 1990 health reforms, the financing shifted and became a sharing responsibility between the government and the private non-for-profit. The nongovernmental sector includes religious organization such as the mission and for-profit organization which included the private companies' hospitals and traditional healers.

The distribution of responsibilities to the stakeholders gave the state a big segment of responsibilities and therefore the government became the largest health provider
The structure of health care system starts at the community level organized at the villages and referral is made up as higher as treatment abroad. The referral system marches as well as the administration as portrayed in the sketch below. The health care administration is organized starting at the national level from the Ministry of health and brought down to regions which are further divided into districts, wards and villages.

The Ministry Of Health and Social Welfare (MHSW) in Tanzania (Moshe) states that the government referral system assumes a pyramidal structure, as it was suggested by health planners. The health planners suggested the system should start with dispensaries narrowing up to consultant hospital.

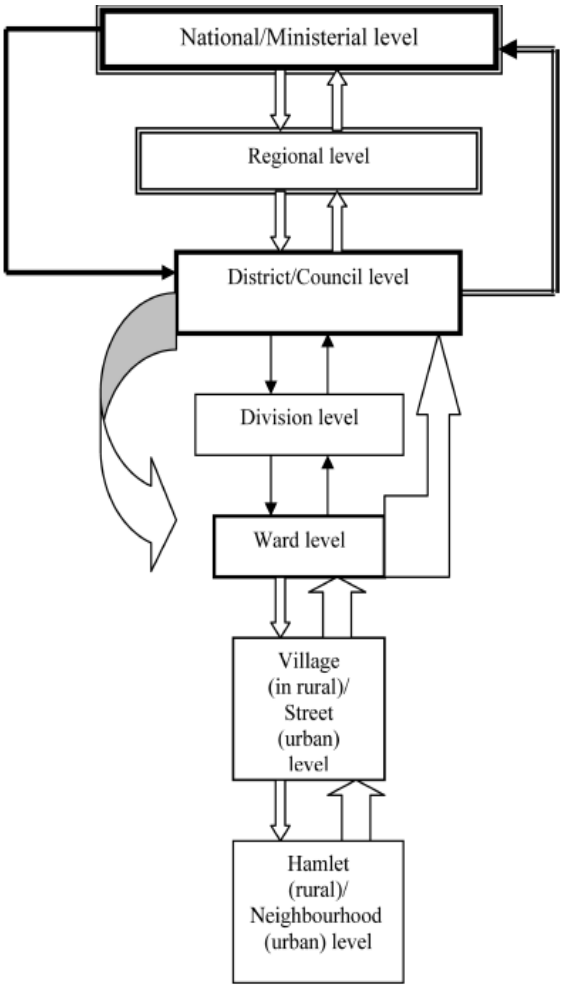

Figure 2-2 Hierarchical priority setting decision-making levels under decentralization arrangements in Tanzania.

Source: Mubyazi, Mushi et al. (2007)

2.4 Methods to reduce cost for hospital based health care users

2.4.1 Health insurance

The health insurance was well described by Nyman (2006) through the historical formation of the insurance. He gives an hypothesis that utility or satisfaction that is associated with consumers' income increases with income but with decreasing rate.

Nyman (2006) suggested that consumers with loss of income or wealth will face two alternatives, whether to cope with the situation or opt for buying insurance when there is a reduction in price. However he further suggest that this theory does not apply to health insurance. They think that spending for medical is not influenced by income, because medical

care spending will not improve utility as it will generate loss of utility. This means that consumers will obtain utility from spending on other commodities rather than health care itself. The model they developed urged that the amount the consumer would spend on health whether covered or not covered by health insurance is the same. The only difference is that the consumer that has bought an insurance will gain the same amount spend on medical as reimbursement which will then be considered an income. This implies that all medical care spending that the consumer will incur is within the consumers' budget constraints (liquidity constraints, wealth). Health insurance does not pay lump sum instead it pays off ill consumers care. This theory made sense to some medical care that consumer might purchase whether ill or not. It did not however make sense for example for treatments that were directed at serious ill.

Consumers vary in their risk probability and loss or payments they may incur on purchasing medical care. Due to that only consumers with loss exceeding premiums are more likely to find insurance more beneficial and therefore be attracted to purchase insurance (Hargreaves et al., 2007).

Due to that it is very likely for insurances companies to be dominated by only sick persons which in general create loss. The insurances directors will tend to increase the premium which will worsen the situation as healthier people will opt out.

Apart from the insurance being as one method to reduce the burden of cost to the consumer, Nyman (2006) says that there are other means of reducing costs to consumers as listed below.

2.4.2 Pre-payment scheme

In this scheme an insurer will be needed to pay out lump sum to cover every possible treatment of different illness. The methods showed two problems, first the program will have to cover a big number of illnesses with different magnitude of severity. Second the physician may be tempted and make mistake in representing the nature illness for financial gain.

One way to solve this problem is to give a physician a budget to which he can make his choices to treat the patients for any illness that may arise at any period of time. At the end the

physician will keep the money left. However the problem with this method the physician will find the possible less costly combination of drugs.

2.4.3 Scheme to affects prescribing behavior

Physician has mandate to choose the best drug which relatively has the same effect but sold at lower price. Physician will be required to prescribe the less expensive drugs. Insurer prepares educational program and some countries prescribers are confronted with the financial penalty failure to abide by the guidelines. Prescribers avoiding expensive drugs save the cost to the insurance firm yet they have reduced patients' access to better drugs.

2.4.4 Patients cost sharing

The methods for patients cost sharing are of different forms: co-payment which means a fixed fee per prescription; co-insurance which means that a proportion of ingredient will cost and/or dispensing fees and charges that vary with the number of prescriptions.

2.4.5 Equity reason

The principal of solidarity tells that people differ on their health risk automatic from birth. These differences when in incorporated in the private health insurances (PHI) it will result into differences in premiums. This will mean those people who have a higher health risk health risk and which is already a disadvantage by itself will have to pay a higher price.

Brent (2003)says that some economists questions if all items of health care expenditure are necessary. They say even if it was true yet the resources available would not be able to meet the demands and requirements. Therefore it is suggested that some of the necessities are more necessary than others.

From this point of view an individual who is being faced with two choices between health care and other social obligation which both needs expenditure will be faced with an option to choose between the necessity which one to finance from the limited resources at his disposal.

At a point when the household remains with little resources they have to consider devoting their limited resources to save one's life and leave the rest of the household members who would also depend on the same resources to survive (Brent, 2003).

In rural Africa where people struggle to feed themselves they will always struggle to choose which necessity they would like to spend their limited resources on. In this process of choosing the best way of spending their little resources, users have to think whether the treatments they have to pay for have an effect on their illness. According to Brent (2003) the question will be on the effect on the health care services paid for. Depending on the reason of expenditure health care services can be seen as benefit or cost.

The literature (Nombo, 2007a, Fofana, 2010, Nguthi and Niehof, 2008) says that although there has been-wide spread education on HIV/AIDS to reduce stigma many people in different areas see PLHA as shameful and irresponsible people. Such belief or notion will lead to stigma, exclusion of the patient family from the community at large.

The spread of the HIV/AIDS epidemic in rural areas is devastating as the rural population is already vulnerable to other problems such as poverty. HIV tends to worsen poverty, and in turn poverty will affect negatively health of the members of the household.

HIV will create and promote inequalities between household with a long time sick member of the household or lost a relative due to HIV and the household that are not touched by the effect of the epidemic (Nombo, 2007a).

The study by Rugalema (2000) showed that prolonged adult morbidity and mortality as caused by AIDS has great effect on the household. They tend to affect the availability of labour at household and also other resources of household.

The affected households were left poorer than the households that were not affected and that made the affected one to switch their ways of looking for food by stopping working into their farms to look for jobs that will give them an immediate income to buy food. By doing so it leaves them more vulnerable to poverty (Niehof and Price, 2008). This suggests that it is important to assess the likelihood of the family failing to access health care because of user fees imposed in health care facilities.

Rugalema (2000), Nombo (2007b) andMüller (2005) says that HIV related prolonged illness and death have changed the household composition, due to that many households were left by their head and then headed by Orphans, widows and elderly. At the end most of the

household would not be in the position to make greater participation in farm and non-farm activities and therefore reduce their income. The production activities are reduced which could be due to the loss of assets or labour. Therefore following the reduction of income generation many households would not be in the position to have enough resources ready to be spent for health care services.

Households need to exchange goods with services to attain health care. According to Niehof (1999) the exchange of goods and services is based on morality. Nombo (Nombo, 2007a) gives an example that the provision of care to household members is based purely on morale. Women are traditionally the primary caregivers for the household unit. However, in many African societies especially in rural areas, the resources for care are not at the disposal of the women, since men controls the resources. It should be emphasized that, basing on Tronto's conceptualization, provision of care demands the use of resources (Negash and Niehof, 2004).

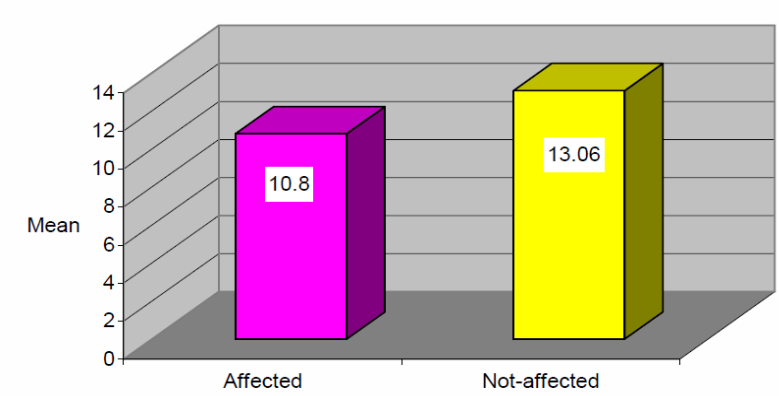

Figure 2-3 Household wealth index by affliction status in Makete District

Source: (Joseph, 2005).

Nombo (2007a) established that in most HIV affected countries the trend of giving care is lessening while the demand for care is increasing due to the effects of the epidemic. The increase of care at household would go concurrently with the demand for hospital care. However the hospital care would not be effectively be utilized if the resources that would have been used to pay for user fees have been depleted during the long illness or funeral costs of one of the household member.

Nombo (2007a) looked at the vulnerability due to poverty into two directions, the external and internal vulnerability. External vulnerability is the vulnerability due to socioeconomic and ecological dynamics resulting into different impacts and developing different ways to cope and adjust to the effect of the vulnerability. One of the common means that have been used to adjust according to the vulnerability is the tendency of people from the community faced with the vulnerability to work together. She pointed that when the community realized the problem then the member of the community will react by forming collective action based on the social vision and social capital of a certain community. The process to realize the social vision is a stepwise process which will involve the group of the individual to identify and raise the issues publicly. After raising issues, the community will engage into discussing alternative solutions, consider their impact and engage implementation.

If the cost sharing policy has been a burden and a hindrance block to the consumers of health care, the community will tend to raise the issues and find ways to solve the problem. For example community insurance has been seen as an ideal solution for many parts, from that, the community will organize, manage and operate programs that will cut down cost per head. When community faced with risks such as death develop strategies to overcome the health risks. For example community in urban form groups which acts as insurances when one of a member is faced with cost due to death of one of the relatives. The groups will raise enough funds to cover the cost and hence reduce the burden per head.

According to Nombo (2007a) the type of risks that that have made people to react by developing various strategies are such as illness, disability, death, widowhood, and natural disasters. People in Makete district falls under the category of illness and death risks as the district is heavily hit by HIV/AIDS.

Jütting (1999) says that more than 90% of the people in the developed world are covered by social insurances which are market oriented or state organized. This is different in the rural remote area whereby the majorities are uncovered against basic risks.

This can be explained by the fact that the developed countries are poor in state institution but rich in community institutions. This makes individuals in developing countries to depend on their network for basic support which consist of family, neighbours and friends(Nombo, 2007a).

Nombo (2007) sees that illness gives a big financial burden to the family and effect on the poor household are more devastating. The financial resources of the household include the cash and other liquid resources such as saving, credit, remittances and pension. HIV/AIDS makes the financial burden more enormous following the direct costs the households incurs on care given to PLHA. The enormousness of the direct cost includes the cost of care and treatment and also the disruption of regular income due to responsibilities of care giving. She further states that the provision of health care through the private sector has made many people in the poor households fail to access health care. Although treatment of people tested HIV positive is free still many people with HIV are scared to be tested which makes them to be regarded as regular patients (patients that are not HIV positive) and be charged normal user fees.

The direct costs for health for PLHA in rural area are very high. The costs are higher especially for people living with HIV/AIDS. Since the immune system of the people living with HIV/AIDS has been destroyed, they are more susceptible to opportunity infections. The susceptibility of the PLHA to opportunity infection puts them in the situation where the need and demand for health care is bigger. Since health care have to be paid in terms of out-of-pocket payment therefore the total amount per month becomes very big. When other non-direct cost such as transport fare to health centres and other basic needs as foods are included the total cost becomes even higher. Private hospitals and dispensary charges are a bit higher than the government owned hospitals.

Nombo (2007a) documented that most of the low-income households were not able to afford the costs and decided not to take patients to the hospital. The low income households decided to keep and nurse their patients in their home whereby they were given painkillers only. Sometimes depending on what was believed to be the cause of the sickness some of the household took their patients to the traditional doctor who also charged extra higher amount.
To cover the gap that was created by the declining of income and increase of the expenditure on health care the household has to find another alternative to generate income. Other alternatives included borrowing and getting from relatives, and friends, sales of crop and other assets, employer, causal work and petty business. The micro credit firms are not a solution to PLHA as most of them cannot secure loans from the credit firms as it is considered that they will not be able to pay back as they are not able to work.

Nombo (2007a) further argues that other difficulties facing PLHA are when they manage to get the loan the money will not be used for income generating activities as it is supposed to be rather it will be used to cover the cost of health care. Following the inability of the household to afford the cost of treatment available assets at the household such as bicycle is sold at low price because buyers tend to take for granted the situation and need of cash for that particular household. An important item for transport as a bicycle would have made the family save more money which could be have been spent on buses as transport fare.

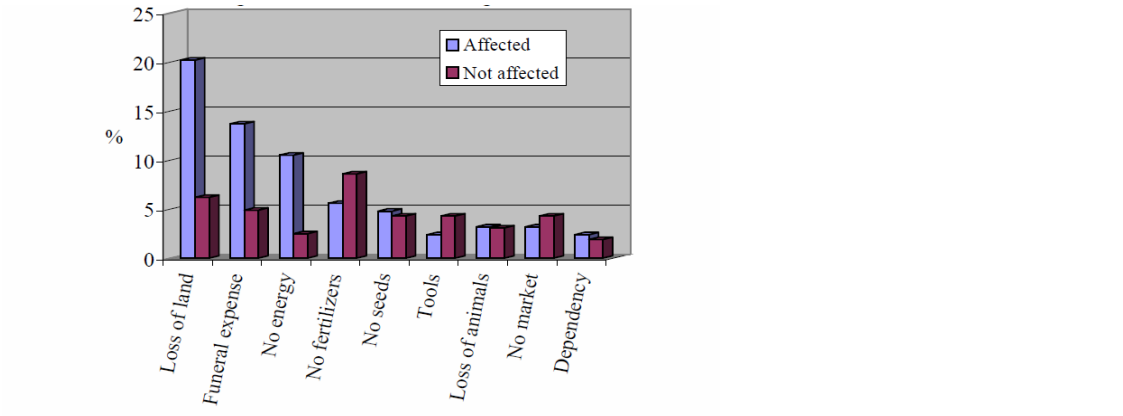

Figure 2-4 Makete household causes of food shortage

Source: (Joseph, 2005).

To enable universal access to health Folland et al ( ) suggests two ways, either the government should pay the bills or initiate and maintain the scheme that involves employees. For people in rural Tanzania who the majority of them are not employed and depend on subsistence farming their desire to access health care will be connected to the rising costs of health. Under individual or household responsibilities the individuals have to purchase health insurance for themselves and for their dependants. The purchase can be either for private insurance or through group purchases, such as work, professional or social group or cooperative union.

The scheme that involves employers will put a mandate on the employers to buy a health insurance for its employees and their dependants. This system recovers the cost through transferring it either to customers in a form of higher prices or to its employees in a form of low wages. Economist suggests that collective action of which the government is being

involved can only be given its weight when there is a market failure or when issues regarding of equity are raised. Usually such issues are raised when the population is struck by the epidemic as the situation with many rural populations of Tanzania with HIV.

Hamilton et al.(2009)says that many research associates the socioeconomic status with aspects of health. The socio-economic will include the financial status of the members of the household, occupation and income. In adolescents the perceived financial status affects directly their health status. The financial status will affect the health of adolescent following its attachment to the material goods, services and other resources derived from financial status.

The Tanzanian health reform was aimed at addressing two important issues, the impact of health on consumer and the equity. However MacPake and Normand (2008b)suggested in health economics it is a matter of choice in handling the two issues. It should be decided either to improve health quality or achieve health equity i.e. fair distribution of health care services. Poor people have limited access to resources it is not possible to have enough financial capacity to access health care services. Further poor people are working hard and still cannot solve the problem of limited access to health services unless there is a purposeful intervention to help.

Poverty is a big contributor to the ill-health and limits access to health care. MacPake and Normand (2008b) states that countries that practice state funding or social insurance are projecting at eliminating the inequalities between health care services users. Normally it is agreed by many that health care should be offered in terms of needs and not by income or ability to pay. In rural Tanzania it is very likely that the introduction of user fees at various stages of health care affects access to health services and promotes inequalities.

The fee can also affect the staff and patients' relationship as it is likely staff in the health care centre to be rude and careless to poor patients. In an uncontrolled system it gives room for rich and people with better financial status to have more privileges than the poorer patients (MacPake and Normand, 2008)

Although the Tanzania government has instructed that the delivery care should be free to pregnant women, yet at BLH the service is not free. Women had to pay some fee for care

and occupational fees which are charged per night spent in the hospital. Women who come from villages far away from the hospital, those who have shown complication during the antenatal period, and those who are under the category of risk group such as too young or too old, or too short are admitted to the hospital as they wait for a day of delivery. These women have to pay Tsh.500 per night each night they spent in the hospital. Depending on the number of days they will spend in the hospital, the more night they spent the more they will have to pay.

The individual's willingness to pay according to MacPake and Normand (2007) depends largely on how the individual values the benefit. Individuals that value the benefit higher will be more willing to pay and be very likely to pay higher. However both incomes and ability to pay could also be determining factor to some extent. In poor countries the for-profit organizations hospital use the out-of-pocket system to collect user fees which resembles a simple market. The rationing is based on willingness to and ability to pay and do not take into account the problem of moral hazards. This implies that people who cannot afford to pay for a service will not get an access. By failing to have an access healthcare user will not be protected from catastrophic diseases. The expenditure on health goes together with consumption of health care services. The tendency of consumers to spend their income at the same time as they have illness reduce their ability to earn. This will result into further failure for users affording health care as they need.

The system will create externalities such as use of unrestricted drugs which at the end causes microorganism to develop resistance. Such a system makes inadequate informed society which will result into people demanding for poor-quality and inappropriate drugs. The introduction of the user fee for many tax financed systems had two aims, first, the intention and the need to reduce moral hazard and the second reason was to increase funding in the health system. The two reasons for introducing user fees are given concurrently with the reason of increasing the revenues dominates (McPake and Normand, 2008a).

Brandl (2003) says some villages had a noticeable number of unoccupied houses following the death of people who lived in the houses. The BLH owned orphanage had more tha 40 orphans by the year 2004 of which among them more than 50 percent had neither father nor mother and some of them hardly had a relative.

The concept of investing and even being able to tell what will happen in future of one's health was well explained by Morris, Devlin et al (2007) as follows; The prediction of ill health in future is uncertain; users are not in a position to predict when they will need access to hospital-based health care. The habit of users not being able to predict when they will fall sick makes difficult for them to think on future cost of their health.

Bulongwa Lutheran hospital which has to cover a larger part of its costs by means of user fees involves two parties, on one hand household who demand health care and pay for it, and on the other hand, Bulongwa Lutheran Hospital the provider who supplies health care in return for payment.

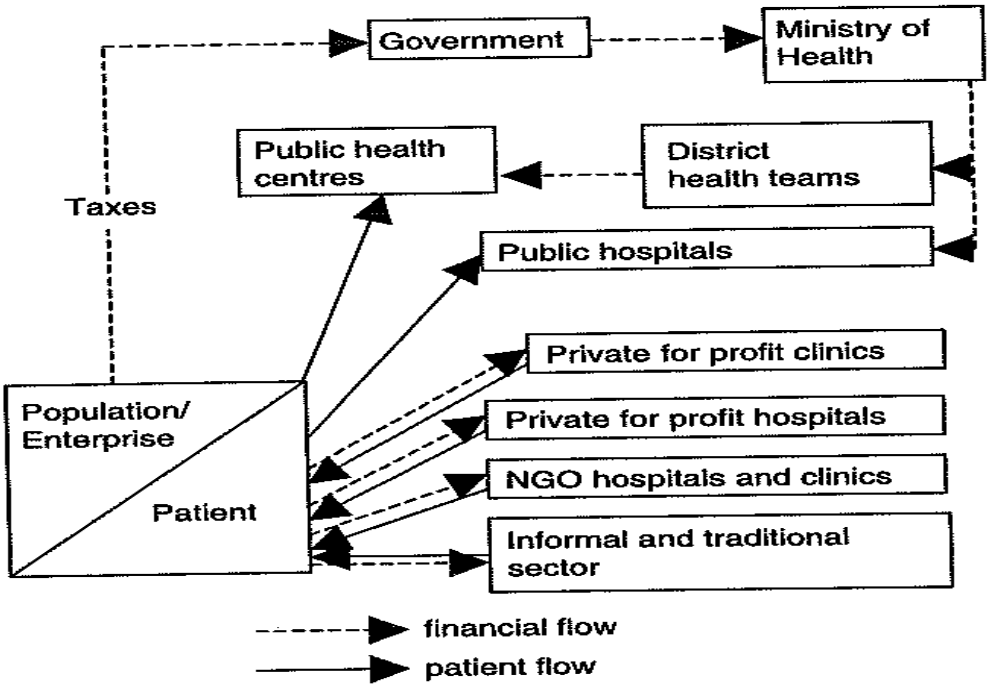

Figure 2-5 Relationship between patients fees and facilities.

Source: (McPake and Normand, 2008a)

Following the two hospitals having two different funding systems the effect of fee is expected will be significant different. This will also make a definition and the measure of equity differ between the two hospitals.

Poverty which itself is magnified by AIDS is a big factor that will make people from poor household susceptible to HIV as a result of adopting to risks behaviours that are perpetuated by economic reasons. By so doing the women especially those who are breadwinner of the household will turn into transactional sex to be able to meet the daily requirements of the family. By going into transactional sex many women will be into risk of acquiring HIV and later on AIDS (Gillespie et al., 2007a).

Because of the poor economic status the members of the household will be faced with the problem of malnutrition the condition which has been proved that it contributes to the weakening of immune (Fofana, 2010).

Chapter 3

Ability and willingness to pay

This chapter give a description and a picture of the concept of the household. The household concept will be discussed through the following items, the household; sources of the resources and its utilization and the decision making process. This means the explanations will cover how the resources are collected and how the decision in utilizing those resources is made at household. Thereafter the description of the respondents and other members of the households follows.

In this chapter the following research question is answered, Is fee paid as cost sharing a determining factor for accessing hospital based health care? This research question is addressed by two hypotheses. The higher the income the higher the willingness to pay. From this hypothesis the study investigates the ability of the respondent to pay for hospital based health care. It investigates if income affects their ability to pay which will affect their willingness to access hospital based health care The higher the quality of hospital-based health care and satisfactions of the health care users the higher the willingness to pay. In this hypotheses the study investigate if good quality of the health care services and the satisfaction level of the consumer do affects their willingness to pay.

After addressing the two hypotheses, the chapter will discuss schemes and programs that are used in paying costs for the hospital-based health care that were found in the research area. What is the source of money to be paid as fee at the hospital and other health related care? Furthermore and investigation is done study mechanisms the society in rural area of Makete developed to solve the problem of inability and lack of willingness to pay for health care. The discussion will include the achievements and the pitfalls of each scheme.

3.1 Household as a unit of analysis

Production processes and means of resources utilization in Makete area start to be organised at household level. At this level people discuss, decide, and considers different options and alternatives to a number of courses.

Nombo (2007a) says “The household is the context in which members interact and pursue the activities to provide for their daily needs and well-being” the definition which does not differ from the perspective of Negash and Niehof (2004) “I see the household as a family-based co-residential unit that takes care of resource management and the primary needs of its members’’. It is important to recognize that, in Makete an ideal household is formed by a nuclear family that consist of a father, mother and unmarried children. However in many cases it has been observed that the household had more than the above three mentioned.

At certain point divorced and widowed daughter comes back and join the parent family. The size of the household which will be under the supervision and guidance of the same head of the household will swell automatically. In many occasion children have found themselves forced to move into their grandparents’ household to live because of the circumstance they faced that left them without parents. With high HIV prevalence rate in Makete the trend of the houses with grandson was also observed to be big.

Since at household level it is where people start organising their income generating activities also from the same unit the expenditure of the resources becomes evident. Therefore the household will become an important unit to be considered as a unit of analysis. The concept of using the household as means of analysis was adopted as the concept as explained by Niehof (Niehof, 2004) and Balatibat (Balatibat, 2004) and the explanation is herein presented.

To be able to organise the information from the household the head of the household and the spouse of the household were the main respondents. Despite the fact that the head of the household and his or her spouse were the primary respondent, other members of the household were welcome to participate when happened they were present at home during the survey and they were willing to make contribution. Inclusion of other members of the household in the survey minimised the likelihood of forgetting important facts from the partially retrospective study. In Makete district most of social issues are organised at the household level. When there is a subject that needs the attention of the members of the household, the head of the household would organise discussion and way of getting opinion from members of the household. Because of that fact the head of the household becomes very important.

Also there are some characteristics which cannot be assessed at individual level and they can only be assessed at household level and that necessitate taking household as unit of analysis. The household acts as the source of economic production by managing and organising resources (Nombo, 2007b). It is an important unit for decision making regarding with pooling and expenses of resources. This means that resource allocation is determined at the household level. According to Balatibat (2004) households in rural area are taken as the primary units of production, consumption and exchange, as well as the locus of all transactions and decision-making that go into these operations.

There are many definitions pointed out by different researchers. However for the purpose of this study, the household in this study only meant the private households as per Niehof (Niehof, 1999), that the definition will not include the non-private household such as boarding school, prison, hospital. And therefore the definition will include two categories either co-residence (people living under one roof) or sharing the house purse (eating from common pot). The household will therefore be considered as a family based arrangement that makes people to live together as one unit. Members of this unit will share their primary needs and will generate income by using common resources owned commonly. Therefore it becomes necessary for household to be the unit of the analysis especially in the rural area as such as Makete district where the study was conducted. Sometimes not all members of the household should be living at the same resident with other members of the household. Sometimes the members have migrated to town where as they work and raise income for the households and therefore at some point they can be regarded as assets (Niehof, 2004).

In Makete the population is divided between those who follow the Christian faith, Islam and Kinga traditions. Kinga is the largest ethnic group in the research area polygamies practices are accepted by the last two groups. The polygamist practiced in this place is that of a man to have many wives.

During the study there were some cases whereby a man had more than one spouses. The two spouses cooking at different pots but consider themselves as one household. In some occasion the two spouses lived very close to each other such as in the same compound and next to each other's house or far from each other houses. When such situation happens this study treated the husband as a head of the household with one spouse and excluded him in a second spouse family.

When it happens that one woman married in the polygamy arrangement dies then the children that had lost their mother will be adopted by the other wife of the husband who is alive. When such a situation happens the children will be considered as sons and daughters of the living father and the foster mother. In some occasion it went as far as the children of the adopted daughters and therefore making the household size big on average. According to Nguthi and Niehof (2008) the enlargement of the size of the affected household will work as disadvantage for most of the female headed household.

In this study the average size of the household was 4 while the mode was 5 however out of 365 households that were surveyed 25.8% were having the size of larger than 6. This means that quarter of the surveyed households had the size of six members of the household or more. The size of the household is becoming important to be considered because at household level the determination for sharing and generating resources starts. The size of the household is a good predictor of how the household is going to be shared and hence forth it will be an important factor to express willingness of the household to spend on health. The relationship between the household size and willingness to pay is considered because the resources in the household have to be committed and shared among members of the household.

The household at some occasion is not necessary to be living under one roof (Niehof, 2004) this was the case in the area of this study where there were a number of households which had a number of houses following a common cultural traditions of polygamist. There were a number of the households that were headed by one household head with more than one spouse. The wives of the polygamist family each has her own kitchen or sometimes a full house however they all the wives and their children will count and see themselves as one family under one name of the household head in this case the husband.

This study will consider resources as anything that can be collected or created at household level and be available for expenditure by the members of the household. According to Balatibat (2004) resources includes physical, natural, social, financial and human. The physical resources will include the soil, water, biodiversity; Human resources are, for example, skills, knowledge, and good health. Financial resources or assets are income,

savings, remittances or pensions. Social resources include social networks, membership of groups, and relationships of trust, kinship, and so on.

Members of the household share the responsibility of ensuring that the household gets its daily needs and well-being. For this study the household is regarded as a unit for primary needs and joint management of resources. The members of the household will have different capabilities, responsibilities, and obligations and will share resources in different proportions. The household will include a number of features such as support units, food units and the social network as part of the household context (Balatibat, 2004)

The composition of the household and functions of the members changes with situations at particular time and moment. For example according to Rugalema (2000) prolonged morbidity and mortality will affect the household as it will consume the household assets as well as workforce. Therefore the resources available in the household will either be used for funerals for the deceased members of the household or will be used to seek care for the ill-healthy members of the household. Even the members of the household that are well will divert the use of their energy toward looking for enough money that will be able to cover the cost of the sick person at the hospital or health care.

Increases in deterioration of health accompanied by increase in mortality rate too is caused by HIV/AIDS accelerate the change in composition of the households. In the research area where many people were affected by HIV/AIDS the change in household headships and composition can clearly be observed. Among 365 household that participated in the survey 18.9% households are headed by either widows or widowers. Literature (Nguthi and Niehof, 2008, Niehof and Price, 2008) says that the female headed household will face a disadvantage as compared to their counterpart male headed household. The difference imitated from the difference of other factors such as the male head of household has higher education than female heads of the household. This means that the chances of the female head of getting formal employment are lower, and therefore affect the diversification of source of income. The figure signifies the devastation due to HIV/AIDS and related diseases. The research area had the highest HIV prevalence rate of between 12 – 13% (Brandl, 2006) .Therefore it is not surprising to see the higher number of widows and widowers. The higher number of the widowers and widows could be are the results of HIV/AIDS.

The female headed household will have a different means for income generation in the household also as well as the expenditure of what has been collected by the household, the options for gaining and making extra income for female headed household are limited. Selling out labour has been one of the of option for the majority. Sometimes selling out of other assets and livestock available for household such as cow, goats and chicken becomes a way forward (Nguthi and Niehof, 2008).

3.2 Characteristics of the household heads

The society in research area has a strong patriarchal system and therefore most of the household are male headed. Almost in every household a male was identified as head of the households. Even in occasion where a man was a sole dependence of a woman still it is a common customary to say the household was headed by man. In some occasions women has surrendered their headship to their sons. Widow and old women who are not married and lives with their sons in the same house reported their sons as head of the household as per case 1.

Case 1 Decision Making process

Hakuna a 21years old married male with two children resident of Mwakauta village leaves with his mother in her parents' house. Hakuna, who lost his father when he was still young together with his wife the sole provider for the needs of their family and mother. In this month when the interview was conducted Hakuna's family was visited by his sister. The sister is married and lives with her husband in Mbeya town. The sister came with her child making a total of seven people in the household who will depend on a 21 years old Hakuna in decision making. At the time of interview Hakuna's mother, Tamali, was sick and Hakuna has to make all the decisions regarding her care and related costs. During the interview Hakuna was identified as the head of the household. Hakuna took his mother to Ikonda private hospital which is 45 kilometre from their village skipping Bulongwa Lutheran hospital which is only 2 kilometre. Hakuna had not enough money to cover the transport and treatment cost, he has to seek help from an NGO, PIUMA, and the mother was transported to Ikonda and treated.

Most of the households 76.2% are male headed and the women make a quarter of the headed houses. The female headed houses will be due to circumstances of events. Most of the female headed house had been in that situation due to death of the male spouse and the wife remaining as widow and head of the household. However that will be for sometimes as temporary measure to wait for very likely the young son to grow up and talk over the responsibility of the head of the household.

The mean age of the head of the household was 46.5 with mode of 45. The youngest head of the household was a married woman of 20 years old with two kids. While the oldest head of the household was an 88 years old who lives with two granddaughters.

The head of the household is very important since they are the one that provides the members of the household with means for their daily needs. The basic needs that the household head is supposed to be providing the members includes, the covering the cost of health care. The age distribution of head of household is important to be considered by the society to be able to determine the dependence ratio. From the research 87.9% were below the retiring age, this means the category of age less than 65 years old were more than 87% percent of the entire sample population table 3.1 below.

Table 0-1 Demographic characteristics of the households

Size of the households	
N	365
Mean	4.55
Mode	5
Range	9
Minimum	1
Maximum	10
Sum	1661

From the table below there were 14 single and head of household however the number of households with one member of the household is 10 giving a difference of 4 households. One would expect that the number of single household will be as the same as the number household with the size of one member of the household. However, during the research it was observed that people who were single the meaning that they were not married but working ladies and gentlemen were not living alone, as soon as they start working they would have someone to stay with them in the house. So it was common to find a newly employed girl or boy unmarried but already having at least one person to take care of under his or her roof most they were the siblings. Unmarried single parents mainly women were regarded as single although they were living with their children.

The composition of the household will include the head, spouses, children, grandchildren, nieces, nephews and parents. The average of the household in the research area was 4 while

the mode was 5 however the size of the household was as big as ten which was the maximum size for the households.

It should be noted that there are significant number of large size of the household. More than quarter of the households (25.8%) have members more than six members of the household

Table 0-2: Education, working and profession characteristics of the Households heads

Educational level		
	Frequency	Percent
Illiterate	77	21.1
Primary education	216	59.2
Secondary education	16	4.4
Vocational training	5	1.4
University	4	1.1
Adult education	47	12.9
Total	365	100
Working status of the Household head		
	Frequency	Percent
Not applicable	14	3.8
Employed	21	5.8
Self employed	321	87.9
Unemployed	5	1.4
Retired	4	1.1
Total	365	100
Profession of the Household head		
	Frequency	Percent
Farmers	319	87.4
Government employees	20	5.5
Private sector employees	4	1.1
Faith based organization	8	2.2
Business	6	1.6
Housewife	4	1.1
Other	4	1.1
Total	365	100

3.3 Income as determinant factor

The average income of people in Makete is very small, with the mean of Tsh 282,736 per annum with a mode of Tsh 300,000. The main income generating activity in the study area was growing crops and keeping animals. The people in the study area are Small scale farmers. The crops that are doing farmed include maize, wheat, potatoes, beans, peas,

cabbage, and spinach. Also this place has a number of fruit varieties such as peaches, and apples. Livestock ranges from keeping goats, sheep, cows, to poultry that includes chicken and ducks.

More than 95% of the economy of Tanzania depends on agriculture (reference). And therefore the village economy is the backbone of the country's income and the economy. Most of the people in the village depend on agriculture. Selling of crop products and livestock products was found to be the main source of financing that have used to cover the cost of treatment.

Table 0-3 Income distribution of households

The total Income the household made the last 12 months	
Respondents	354
Mean	282736.05
Mode	300000
Minimum	2000
Maximum	8223400

The agriculture practised in the study area is subsistence farming. From subsistence farming the food produced is enough to cater for food needs at household. However some few household that can produce more than what required eating will sell the surplus at the small open market.

The people depend on selling of crops and livestock to be able for cover costs that are related to health care and other social needs. For example the household will sell crops to be able to pay for school fees. Households that were not in position of harvesting enough crops to appoint of having small surplus that would have been sold so as to cover the cost of health they had to look for another alternative to raise funds.

There are people who not depend solely on agriculture as their source of income. Employment forms another source of income second to agriculture. Many of the employees are employed by the government as civil servants the rest who are in small percentage are employees of the faith based organisation and the non-governmental organisation. The employees draw their salaries on a monthly basis.

Table 0-4 Source of money used in paying for cost of care when a member was sick

	House hold member													
Source	Head		Member 2		Member 3		Member 4		Member 5		Member 6		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent	Frequency	Percent
Saving	14	3.8	9	2.5	7	1.9	1	.3	2	.5	1	.3	34	8.6
Sell of Assets	3	.8	3	.8	2	.5	4	1.1	1	.3	1	.3	14	3.5
Selling crop or animal	98	26.8	94	25.8	55	15.1	36	9.9	28	7.7	10	2.7	321	80.9
Borrowed	0	.0	1	.3	0	.0	0	.0	1	.3	1	.3	3	0.8
Insurance	10	2.7	6	1.6	5	1.4	3	.8	0	0	1	.3	25	6.3
Total													397	100

Table 0-5 User fee as an impediment from accessing health care 2009/2010

	Frequency	Percent
Very Much	233	64.9
Much	26	7.2
Neutral	4	1.1
Not Much	70	19.5
Not at all	26	7.2
Total	359	100

Table 0-6 Alternative when in debt to the hospital

Owes the Hospital			No Money for care	
Does not apply			Sale of a family asset	
	Frequency	Percent	Frequency	Percent
Yes	243	67.9	307	86
No	115	32.1	50	14
Total	358	100	357	100
Goes to the hospital and explain			Find a paying Job	
	Frequency	Percent	Frequency	Percent
Yes	277	77.2	262	73.2
No	82	22.8	96	26.8
Total	359	100	358	100
Goes to the hospital and do not care the past			Keep the patient at home	
	Frequency	Percent	Frequency	Percent
Yes	33	9.4	15	4.3
No	319	90.6	335	95.7
Total	352	100	350	100
Seek care at home			Seek care from Traditional healer	
	Frequency	Percent	Frequency	Percent
Yes	21	5.9	23	6.6
No	332	94.1	326	93.4
Total	353	100	349	100
Seek care of the traditional healer			Seek care from Spiritual healer	
	Frequency	Percent	Frequency	Percent
Yes	24	6.8	165	46.7
No	328	93.2	188	53.3
Total	352	100	353	100
Do not go the hospital at all			Look for other means (borrowing)	
	Frequency	Percent	Frequency	Percent
Yes	11	3.1	11	78.6
No	340	96.9	3	21.4
Total	351	100	14	100
Seek other means, (Buy drug, spiritual healing)				
	Frequency	Percent		
Yes	95	99		
No	1	1		
Total	96	100		

Most of the government employees are entitled to national health insurance. The government employees are the one who are enrolled in the NHIF.

Table 0-7 Knowledge on availability of program

	Frequency	Percent
Yes	25	6.9
No	190	52.8
I am Not sure	145	40.3
Total	360	100

Table 4.6 Knowing the program and willingness to pay

		Knowing a scheme			
		Yes	No	I am Not sure	Total
Willingness to pay	Not at all	1	25	11	37
	sometimes	9	134	68	211
	Yes	15	30	65	110
	Total	25	189	144	358

Table 0-8 Household members joining scheme for costing

	Frequency	Percent
No	233	65.4
Joining the community health fund	11	3.1
Joining the National Health Insurance Fund	20	5.6
NSSF Health Insurance Fund	1	0.3
Applying for poor patients funds	1	0.3
Mutual groups (cost sharing groups)	13	3.7
Other (FBO, NGO, Mutual groups)	77	21.6
Total	356	100.0

Table 0-9 Initiative to solve the cost issue as reason to join to the scheme

	Frequency	Percent
Employer	15	10.9
Personal Initiatives	105	76.6
Friends and Colleagues	17	12.4
Total	137	100.0

Effectiveness of the Schemes

	Frequency	Percent
Not at all	6	1.7
Not Much	42	11.8
I do not know	179	50.1
Much	108	30.3
Very much	22	6.2
Total	357	100

Meeting to address cost on health care

	Frequency	Percent
Not at all	178	49.4
Not sure	87	24.2
Yes	95	26.4
Total	360	100

The members of the household would either sell an asset at the household or would look for a paying job to be able to get the fund. The paying job will include either selling their labour and work in a farm of one of the villagers or take a non-farm activity such as carrying timber and sand as the case of Zaina. However the selling of crops would be the main source of money that will be used to pay for the hospital health care bills.

The number of the respondents that are government employees was significant during the study time as displayed in the Table 3.3. Most of the government employees who participated in this research are the primary and secondary school teachers available in the research area.

The result of income might not be correct because many of the respondents were not able to recollect all the information regarding of their income for the last 12 months. People in Makete do not keep their accounts in books and therefore they could only recall the income they made in 12 years by heart. Because of that it is very likely that the figure presented were not very correct. It was possible to get a clear estimation for people that have been on formal employment as they had monthly salary which could be calculated easily on monthly basis.

So as to make the minimum error possible the research has to guide the respondent into memorizing of what have been collected throughout the year. The respondents was able to remember when they were asked for a simpler way like if they could remember having a red goat and where it is of if they have ever had someone who had ever come home to buy grain. The respondent through these simple questions was able to recollect their information and then they were quantified.

Table 0-10 Correlation of willingness to pay with other variables

		Quality	Income	Cheap	Expensive
Quality	Correlation	1.000	,289**	-,540**	-.102
	p-value	.	.000	.000	.054
	N	365	354	365	354
Income	Correlation	,289**	1.000	-,361**	-,173**
	p-value	.000	.	.000	.000
	N	354	354	354	345
Cheap	Correlation	-,540**	-,361**	1.000	,283**
	p-value	.000	.000	.	.000
	N	365	354	365	354
Expensive	Correlation	-.102	-,173**	,283**	1.000
	p-value	.054	.000	.000	.
	N	354	345	354	354

Note

** Correlation is significant at the 0.01 (2 tailed)

* Correlation is significant at 0.05 (2 tailed)

The willingness to pay for hospital based was correlated with other variables. From the results WTP is positively correlated to income which means that as income increases the more willingness to pay. However WTP was significantly negatively correlated to quality may be because as quality increases the price cost for the health care service will increase and therefore will affect the WTP negatively. There is positive correlation between WTP and the decrease in price, this means that WTP will increase as the care becomes cheaper. In the correlation shows that the WTP is negatively related to HIV status, although in the regression analysis it shows that it has no impact. The other variable was correlated as shown in the table above.

3.4 Fee as impediment

When looking for the user fee one has to look at ability and willingness to pay. Literatures identifies user fee as an impediment access hospital-based health care in most cases. Since the community members will be hindered from accessing hospital-based health care as results of user fee, the community find means to communicate and find a solution about it(Msuya et al., 2007).

After the community discovering the problem and discussing, they will develop means to solve the problem. In this study the majority of the respondents said they have never heard or participated in any meeting called by the community of village government to discuss the problem.

Although the majority (figure) said that they could not remember if there have ever been in a meeting to address the costs. Respondents were not many only 26% of respondents that remembers such meetings. According to Mtei and Mulligan (2007) in many districts, members of the community were not invited in meetings to discuss the organisation and adminitration of the CBHIF. The tendency of not welcoming the members of the community to participate in meeting that discusses the programs denies their chances to learn the advantages, benefit and the management of the schemes. The perceived and acquired knowledge will lead into creating positive attitude of members of the community towards such schemes.

Table 0-11 Regression results for willingness to pay in Amount (Dependent variable) and other explanatory Variables

	Model 1		Model 2		Model 3		Model 4	
	B	Beta	B	Beta	B	Beta	B	Beta
(Constant)	27645.62****		28007.81****		28357.76****		28529.63****	
Care offered being expensive	-10936.44****	-.215	-11045.35****	-.217	-11199.34****	-.220	-11200.90****	-.220
Total Income	.01	.069	0.01	.069	0.01	.064	0.01	.064
Good quality and Satisfaction	7986.11***	.164	8057.05***	.166	8230.27***	.170	8269.36***	.170
Care being cheap	-9293.37***	-.187	-9157.02***	-.184	-9082.90***	-.183	-9124.29***	-.184
HIV status of Household head			-5133.48	-.061	-5057.17	-.060	-5092.32	-.060
HIV status of the spouse of the head of the household			491.85	.005	177.34	.002	127.02	.001
HIV status of the dependant			951.66	.006	1142.51	.007	1149.54	.007
Size of the household					113.66	.008	105.56	.008
Gender of the head of the household					-1326.61	-.024	-1387.57	-.025
Age of the head of the household					19.95	.013	19.81	.012
Knowing and Joining insurances schemes							-1452.58	-.012
R Square	.192		.195		.178		.196	
Adjusted R Square	.182		.178		.170		.168	

Note.
**** p = 0.000
*** p < 0.01
** p < 0.5
* p < 0.1

In the first model WTP = ß+ß$_1$X$_1$+ß$_2$X$_2$+ß$_3$X$_3$+ß$_4$X$_4$ in the table above the results shows that when care becomes expensive and care being cheap it will have a negative impact on WTP however good quality, satisfaction will have positive impact on WTP. Other variables size of the household, gender of the head of the household, HIV status of the household head, HIV status of the dependent, age of the household head knowing and joining the schemes has no significant impact.

Every person would like to live a healthy life, safe from diseases; people would like to correct the health problems immediately whenever it happens. Hospital and other health care services available are meant to help people. Although the service may be available and people may be willing to utilise them, still there are still some obstacles that may hinder people from utilizing the health care services.

Following bad transport infrastructure in the district then walking distance would be one of the limiting factors. Therefore to avoid the walking distance to become one of the limiting factor the respondents were sampled from village that are not more than 10 km from the hospitals.

Although there might be other many factors that affect consumers' willingness to access hospital-based health care service, the study limited itself into assessing if the cost sharing does have a contribution role.

Many respondents recognised that user fee was an impediment to the use of the health services. Consumers that have found that the fee is an impediment to access health care have thought on means to tackle the problem. There are schemes that have been established either by law or voluntarily to help people. Schemes like the Nation Health Insurance Fund, The Nations Social Security health insurance fund, the community health insurance Fund are part of the schemes that have been established to ensure that consumers use them to help in covering the user fee.

When in a process to decide to go to the hospital people put into consideration the cost that will be involved. People looks at direct cost that is the cost to be pays to the hospital for treatment and indirect costs which are cost that are involved although not directly related to treatment.

Patients that are accessing health care their services at the district hospital have been able to come to the hospital even when they have no money. The only problem that faces them is during the rainy season it will take some few days before they arrive at the hospital with the patient. The geographical nature and the infrastructure might be one of the factors that affecting the choice of type of health care services people opting for. This may be because of the fact that Makete district experience poor public transport system (Joseph, 2005). However Walraven (1996) says in other area where transport would not be an issue to follow a hospital-based health care patient will tend to skip dispensaries and health centers because of lack of medication and lack of proper care.

However recently the government hospital has solved the problem by buying an ambulance which is available to everyone and it is for free. Therefore villagers when get sick they have got telephone number which they can call and the driver of the ambulance is available all the time and come to pick the patient from the village.

When the driver receives a call he informs the doctor or clinical officer on duty. The doctor in charge of that day will prepare to treat a patient immediately as he arrives.

The situation is not the same as at Bulongwa Lutheran hospital. At Bulongwa Lutheran Hospital, patient will call an ambulance from the hospital yet they will have to pay for the service. The Bulongwa Lutheran Hospital charges an average of Tsh. 1500 (€1) per kilometre for a transport.

3.5 Alternatives for out of pocket fee

3.5.1 Mutual groups

There are other schemes that have been established by the consumers themselves through their own initiative at local levels, schemes like the women's mutual groups which were observed in all the village the where the study was conducted. Women have been using these schemes to help with covering cost incurred at hospital as they access health care. The recruitment of the members is done very carefully. If it happens that one member fails to pay there is no legal measure that can be taken against the defaulted member. Members of the groups they always know each other and most of them are related to each other. Literature (Niehof et al., 2010, Nombo, 2007b, Nguthi, 2007, Nguthi, 2008)says that many women are

involved in the schemes as they carry more responsibilities' in the care of the patients and the household members in general.

People who feel fee is an impediment still see the importance of using health care services and therefore try to find means of reducing the burden of fee. Their search for means will lead them into knowing the insurances programs and other schemes.

Sometimes it was not necessary for the consumers to search for existing schemes rather people discussed their problem and shared their concern (A case of Ludi). Following the fact that many people in the village will have the same common problem then they would resolve into coming up with scheme that is owned by the consumers. Most of the time the schemes have been, either a small micro credit firm, church based group and cooperative based schemes.

The mutual groups help in covering costs related to health services, the hospital facilities and service providers they recognize the presence of mutual groups and that shows that people are aware of the calamities that may happen any time a regarding their health such as being sick and dying.

In these mutual groups sometimes people have paid full amount that needed to be paid at the hospital as determined by the service provider or they have covered part of it. Some group they have gone as far as transporting the body of the dead one in helping members to meet the cost of transporting the body.

Table 0-12 Common characteristics of the mutual groups

Membership	Founding members plus by application; payment of a membership fee; annual fee; some groups particular membership restrictions (women, religion)
Insurance scheme	Sickness and funeral, payment schedule conditional on relationship of deceased to member
Form of Pay Out	In cash plus in kind (food plus use of capital goods) plus labour
Rules and regulations	Written rules, and simple book-keeping. Fines for non- or late payment or no show , regular meetings most mainly monthly
Governance structure	Elected Committee,
Spread	Large number of groups per community, with individuals that are members of several groups

Data were collected during the research and they agree with observation by Dercon, De Weerdt et al.,(2006)

Although schemes are formed and available in the villages, the knowledge and awareness of the villagers of the presence of the schemes becomes another important subject. It is expected that the scheme formed should be known to the members of the society so that they can use and benefit from it. From the results of the respondents in this study the majority of the respondents were not sure whether they have information.

Many of the respondents were not aware of the availability of the health insurance fund. Therefore to be able to cope with the pressure to pay fee for health care they had to organise themselves in groups. The groups were used to help raise funds and contribute when one is sick and help to cover the bills as the case with Ludi and Zaina.

The women's group observed in Makete displayed the same characteristics of women's groups that were studied in other places by other researchers such as Nombo (2007a) in Morogoro. The women meet together and have discussion on how they can improve their livelihood. Fofana (2010) says the women groups are more convenient to women as they provide the women with moral support and financial aid.

The groups are not registered and they the fund is raised from the members. They have governing rules and penalties for wrongdoers. The income is raised by the contribution of members. The members contribute some money in their group's fund, and then the money is borrowed to the members and the members will have to pay back the money with some interest. In many groups the repayment was on monthly basis with 10% interest rate. The contribution from the members is used to help members during sickness and during funerals. The trend of the groups being used to cover the funeral cost was also observed by a number of researchers (Dercon et al., 2006, Nguthi and Niehof, 2008, Nombo, 2007b). Sometimes members borrow the money to be able to meet other social obligation such as school fees. Almost all of the groups had a flat rate for their contribution. The *Naishi kwa matumaini (NM)* group of Mwakauta village was able in a period of one year to raise money from Tsh 80,000 to around Tsh, 2,000,000 and they have twice paid dividends to their members.

The groups have defined when they should support members. Many groups had an agreement of helping with cash during sickness. They can give money to a member if she or one of her dependent is sick. The dependent had been defined and determined during the formation of the groups. The groups will help with covering the hospital bills and some groups give assistance with items or materials. Some groups have made a step to having a written statute which stipulates the role and responsibilities of members further more in the constitutions they have stated what will be the benefit of the members the trend which was also observed by Dercon, De Weerdt et al. (2006). The groups have their own code of conduct which has to be respected by all members. The members that will behave contrary to the code of conduct of the group are fines or punished. Serious misconduct or failing to adhere to rules and regulations could result to expulsion from the group.

Apart from the benefit which are for the member when alive some of the groups had membership inheritance once the member for one reason or another cannot participate any more, such as death can make the daughter or a son of the deceased member to inherit the membership and continue the responsibility and the benefit as it was with the predecessor.

Religious groups

In this research a good number of respondents reported that they got the money from their religious groups to cover part or the whole cost of their care at the hospital. Although the religious groups seemed to be stronger and richer than groups that are not attached to a

religion the religious oriented groups were helping religious people and not the non religious. Even the members of the community that are not attached to a religion were not willing to seek financial assistance from the religious groups knowing that they will not be assisted.

3.5.2 Non-Governmental organization

In this chapter the NGO and the FBO are looked as one way of alternative for covering costs associated with health care. The NGOs mentioned are those that were operating in the research area during the time of the study namely SUMASESU, MASUPHA, PIUMA, LCCB, and TUNAJALI.

During this study it was found that MASUPHA and PIUMA were member oriented organisation. All of them depended heavily on foreign aid to sustain their activities. The organisation was providing a number of services such as education, and trainings, prevention and treatment. MASUPHA and PIUMA were all running voluntary counselling and testing centres. PIUMA was dispensing drugs to sick people from its store. The organisation had been helping people with treatment cost and other requirement such as food when people are admitted to the hospital. Some orphans were registered under the TAHEA medical assistance program. These orphans were taking treatment at the MDH and the bills would be sent to TAHEA which will be covered.

Case 2. Assistance from NGOs, A case study of PIUMA

PIUMA is self-supporting registered non-Governmental organisation in Makete with its office in Bulongwa village. The organisation helps people with HIV/AIDS. The members of PIUMA are people living with HIV/ AID themselves. Membership in this organization goes with the registration fee of Tsh.1000 and the annual fee of Tsh.500.

The members were entitled to several benefits from the organisation. The members would get the free voluntary counselling and testing. Also the organisation was conducting the home-based care for it members. The home-based care activities were conducted by the members that had been trained to do the job voluntarily. The care provider was visiting the houses of other members who are sick and they would take care of the sick members. The care provider was also visiting the in patients members.

PIUMA had a good number of patients that they have assisted with money to cover bills at the hospital. The members that had been at the hospital and would not be in a position to cover their bills were assisted with money equal to the amount they have to pay at the hospital. However apart from that PIUMA has employed a clinical officer and nurses as well as a doctor from Myanmar. The doctor was seeing all people that come to a small PIUMA clinic. The patients that had been determined by the PIUMA doctors that they needed to

further investigation or treatment from the hospital were referred to Ikonda hospital. Ikonda hospital was about 60 Km from PIUMA office in Bulongwa. Members of PIUMA that had visited Ikonda said they decided to go to Ikonda hospital and skipping BLH which was only 4 km from PIUMA office and MDH which was 20 KM on the way to Ikonda because they were not happy with the quality of care provided in the two hospitals as compared to the amount paid. The patients were more willing to travel to Ikonda for a treatment by lacking transport cost and cost related to treatment was covered by PIUMA.

A number of vulnerable children have been benefiting from NGO that are supporting orphans and vulnerable children. For example in Makete district the Tanzania Home Economics Association (TAHEA) has files of children that will be treated with the expenses covered by the NGO. The names and file of the children are kept at the hospital and the children are given a card which they have to carry and present it at any time they visit the hospital.

3.5.3 Insurances

The schemes that are formed by law needs to be made available to the people and consumers need to be aware of their availability. Surprisingly enough many respondents who know the schemes have known the schemes of their own initiatives (Nyman, 2006). From this observation it gives a picture that there are little initiatives to make people aware of the programs and schemes that will help in solving the problem.

Apart from the NHIF apparently there has been no other health insurance working in place for people to help with covering up cost related to health care. The health insurance has got a good reception from the community. The CHF works by direct reduction of funds from the worker's salary and that makes the workers and their family legible for treatment throughout the year.

Wide coverage of initiative will ensure easy, fast and implementation of the millennium goals. The millennium goals include universal coverage for health (reference) and to attain that the cost of health should be affordable. When the cost of health is not affordable community health insurance was sought to be a mechanism to ensure that health care is accessible to everyone(Mladovsky and Mossialos, 2008).

The community based health insurance fund was once established in the research area as described on (chapter 2). The scheme later on failed to operate and collapsed. According to the report from the district health officials on interview it was said that there are new initiatives from the government to establish a well functioning community health insurance

fund in the research area. According to (Msuya et al., 2007) joining the CBHIF is family based and voluntary. The head of the household will buy the premium and receive a membership card and other members of the household will become members automatically. Single mothers and women who are in polygamies were regarded as head of the household.

The universal coverage to for health is one of the millennium goal (reference) and to attain that the cost of health should be affordable. In their conceptual framework for community based health fund, Mladovsky and Mossialos (2008) say that when the cost to health is not affordable, community health insurance was sought to be a mechanism to ensure that health care is accessible by everyone. They also insisted that from the community health insurance the European nations the 19th C were able merging community based health insurance funds into national health insurance that covered the health care for all and obtaining universal coverage.

At a time of this study member of the community had a temporary way of handling their health related financial problem and these were by establishing self-support groups. The self-support group were formulated with faith based background or women's groups. The trend is supported by stories of Ludi and Zaina who is a member of the church oriented organization which supported by paying her treatment cost in the Makete district hospital.

From the story of Zaina and Ludi it emphasises the importance of establishing the community health fund. According to Hsiao (2001)community health fund will have the benefit of protecting consumers from the devastation they would have faced from the cost of seeking health care. Since the community health insurance will be made by a system that will involve the repayment of the consumers, consumers have a control and it will involve voluntary membership therefore the community based health insurance can be functional and help many people.

However some studies are sceptical about the introduction of community based health insurance as it has been explained by district health official in the interview of causation that it would not be appropriate to assume that the community based health insurance fund would be able to merge into big national insurance fund and help as many people as it was in European countries during the 19th Century. The worry of the studies is due to the fact that the community based insurance funds started in Europe was owned by farmers and workers

as opposed to the top down approach of most of the community based health care system that has been established in many African countries. The literature suggests that informal mechanisms are more efficiency and equitable as compared to formal mechanism. The informal mechanism is efficient because it is built on social norms. Furthermore there is more trust between the people forming the CBHIF at local level which increases the level of willingness to pay. The willingness to pay is facilitated by the fact that people forming the CBHIF have more close links (Mladovsky and Mossialos, 2008). Furthermore Msuya, P. Jütting et al. (2007) says that the CBHIF will increase community health risk sharing between households and individuals. In Tanzania the scheme was established in 1996 by the MoH of Tanzania through the support from the World Bank.

The Tanzania government is planning to establish national wide coverage community based health insurance fund after implementing a pilot in some districts. The pressures that push the Tanzania government into establishing a national wide coverage health insurance fund due to two reasons. On one hand the pressure is due to small budget on health as a result of lack of availability of funding for health care and on the other hand the high demand on health.(Mtei and Mulligan, 2007). However the success of this program will depend very much on the awareness of the people in that particular area. The motivation to join community based health insurance funds is a problem in rural communities. This may be because of lack of education and promotion activities regarding with the schemes. However low income and unreliable source income could be one of the factors that would reduce the rate of enrolment from the community members. In places where the CBHIF have been in active, most poor people have failed to join the scheme. The poorest people will fail to buy the premium because they could not afford. Sometimes the poorest people in the community are the one who lacks information and awareness. The current system may be favouring the better off than the most vulnerable people for the better off are more influential in the community. The size of the household can affect the willingness to join the scheme or not. Household that are big in size are more likely to join the scheme than the small sized household (Msuya et al., 2007, Mtei and Mulligan, 2007)

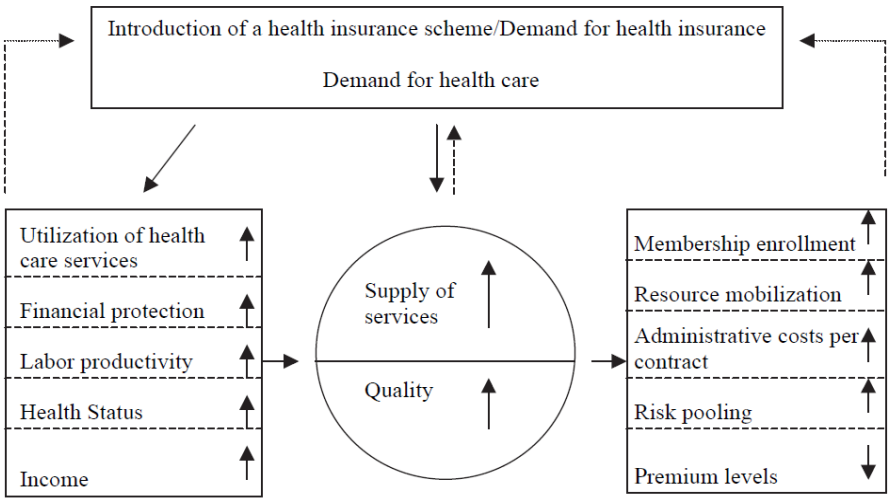

Figure 0-1 Demand and supply effects after the introduction a health insurance scheme

Source: Msuya, P. Jütting et al.(2007)

Regardless of the presence of national schemes such as national health insurance, NSSF health insurance fund yet the majority of the respondent did not know any formal scheme that can help to reduce the cost related to health care costs that are available within their locality. The district management said when the community health insurance will be in place many People will available for using the service although there were no strategies in place during the time of this study for creating awareness CBHIF and ensuring that people know the availability for other schemes conducted by the health officers.

The recently strong and fast rise of the CBHIF in many developing countries is caused by the failure of the respective government in implementing a compulsory health insurance system that will ensure universal coverage for all the people or at least for most of them (Mladovsky and Mossialos, 2008).

Knowing the presence of the scheme in the locality of the respondent is one thing, appreciating its value and function is another thing. Although many of the respondents were not sure if they have information on the availability of schemes yet they also did not know the effectiveness of such schemes. Schemes should help people when needed and people should be aware but that was not the case with Makete residents they did not know if the schemes and programs available have any importance.

According to Mtei and Mulligan (2007) the attitude of health care members of staff can either promote the willingness of people buying the premium or not. When the attitude of the staff towards consumers is not good community members may not be willing to purchase a premium for the CBHIF. The schemes are established with the intention of helping to solve the problem of inequality in health care. If the schemes will only be able to reach a small proportion of health care users it will not be able to work with the aim of its establishment to reduce the rate of inequality. The CBHIF aims at establishing equity among health users.

Mtei and Mulligan(2007) stated that for the CBHIF to function well it needs to have a composition of poor and rich people and healthy and those who are un-health. The people that are rich will subsidise those who are not rich and those who are healthier will save spending on the amount collected by the premium schemes and the saved amount will be used to help the one who are not healthy who have high demand for health. Sometimes the difference in geographical potentials from one place to another can affect the possibilities of the people from one place to be able to buy the premium or not.

Table 0-13 Details of the Community Health Fund

Payment and benefits

- Members pay fixed annual fee per household but no co-payment when using services available at primary level health facilities.
- Households unable to pay the fee are, in principle, entitled to an exemption.
- Households not joining the CHF pay user fees when attending health facilities.

Organization

- District Council required to establish autonomous Council Health
- Service Board (CHSB) with members from local government and community to manage CHF (monitoring, mobilizing and administering funds, setting exemption policy and targets).
- CHSB works with Council Health Management Team (CHMT) to ensure quality of care and facility supervision
- Secretary of CHSB is District Medical Officer (DMO), head of CHMT.

At ward level, Ward Development Committee (WDC) is overseer of CHF and establishes Ward Health Committee (WHC) to mobilize communities to join, award exemptions and develop community health plans for submission to district.

Source: (Kamuzora and Gilson, 2007)

The rate between men and women on utilizing the schemes and forming groups so to as to tackle the problem of cost sharing as impediment to health service utilization is different. When compared to men there are more women that are members of the mutual groups. The mutual group helps women to cover the cost related to funeral activities and treatment.

The that reason there are more women in the mutual groups that support health related costs is the fact that health care is gender biased. At household level women are involved with care more than men. (Niehof et al., 2010, Nombo, 2007a). Therefore women become more concerned and involved with health of the members the household than men. Women will be concerned with cost related to care because they are the one who take care of the patients at the hospital, and women are the one who take care of the sick patients at home (Nguthi, 2008) it is evident that they would be more willing to join any support group or schemes that will help in covering cost related to health.

For people in the village with limited exposure to media and such as radio, television and print media it would be very difficult for them to have information regarding the existing schemes on health and health care. There should be an intended sensitization so as to create awareness of the people. The awareness creation could only be made possible if local leaders would conduct meetings to initiate the discussion. In the meeting people will be able to know how big the problem is and also they will come up with solutions. There was a handful amount of people who could remember if there has ever been a meeting to discuss the problems related to health cost, the majority did not know if there have ever been a meeting of any kind. This made many people to be not aware of the effectiveness of such schemes when they are available which reduces the chances of utilising them.

Concept, scope, basic of computer application

Case 3: The poor patient fund of the Bulongwa Lutheran Hospital

In the late 90's the scale of HIV and AIDS prevalence and effect was at the peak. Many people were sick and dying and from the disease. The number of orphans, widows and widowers has reached its highest level ever reached in the district. People needed hospital-based health care services. Not everyone in the village around Bulongwa Lutheran hospital was in position to afford it. Here there is a good number of people who could not afford the treatment. The hospital management sought a way of helping the poor people in the surrounding villages. Funds to help the poor patients that will not be able to afford the cost of treatment were fixed. The church's mission organisations in Germany and Austria were the sole donor of the project. The system of getting the person qualifying for the fund was put in place. People to qualify for the fund were to be determined and approved by the community of their origin. The fund operated for few years and later on it stopped its operations after donors withdrawing their support. The donors withdrew their donation because the money that was donated with intention of covering treatments and the hospital management costs were embezzled. So since 2006 there had been no more funds for this fund and all the patients have to ensure that they pay for their treatment at full cost at BLH Source: Interview with the BLH staff

In chapter four it was discussed that consumer hesitates going to the hospital due to two factors namely 1. Women will wait to get permission from their husband before they seek health care services from the hospitals 2. The amount of money people will be needed to pay for user fees to access the health services at the hospital. In this chapter the discussion will be based to see how the willingness to pay affects the access to health.

When one is considering the willingness to pay is considering it into two dimensions, first the tendency for willing to pay and the second scenario are for those who are willing to pay how much they would be willing to pay. For the first scenario many people were not willing to pay for health care services. The respondents that consider paying at the hospital are considering paying the amount of Tsh. 5000.00 was the amount many would like to pay.

People will be willing to pay because of some motivational factors such quality, cheap price etc. Respondents in this study expressed a number of reasons reason for their willing to pay for health care services at hospital level.

The study found that many respondents are willing to pay would do so for two reasons. Some of the respondents would be willing to pay for health services because the quality of the services is good. The other segment of the respondent would be willing to pay because the service is cheap.

Table 0-14 Willingness to pay

	Frequency	Percent
Not at all	39	10.7
Sometimes	214	59.0
Yes	110	30.3
Total	363	100.0

Although the policy requires everyone that is using health care to share the cost that has incurred with exception of two categories, exempted and those that qualify for a waiver, pregnant women and under five years old children are under exemption category. Other people that are not capable of paying the costs are classified under waiver category. There are a number of people that are willing to pay for hospital-based health care services. From this study a 10.7% of the respondents had no willingness to pay for hospital-based health care. Consumers that showed no willingness to paying for health care lost their willingness due to mainly two reasons. Some (12.6%) were not willing to pay for hospital-based health care because of the pressure they have to pay for other social obligations they had to fulfil first. A number of respondents (17.4%) expressed that the quality will affect their willingness to pay for hospital-based health care services.

According to Mtei and Mulligan (2007) patients that are not legible to share the cost for health fall under two categories. The group of people that by mandatory should not pay the user fee and they are said to have been exempted. The group of the exempted people includes the children under five years old and pregnant women. The second group is the group of the people that are supposed to pay but they are not capable of paying. The patient in this group does not fall under the exemption category rather it is said they are waived. The people under the waiver group by statuary are supposed to pay but they cannot pay as they are poor.

Patients that cannot pay the amount requested will be asked to get letters from the hospital management. The letter will be sent and endorsed by their leaders of their villages and signed by the district commission to authorise the person to be treated for free as he has no ability to pay for the treatment. In the village the village council will determine to give an endorsement to a patient as a poor one.

The patient needs to start working on the exemption procedures before he has been sick, He has to start from the village level. It is important to start from the community because it is only members of the community that can tell the situation and wealth of a person in the village. The members of the community in Makete knows source of income of each member and understands how much people own. Therefore the community through their local village government will determine who to be exempted and the process will therefore proceed as far as to the office of the district commission.

The letter from the village will get the signature of the village leaders and the district commission and it will be brought to the hospital whereby the doctor in charge of the hospital will sign the letter which will now be a certificate to justify exemption. The letter will be kept in the patient file and copies will be sent to the stakeholders that have been involved in endorsing the letter. The procedure of weaver is not applied at BLH. The patient treated at BLH if he is not capable of paying for the cost for his or her treatment he will be asked to do a job so as to compensate the amount of money he has to pay.

Different sources (Mtei and Mulligan, 2007, Msuya et al., 2007) suggest that while the patients in the statutory exemptions category has no problem in identifying them. The patients under waiver group bring serious problems on the criteria on how they can be identified. Hargreaves et al., (2007) in their interviews with eight district managers in Tanzania found that managers at district level were aware of the exemption policy but they either did not implement it or left it to the villagers. At the same time all the household who were interviewed were not aware of the exemption as in our survey. The district officers interviewed in Makete were in a position that the guideline would be developed at national level and it will be brought to implementation. The government at national level was expected to train social workers as well the concept which is contracted by Hargreaves, Bonell at (2007) who interviewed the ministerial officer as well as World bank representative who is in-charge of the CBHIF says the requirement of the CBHIF is the managers at the district level to develop the guideline.

Table 0-15 Amount people are willing to pay

N	339
Mean	21436.58
Median	10000.00
Mode	5000
Std. Deviation	23503.046
Minimum	500
Maximum	240000

Table 0-16 Reasons for paying user fee

	Frequency	Percent
Good quality and satisfaction	131	38.4
Cheap price	125	36.7
The feeling of owning the health care service	9	2.6
It gives me power to demand for more quality	76	22.3
Total	341	100.0

Table 0-17 Reason for not paying use fee

	Quality		Expensive		Other social obligation	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Yes	297	81.8	247	69.8	305	83.8
No	63	17.4	104	29.4	46	12.6
Not sure	3	0.8	3	0.8	13	3.6
Total	363	100.0	354	100.0	364	100.0

From the interviews the respondents thinks that there are a lot of advantages obtained from the cost sharing by the patients; actually even though services that people feel they are offered for free they are not really free offer. Instead there is someone somewhere who is paying for them.

People will be more ready to contribute and value the CHF when everyone will be able to contribute. For example many people in Makete depend on their children for whom some are working far in town and therefore if the children will make a ready paid insurance for their parents these parents will be more willing to use health services as they will feel it is something connected to the money children have worked for.

People who are paying through premium are categories into different classes. Premiums are divided among the expensive and cheap, members that have bought expensive premium will have more opportunity and benefits. Those with a certain class of the premium will be able to be treated at any place and any hospital. Hospital will accept certain premium in respect to the amount the respective hospital charges. In some hospital it would not be possible for people with a certain type of premium to be able to get treatment.

In the government hospital the care given will not be determined by the type of premium one owns the service provider in the public hospital will provide services to the clients as to the same level regardless of the contribution made by the client.

The insurance agencies have their own restriction such as they have primary and basic kind of care that has to be provided to a patient or client before the doctors have considered another type of the services. Therefore services providers in the hospital they found themselves bound to abide with the instruction and requirement of the insurance agencies.

However the insurance agencies give the recommendations of health care to be refined at health centres according to the level of the health providing facilities, for example dispensary, health centre, and the hospital will have different health services care provided. Dispensaries are smaller that hospital with no trained medical doctors therefore there is kind of services care that will not be provided at this level. It will only be provided at the higher level. Therefore doctors will have to prescribe in the lines of the insurance agencies.

The insurance agencies came with that design because as a patient goes higher in the hierarchy of care and treatment the more and expensive the treatment and care the patient will be given. The cost increases because the higher the as one goes up in the hospital-based health care the well trained the expertise and service providers are available. Also the equipment available in the facilities differs from one facility to another according to the level of the facility itself.

The restriction the providers face one of them for example when a medical doctor travels to the dispensary for mobile clinic let say and at the dispensary meets a patient entitled to be treated under insurance, the doctors will give the treatment as will be required at the dispensary level.

3.6 The implication of payment out of pocket

First the willingness was assessed, it was established that many people will not always be ready to pay for the hospital-based care. In the question if they are re sick will they be willing to pay it was found out that 58.6% will sometimes have the willingness to pay and sometimes will not. Their willingness will depend on a number of factors that will be explained below.

The patient sometimes is subjected to different situations and those situations may affect their willingness to pay and henceforth determine if they should seek hospital-based health care or not. Some of the factors were put into assumption were having debts at the hospital due to bills not settled in the previous treatment or

In many rural areas of sub Saharan Africa where HIV prevalence is very high the members of the household in these rural areas cannot reach their health care services cost without either selling an asset from the household or going in debts. As the situation of the ill health is prolonged in the household as due to HIV/AIDS the more the depletion of the assets as well as the animals and crops (Rugalema, 2000, Nombo, 2007a, Niehof et al., 2010).

From their research in Lushoto Tanzania Mubyazi et al. (2007) found out that people do not see the introduction of the user fee as has a positive impact on quality of health care services, and furthermore there was feeling from the respondents that the fees has added a burden on the health users. Some people noted that the quality of the health care at hospital has decreased after the introduction of the user fee. As noted by Hargreaves et al., (2007) the decrease of quality for health care is due to poor management. However there was some acknowledgement that there was an improvement of the health services by some few people in the research area, and the people that have appreciated the improvement of the health care services they attached it to the availability of the drugs and renovation of the hospital building and supplies of the amenities such as water.

During the introduction of cost sharing concept which was introduced in the mid 90 had a number of good intentions as explained in chapter two. More reason was the user fee will help the hospital administrator to have money to find resources so that will be needed to cater for the patients that will be followed for the services at the respective hospital according to the key informants from district medical office. The point is supported by literature (Walraven, 1996) by the fact that the revenue obtained from out of pocket could also be used

by the local hospital to improve its quality. However fee paid as out of pocket is very much dependent on the price and quantity bought and sold which will simply mean the interaction of demand and supply. Therefore according to McPake and Normand (2008a) the portion of the market will very much be determined by willingness and ability to pay. Because of that the problem of "moral hazards will not apply"

The ability of the households to raise enough resources can be affected by a number of factors. Balatibat (2004) mentions a number of factors that can put the household vulnerable such as calamity beyond their control, food price fluctuation, pests infestation, loss of jobs and income. Also socio cultural events such as wedding, funeral and other social obligations may also have impact on self sufficiency of the household.

Case 4: Ludi

I was told that I was given a name of Ludi just after my birth in Iniho Village 32 years ago. Later on I was sent to Primary school in the same village. My mother had to raise her two kids alone as my fathers had died some years ago while I was still very young. After completing my primary school education my mother sent me to a secondary school in a nearby village of Bulongwa. As I was in my first year of my secondary education my widowed mother who has no education, no proper job and who lived by subsistence farming became seriously ill.

Being the elder child and a daughter it became evident that the responsibility of taking care of my mother was mine. I stopped going to school came back home to support my mother and my young brother. I thought the sickness would be with my mother for a while, I was wrong, the sickness went for about three years.

After three years my mother sleeping in bed sick she got a relief a bit and would come out and do some small household work at home. I was happy as I thought my dream of going back to school will come true. I was looking forward to that, it was not the case.

I came to realize that we had spent so much money on my mother's sickness treatment. We remained with very little not enough to enable me to go back to school again. My mother did not stay long after that relief, she was sick again. I had to take care of her again for some more months before she died.

She left me with my young brother who was very young and just started studying in the primary school by then. I felt loneliness as my mother's departure was so sudden and my brother had to be at school during the day. The best thing one would do in my village was to get married though I did not opt for that. I was scared to leave my young brother behind, or even if I would have an option of moving with him too which would be my new home yet I was afraid and scared. I was not sure if my brother would live comfortably with his brother in law and cope with the sudden changes.

I resolved to finding a baby of my own to help with taking out my loneliness. To date I am an unmarried woman and a mother of three children. I support the children alone without an

assisting hand of a man. I cannot demand care and maintenance of my children from their fathers because I was not married to them. I do not know if they are responsible culturally or by law to take care of their children. I am just happy that I had someone to talk to at home and that I have a family.

Two children are less than five year old, therefore, they are entitled to free treatment at the hospital especially when they have gone for regular normal child clinics. But I had to pay when they have to be treated in the hospital for sickness not related to normal regular medical checkup.

Being a single mother who is raising three children and struggling to make living make my life in the village is very difficult. I remember some years back we were in normal women meetings. While in these meetings we realized that we had many common problems which were financially oriented. We were concerned with issues related to death and sickness. Burial and funerals activities are usually handled by men in the village; however care for sick and food requirements at during the morning of the deceased one were roles of women.

We realized that we needed to find a way where we could be able to support and help each other in times of sickness. Many women from the village liked the idea and therefore we started forming groups. I was one of the founders of one the group which later on grew up to about ten people.

In our small group we started micro credit program. When we started we made contribution of one thousand shilling as capital. The money was loaned to members who had to pay back with some interest. We started with loaning out very small amount but from the profit made out of interest our capital has grown up enough to support us intensively.

When a member is faced with care problems that needs to be solved financially such as being sick and admitted in the hospital the members of a group take some items from their home like food and firewood to give to a person in need. Together with the supply of materials they would give five thousand shillings in addition from the group account. The support is given when members, their spouse or children are sick or when they are involved in an accident.

Sometimes when one is sick but still in good form and decides not to seek care from the hospital, stay at home and is able to work then group members are not complied into giving you support. But when you are sick sleeping in bed at home because you cannot visit hospital as you may be has no money to pay for the service at the hospital. Therefore members of the group will come to see you and give you money to enable you to go to hospital.

As a group we do not give assistance to a sick member that does not go to hospital, this advantage is rendered only to those members of the group that have been hospital admitted. The condition was not only admission to the hospital to qualify benefit but also you have to be at least in the hospital bed for more than three days. In case a member is treated as an outpatient then will not be assisted with this arrangement.

Five thousand shillings are not enough to cover all the financial need one can have when is sick. The money sometimes is not even enough to cover direct costs incurred in the hospital leaving alone the indirect costs such as food. For some of us were forced by the circumstance to enrolled in many groups. For instance I am a member of twelve different groups. From different groups I have enrolled, I receive different benefits from each group when I am in need, one group can bring fire wood while from the other one I might get rice or maize meal.

Last year I was sick and was admitted to the hospital once and my youngest baby at different times was also sick and admitted. The members of the groups had to see that money would not be a problem for me to get treatment from the hospital. I was comforted with some contributions from members of the group. If I was married the benefit would have included my husband too.

I was suffering from chest pain and went to the Lutheran dispensary available in the village. I was admitted for five days and used about five thousand shillings as cost for medication and hospital consultancy for my sickness. The members of the group came to see me and they gave me their contribution amounting to five thousand enough to cover all the hospital bills.

After I recovered from sickness I did not stay long, one of my babies was sick, I had to take her to BLH where she was admitted. On our arrival at the hospital reception I was supposed to pay four thousand shillings for registration as an advance for all cost that will be involved in treatment.

My baby was attacked by tumors and admitted for five days. The treatment involved surgery operation which went well and he recovered. At times of my discharge there was a bill of eighteen thousand shillings as direct costs of treatment. Because I am member of the group so it was easy for me to pay the bills. Without this arrangement I would have not been able to cover all these costs. I was able and managed to cover the whole amount of the treatment from the money donated by members of the group.

If I was not a member of any group it would have been difficult for me to afford costs related to treatment. Once you are not a member then you can only depend on the sales of available crops in your field and animals. One can come back home from the hospital sell chicken, goat or grains. We have been raised in such a way that we have always to keep small livestock as insurances.

Regardless of working on the farm I also sell fat cakes around my house every evening. Part of money gained by selling of fat cakes is contributed to the group. For example if it happens that on a day I managed say to sell about two thousand shillings, I will spend one thousand shillings for my contribution to the groups and the one thousands remaining is used as a capital for business for the next day.

I inherited a small piece of land from parents in which I am farming maize, wheat, and potatoes. The crops I am farming are enough to make me self-sufficient with food for the whole year. It happens some years of good harvest I get some surplus which I sell out.

I get some money from the sale of the surplus crops but the money obtained had never been spared or saved to help in treatment costs sometimes in the future. It is difficult to keep the money because when I sell crops I have already another social obligation that needs to be covered with the same money. I spent this amount to solve other social demands, I do not think much how I would need to pay when I am sick because I know my group members will be available and cover the cost for me. So I do not think so much about saving for treatment.

In this study it was found that Cost sharing helps to a certain extent for example when the medication in the stock goes down the money collected from the amount patients has contributed can be used to buy the required medications. Sometimes the hospital are facing

the challenge where by the medications needed are not available from the Medical store departments (MSD) therefore they will need to buy the medication from some another supplier, they will have to use the money from the accounts to get the medication supplied as soon as possible.

This money helps to get the supply that is not available in the MSD because the money from the MOH is sent to MSD and the hospitals will order according to their requirements. In ordering the hospital will keep the following criteria.
Analysis of the problem present at that present area, they always work with a list of the 10 commonest infection diseases
There is some medication which is under vertical program such as medication for TB and HIV

The clients will value the services, in old days when the medication and care was provided for free the clients could even throw away the medication prescribed and given by the doctors; however after the introduction of the fee as cost sharing it has reduced this behaviour.

The government has no capacity to build enough hospital to help everyone and put all the equipment and medication that will suffice the entire population, therefore it becomes necessary for the government to put in its input and the community in that place to make their contribution.

The remaining money from the amount that has been obtained from contribution of the patients will be sent to the central government and it will be incorporated in the next coming budget. The money is always available in the hospital, so the money is always available to use in buying more drugs (drug revolving fund)

There are some problems associated with cost sharing policy in terms of fee paid by customers. People who are not aware that they could be attended even when they do not have money to pay they will tend to be scared and will not approach health care services provider and be seen by the doctors
There are initiatives, all the in charge and the head of health centres informs the customers about the exemption and the right to health services.

3.7 Conclusion

From this chapter the following conclusion has been drawn based on the results and discussion here as presented. That income has a positive correction with quality. People with more income will be more willing to pay for better quality. This means that private hospital with her quality than the government hospitals and dispensaries will attract rich because the rich will be able to afford higher price.

People that would go for low cheap price are very likely to go also for poor quality. Their willingness to pay tends to be that of paying for cheap as the quality goes down.

People that are willing to pay for expensive care service also they would like to see higher quality.

Members of the household depend on crops and sale of the animals as their source of money to pay at the hospital as user fee. Therefore in rural area where people depend on subsistence farming and they do no earn much from the selling of crops and animals their ability to pay for health care will be negatively affected.

The effect will be determined by the amount they have gained from sells of crops and livestock. With subsistence farming whereby farmers do not have much surplus to sell then many people will not have no capacity to pay for health care even if they would be willing.
When due to unavoidable circumstances the members of the household do not have savings from selling crops and animal product they will revert into selling the family assets or looking for paying jobs. Therefore selling of assets and labor is an alternative to raising money from the agricultural products.

When the people owe or do not have money to pay their debt at the hospital they will tend to look for other alternatives of care, they will go for spiritual healers and buying medication in the medical store, they will opt for home-based care at last point when the situation has deteriorated they will go to the hospital and explain. The traditions healers were not as popular as the two options.

The availability of the cost effective alternative such as national insurance health Fund, Community based health insurance health fund is not known to many health users. Consumers are not aware of the existence and the importance of the health funds. The same problem was also noted by Hargreaves, Bonell et al. (2007) study realized that people even confused between CBIHF as they thought it was special program with a lot of money and not CBHIF.

There was no correlation between knowing the health fund schemes and willingness to pay. The feeling of people on the willingness to pay for health following the result of knowing the alternative schemes or not was mixed. However people being more aware of the availability of the schemes makes them more willing to join the scheme.

Although many women have showed involvement with the mutual groups, but there was no correlation between the WTP and their involvement with the groups. Most of the mutual groups they operate also as microcredit firms that helps people in achieving their social needs and demand. A person gets support at time of difficult when they need money mostly.

Non-government organization (NGO) have a played a major role in creating awareness among health users. NGO have played an important role in raising the awareness which could be the impact of the decrease of the stigma toward s PLHA

Chapter 4

Alternative to hospital based health care

This chapter will address the alternative to hospital-based health care. The discussion will be based on two research questions.

1. What are the alternatives to hospital-based health care? In responding to this question the alternatives that have been studied in the study are described. The alternatives that were found common practiced includes home based care, traditional doctors and spiritual healers

What is the perception of HIV+ people related to health care and costs?

This research question is addressed with a hypothesis that there will be less willingness to spend on people living with HIV/AIDS and therefore there will be less willingness to take them to hospital.

To be able to understand the process of care and how is organised it was important to address the decision making process at household. The decision making affects the type of care a member of the household should be given. The chapter address the alternatives to hospital based health care and perception on HIV positive patients.

4.1 Decision making

The decision in the household to seek health care is a complex process comprising a number of factors. Decision members of the household will face psychological, economical and medical. The factors will include the recognition of the users on the need for health care, influence by the community norms and cultures, the presence and availability of staffed and equipped health care facility, the perception of quality as perceived by the users of healthcare and the providers, transport infrastructure as means of accessing the facility and cost to the user including fees, opportunity costs and transport. The tables below show a number of

Table 0-1 Time spent in the hospital

N	258
Mean	24.57
Mode	2
Std. Div.	129.944
Minimum	1
Maximum	1800

Table 0-2 Decision making

Who decided to take the patient to the hospital

	Frequency	Percent
Household head	60	30.2
Household spouse	37	18.6
Household head and spouse	76	38.2
The patient	22	11.1
Other	4	2.0
Total	199	100.0

Who decided to take the patient out of the hospital

	Frequency	Percent
Household head	4	1.6
Household spouse	1	0.4
Household head and spouse	5	2.0
The patient	2	0.8
The doctor	233	94.7
Other (Social worker, relatives, HBC)	1	0.4
Total	246	100

The reason for taking the patient from the hospital

	Frequency	Percent
Patient recovered from sickness	195	89.4
The services offered was not satisfying	5	2.3
The patients were not showing signs of improvement	2	0.9
The costs were becoming too big following the daily charged fees	2	0.9
The patient was transferred to a traditional healer	1	0.5
The patient was brought home	13	6.0
Total	218	100.0

decisions that has to be considered at household level that are associated with health care, and also the of process and who makes which decision.
For a period of one year 63% of the respondents used health care services. The percentage of people accessed health care at one point in the year indicates how the demand for is higher in the area. Higher demand shows that the health of the people in the research was poor and therefore raises the demand for health.

Health and health care are the results of the complexity and interacting relationship of household that involve social relationship and authority within members of the household. (2010)

The decision power at household level depends very much on the traditional setup and culture of the society in certain places. Although the Wakinga society in Makete is a patriarchal society the results from this study show decision making process on issues related to health were shared equally between husband and wife. However when speaking to the doctors of Makete district hospital in an interview it was revealed that although the number of women that seek care from the hospital is bigger than that of men, the doctors says women had been seeking permission from their spouse before goes to the hospital. According Nguthi (2008) culture may have no direct link to economic values however it has great consequence in people's lives, their choices and their wellbeing. The power relationship between members of the household affects the access to resources, activities at the household and the outcomes.

The nature of decision making in the society depends very much on the traditional set up of the society. The patriarchal system is responsible for imbalance of power in making decision between male and female. Male dominates the decision making process. Furthermore the general and traditional view that the economy is patriarchal is one of the factor responsible for power imbalances in decision making between the two sexes (Nombo, 2007a).

Women apart of their role as child bearing and rearing children, plays another great role in caring for sick household members. Women participate in the reproductive roles such works in the agricultural or work as wage labourers to supplement the income of the household. Sometimes they are involved in some economic activities such as weaving and petty trading (Balatibat, 2004). Although women take part in many productive activities still the issue of making decisions is vested so much in the hands of men.

For instance when a man is not around home, he has travelled away from home, at the same time if it happens a woman who stayed back at home is sick, the unhealthy woman will not immediately respond by going to the hospital. The delay of going to hospital happens as a result of waiting for their husband to come back home so that they either seek permission before they go to the hospital. Some people do not consider it as asking for permission rather it was described as informing the husband which creates better understanding in the family. They believe that by not waiting to get an approval from the husband it will be being rude and disobedient.

However women will have another reason for delaying seeking hospital care in the absence of their men. Although women would be waiting for their spouses to get permission before they go to the hospital as they consider the welfare of other members of the household. In case the family has young children who would not take care of themselves in the absence of their mother, a woman would take more time before she decide to go to the hospital as they contemplate how the children and husband will be cared on her absence. When the family lacks a grown up girl in it makes woman more hesitant going to the hospital when they are sick.

Despite the fact that most of the household being male headed even though there is small difference between the numbers of decision that were made by the head of the household alone from the decision that were made by both the head of the household and his/her spouse. The decision to take the patient to the hospital bases much on the members of the household. If the willingness to access hospital-based health care was low the low chances f the patient to be brought to the hospital. At the hospital the patient will either be treated as an outpatient and be allowed to go home or will be given bed and admitted. The patients were not much involved in deciding whether they need to be taken to hospital or not. Patients were not consulted whether they would like to be provided other alternative of care instead on behalf of hospital-based care.

Nguthi (2008) says that for resources to be used effectively at household level it should be utilised sustainably. However she recognises the number of factors that can affect the access to resources. The factors which are attached to the household will include the social relations of norms and structures.

When patients are in the hospital there will be three things involved with their care. The doctors and the nurses will be involved in determining the kind and type of treatment. The doctors see the patients and record their progress on their daily basis. The other side is the general care that is involved with food, hygiene and social support of the patient which is mainly left to the women. When there is a member of the household in the hospital regardless of his sex the caretaker will be mostly likely to be a woman, unless there is no woman in the household. The last angle is that which involve cost. The cost will always involve the resources of members of the household. The cost will mostly involve men and the patient in the household. The patients that own assets will be advised to surrender their assets. Otherwise the male members of the household that are remaining back home will either try to borrow or find a pay job to raise the amount equal to the amount required.

When the patient is taken to the hospital the members of the house will not be able to involve themselves with the decision on when should the patient be taken either home or to another different type of care. Many times the members of the household will wait for a permission from the doctors to allow the patient to be taken home. The doctor may decide the patient to be kept in the hospital as much as pleases the doctor. Even at time when the members of the household consider to take the patient for other alternatives to care like the spiritual or traditional healing they will not tell the truth to the doctor. The relative of the patients they will not tell the truth to the doctor to avoid disappointing the doctor.
In Makete patients do not demand for what they think is the best treatment for them, most of the time they accept what the doctors tell or give. Therefore there is no conflict of interest between patients and the doctor's prescription.

There are few patients that can ask what kind of care or treatment they would like to be given and most of them are health workers. However the practitioner thinks that it is the doctors who know better what it suits which condition and symptoms. Patients can only tell symptoms and cannot tell what the cause is, and the treatment goes with causes and not symptoms only, therefore the doctor only will be able to match symptoms, cause of the treatment. The doctors say that they act according to their professional standard and they take the history and later on do a confirmatory test in the laboratory.

Case 5: Zaina

I was born in Ndulamo in a family of six children with five of us sharing a mother and one brother was from another woman somewhere in town and my father brought him to stay with us. He was his son so my mother has to care for him as his son too. I am a fourth child by birth to twenty three years this year.

My father was a timber maker so he was travelling a lot to look for jobs in big forest in distant places. He used to go to Songea to make timber. Some time when I was still young he came back from Songea sick. He was sick for about two years. My mother and everyone in the family were involved in taking care of him.

My mother and uncles struggled to help my father by bringing him to the hospital. They sent him to the hospital several times, they could bring him back home after some relief then after sometimes he would be sick again and they would bring him back to the hospital again.

We used to send him to Makete district hospital. We could not afford the cost of sending him to good private or mission hospital. My father did not keep any animal at home which we could be sold for his treatment. It was difficult to get him proper and good treatment. He later on died.

We started new life to live with our mother who was a widow by then. After one year some illness caught my mother, she was sick for nine months. She later on died after being admitted and treated in Makete district hospital without success.

After the funeral ceremony my elder brother who was jobless travelled to distant towns to look for a job and I hear he still has no jobs to this day. Another sister who was older than I went to a nearby town and found a job as housemaid. I was left to stay with the other two young sisters.

I was still young, seventeen years old; my sister who was working as housemaid sometimes was able to support me with some money from her wages which was also very small and could not help much. The responsibility of taking care of my two siblings was placed on my shoulders. We had a very poor house built from trees and roofed by grasses.

I had already stopped going to school before my father died. I was already a school drop out for some years even before my parents died. I dropped out of school because I was the only child who could support my parents when they were sick with care. When my father was sick my mother would stay with him in the hospital and I would stay with my sibling cook and look after them at home. Also I was responsible for supplying her and my father with food from home.

Later on when my father died and my mother started to be ill. I had to take care of my mother in time of her sickness. I was responsible for ensuring that she is being taken to hospital, treated, eat and then she is given all other important requirements for a sick person. I was not able to afford all the required care needed with my mother.

Our sister who was working as housemaid to a far away town did not take much time since the death of our parents, she found herself a man and they got married. She was married in Usalule a village in another district from the district my village is. I was now like a mother to

my two young sisters.

I thought of going back to school. From the assistance of government funding, I was enrolled in adult education program. My two younger sisters were enrolled in primary school.

As I was leaving with young sisters, one young man I do not even understand how he managed to convince me to be his lover agreed with him. We became lovers and after sometimes fall pregnant and had a baby Victor with him.

He did not want to get married but after realizing that I was pregnant I moved to his place by force. After moving in he ran away and he had never been back in the village since that day. I have two children who depend on me, victor who is 3 years old and Fikiria who is eight months old.

During the time of the pregnancy of the second baby I became sick twice. Both times I was sick I was admitted twice and delivered my baby by a Caesarean operation. Normal treatment a patient has to pay some fee, since I was admitted to the government hospital caesarean operation service is given for free of charge.

When I was sick the first time my mother in-law had to get a loan from a neighbor. She got a loan of ten thousands shillings which later on she has to carry timber from people to pay back the loan. When I was sick the second time one of my brothers took a loan again to his friends for about seven thousand. He gave the money to my mother in-law we used the money in the hospital. When I came home from the hospital after I was discharged I was told that my brother got temporary job to make timber of a certain person in a village to get money to pay back the loan.

Since Victor has been born I have been in the hospital with him once and I was also in the hospital with Fikiri once. Victor is four now but been admitted in the hospital with him once when he was two years old.

Recently I was admitted in the hospital again because this time Fikiri was sick. Fortunately there is no fee we to pay for children in the government hospital, all the treatment for the children is free.

Life is very hard to go ahead alone, so I joined church oriented women's group. We give contribution and give the money in turn to each other. I use the money raised from this group in buying food, soap, and cooking oil. We meet on weekly basis, we are ten women so when we meet on weekend each of us brings one thousand and we collect the money amounting to ten thousands and we give this money to one of the group members.

But I am also a member of another group that we make contribution of five hundred shillings whenever one member of the group is sick. We also give her food that has been also raised from our contribution and we give it to her in the hospital. When I was admitted to the hospital from my caesarean operation they raised food and money from the contribution of the members and came to see me. So when I was in the hospital I did not suffer from lack of food, but the story could have been different if was not a member of the group. I think it would have been very difficult to get all the food and money enough to support me the time when I was sick in the hospital.

After being discharged from the hospital I came back home and went back to my daily life. In my daily basis I carry sand from the river to the village where people are building houses. In the village I can notice the houses which are in construction. I approach the people who are

building or the owner of the house and ask if they are in need of sand and if I can do the job of supplying them with sand. I carry more than twenty five kilograms of sand on my head and walk a distance of not less than two kilometres.

I also carry timber from the forest where timber making business is going on in the village or nearby the road for easy loading in the vehicles that takes them to towns for marketing.

When the season for farming reaches I work for people in their farms for a pay. I have a piece of land but it is somehow difficult to work on it. I fail to get enough harvest because the soil of this place is not very well and therefore I need to have fertilizers to make it productive. The fertilizers are expensive to afford as results I do not apply fertilizers ending up with less harvest. It has never happened to have enough food for myself and my children, therefore I do not expect to have surplus to sell in case I need money say for example for treatment cost.

I can be willing to pay around four thousand shilling for treatment in the hospital which I can get by carrying sand for two days. But when the cost goes beyond four thousand I will not be in a position to afford.

4.2 Home-based care

Apart from the formal health care services that are provided in Makete district, people also seek for another alternative for care. The other alternatives for care which were considered in this study include home-based care, traditional healers, buying medication from medical shop, and self prescription, seeking care from spiritual healers. According to (Msuya et al., 2007) the financial situation makes people to be forced to seek for another alternative to care.

Table 0-3 Situation on HIV Positive person when sick

	Frequency	Percent
Keep the patient home	14	3.9
Bring the patient to the hospital	339	94.2
Take the patient to the traditional healer	4	1.1
Preferred not to answer this question	3	0.8
Total	360	100.0

Several researchers (Fofana, 2010, Niehof et al., 2010, Nguthi, 2008) agree with the fact that stigma on PLHA will results into discrimination, violence and rejection of PLHA. Due to stigma the rate of silence, denial is fuelled and that will put many people into risk of being infected by the virus. Stigma will cause more risk to people as the effort for prevention and care will be undermined and not taken into consideration. Furthermore the seropositive people that do not know their HIV status will delay to get tested. People delays to get tested as they contemplate how they will face the fact if test HIV positive. By being HIV positive at

the same time not knowing their status make them easy to infect other people by engaging in non-protective sexual practice. People Living with HIV/AIDS are stigmatised due to the normal faith that have been preached by many years of AIDS's virus existence that people with HIV and AIDS are adultery, those who engaged in extramarital affairs, prostitution and commercial sex. People that have been suspected or believed to have been practising prostitution are the more stigmatised. The belief reduces the willingness of many people come forward for a test. Those who tested positive were not willing to let it be known that they are living with the virus as they were scared their families will no longer take care of them and be left to die (case2). Furthermore stigma builds fear into people to a point that they could not register for treatment and be enrolled for ART program. But stigma is due to the poor knowledge of people on proper precaution on how they should take care of PLHA with AIDS.

Case 6: PLHA and Stigma the Case of Manusa and her nice

The time I came to know that my aunt was sick with AIDS I was so much disappointed, worried and despaired. I was in that in tormented situation because I reflected all the care I have provided to her without proper protection and saw the risk of infection so close. I washed her and her clothes with bare hands without gloves. I could not take all the precautions because I had believed my aunt was sick with cancer as she used to tell all of us in the family except this one day.

Manusa was living in town for many years until when she came back home sick about seven years ago. When she came back home in the village to live with her old mother she told everyone that she was sick with cancer. Cancer was not very well known in the village therefore it had very little stigma associated with it. People had no knowledge on how the cancer is transmitted, how to care for the patient and even treatment. Therefore Pamela being the old daughter with family had to be responsible for the care of the patient including taking her to the hospital, cooking for her and washing her clothes. Pamela was doing all these works including bathing and washing her aunt's clothes including her underwear without gloves. The washing of her underwear was more difficult because Manusa had a problem with breeding constantly. It was this day when Manusa broke the news to her niece Pamela that apart from being cancerous sick she had AIDS too. Although she was able to disclose to Pamela her HIV status yet Manusa warned Pamela not to tell anyone whether relatives in the

household or not. Manusa told Pamela that if she would have told people in the relatives about her HIV positive status she would be left without care to die as everyone would be scared of acquiring the infection from her. After receiving the news Pamela was upset terribly, she said she cried for number of days. Pamela was upset because she saw herself being infected and all other members of the family were vulnerable of infection.

Stigma has been brought down to a bigger extent and people were more free to come out openly and declare the positive status. The development and success of bringing down stigma in this society were the result of combination of factors. There has been a big campaign on helping people who live with HIV to recognise and accept their status. The activities were mainly done by many NGO that had been operating in the district including SUMASESU, MASUPHA and PIUMA. The last two NGOs are PLHA members oriented whose after testing positive and coming together into groups they started working as volunteers in teaching other people and members of the society about HIV. People with HIV have been good teacher as they teach others from what they have learned in group counselling and what they have acquired from the experience of living with HIV/AIDS. Also the presence of four VCT in the area and two and CTC made it possible to create awareness among the members of the society.

4.3 Non-Governmental Organization

A number of NGOs and faith based organisation were established to help in handling the problem of health care. The organisation trained people who can provide health care support at home household level. During the time of research there was more than 50 registered NGO working in Makete district. Even though respondents mentioned SUMASESU, PIUMA, TUNAJALI, MASUPHA and TAHEA as organisation which at one point in time they helped providing them with care at home and other support. Some NGO such as PIUMA and MASUPHA are membership oriented while SUMASESU and TAHEA are not members oriented. However all together they work on health care and prevention. All the NGOs are involved with HIV/AIDS and the effects that resulted from HIV/AIDS.

The organisations find volunteers that are willing to provide care to the patients at home. Then the volunteers are trained following the government authorised training manual and by the government trained and authorised trainers. When volunteers have completed their trainings, they will be supplied with necessary equipment like medication, gloves and

bandages. The HBC providers come from different villages and different neighbourhood in the villages. They will identify the patients and people that need to be to be provided with care. The routine visit is made by the care provider volunteer in the household with sick people.

During the visits the health care volunteer will help the patients with eating when the patient is bedridden, the care provider will help the patient with sanitation and hygiene at home of the patients, will take care of the dietary needs, he will help the patient with taking of drugs. Furthermore one of the patient's relative will be identified to be trained with basic principle but important for taking care of the patients at home.

There are sometimes when the patients and the relatives of the patients will be hesitating from taking the patient to the hospital. Sometimes the hesitation may happen because the relatives and the patients considers the patient' condition as life threatening, sometimes because they economise on the money that they will have to pay at the hospital. When the patient's condition has deteriorated to a greater extend in some occasion the relatives have hesitated taking the patient to the hospital after being despaired.

The HBC providers in some occasion take the role of making decision to bring the patient to the hospital. The HBC provider will either make an arrangement for the relatives to bring the patient to the hospital or will make other arrangement such as contacting neighbours and villagers for a help. The intervention is not only from the HBC providers sometimes other close people such as neighbours, local government leaders and church leader have asked the relatives to bring the patient to the hospital.

Apart from the registered nongovernmental organisation in the research area also the there were some FBOs through their different programs such as TUNAJALI and LCCB were providing health care in the area. The entire organisations available in the area were depending on the foreign aid to be able to organise and run their activities.

When the patient has been taken to the hospital and the treated according to how the doctor will feel it suits the patient to be treated. There is little chance of the relative of the patients enquiring on the progress of the patient. The decision whether the patient should be allowed to go home or not will depend very much on the doctor. The relatives of the patient and the

patient had very rare made decisions on their on whether to leave the hospital or not by themselves.

The time spent in the hospital by the patients was ranging from one day for those with occasional sickness to a year for those who were suffering from chronic diseases. Outpatient will be treated on the same day and go home, patients that will reach the hospital and be found that they needed to be seen regularly by the doctor or need intensive care will be admitted. They will spend a number of days in the hospital until when the doctor will see the patient has recovered well.

Patients are taken out of hospital for various reasons. The matters that were considered as reasons for taking the patients out of the hospital included the following, the patient and the patient relative not being satisfied by the quality of the health care provided by the hospital, the patients do not show any signs of improvement, when the cost becomes big due to the increase of fee to be paid as a result of the occupation charges. Some had patients and patients relative had lost a hope that they will be able to recover from the service provided in the hospital.

The tendency of giving up is due to a number of reasons such as believing that the disease they are suffering cannot be treated in the hospital except by tradition doctors. By so doing they will take the patient out of the hospital and bring the patient either home or to another place that provide another type of care such as to the traditions healers.

Taking the patients from the hospital either for whatever reason, be it to seek care from another institution, to be cared at home, or any other alternatives for care as such as spiritual and tradition healers services the decision will have to be made by the doctors. The decision to discharge patients that have been admitted is entrusted in the hands of doctors.

4.4 Traditions healers

The health of the general population was not good as reflected in the results that 63% of the respondents needed health care used health care services within a period of the past 12 months. This means that demand for health care was big. Because the demand for care was high other means and alternative of health care apart from the hospital emerges. People take

an alternative to seek care from the traditional healers that are available in the area. The traditional healers help people in area where people think that they cannot get a proper assistance from the hospital. People sometimes believed that there is some sickness which cannot be treated by modern medications in the hospital. There are also some people that that believe that there are some diseases which cannot be diagnosed by modern diagnosing technology available in the hospital.

However many people in the research area were followers of Christianity. Because of that the likelihood of respondents admitting using the traditional care service was very minimal. The probable of not telling the truth with regards with the use of traditional healers was because Christians considers traditions healing practice as sin. People are not very open on the issues related with using of traditions doctors and traditions practices as the practices were considered by many Christians as unacceptable. The researcher has to rephrase the questions to get right answers so that not to ask the direct questions to the respondents. The questions were set in such a way that they were discussing a third party.

The government nullification of traditions doctors' permission of practicing in Tanzania was one of the causes of people to avoid talking and discussing on the role of the traditions healers on treatment. At the time of the research the traditions healing practices were banned by the Tanzanian government. The ban was attached with court law of which if it is not observed it might cost the defaulter imprisonment. The ban was due to the high killing rate of people with albinism which was believed to have been associated with witchcraft practices. It was believed that organs from people with albinism could make a concoction that could make one rich. Since the government could not differentiate between genuine traditional healers and those that were involved in criminal activities of the killing of people with albinism it had to ban all the activities that were related to traditions healing practices. Because of that people were reluctant away from giving information to the researcher. Both the care receiver and the traditions healers as the caregivers were scared to be reliable to court by testifying to researcher that they were practicing tradition healing. However there were a handful amount of respondents who were still appreciating the care given by the traditions healers.

Some patients will come late to the hospital or even not come at all because of wrong belief. Sometimes some patients believe in being bewitched and therefore tend to think that if they come to the hospital they will not get the right treatment. Following misconception the

patient will go to see traditional doctors for treatment. In some areas some people also when have been sick for long time on the same symptoms and problems tends to believe that the problem they have will not be recovered by treatment in the hospital. Also the old generation also has the tendency of looking for their own medications from the herbs.

Same patient is also concerned about the cost that they will have to incur at the hospital and therefore will try to seek help from other alternative before they go to hospital for health care. In so doing they may deteriorate their health.

For example a patient with episositer complication believes that the disease is not treatable at the hospital and therefore it needs local medication from traditional doctors. Sometimes the patients are given herbs that make them to experience diarrhoea by so doing they believe that they are clean dirty blood or kind of dirtiness in the body something which they think they cannot be offered by the hospital-based health care.

When accessed from the WTP people that had an access to traditions doctors showed an impact to WTP.

Table 0-4 The distribution of health care as sought by household members

	Frequency	Percent
Hospital	599	59.8
Traditional Healers	46	4.6
Home-based care (HBC)	39	3.9
All (Hospital, Traditional, HBC)	49	4.9
Others (e.g. Medical shop, spiritual healing)	269	26.8
Total	1002	100
Members used health care	1002	63.4
Members who did not use any health care	579	36.6
Total number of household members	1581	100

From the results in the table above respondents have shown the reason why they would choose each type of health care. People will go to the government hospital because it is cheap and will also access health care at private hospital because of quality. Dispensary and other services such as spiritual healing centre's and medical shops their access will be determined by their distance.

Government hospital attract more patients in the rural area because they have great subsidies from the government and therefore the cost that has to be beared by consumers as out-of pocket fee is relative small compared to that which is charged in the private hospital. The MDH charges lower amounts as compared with the amount charged by the BLH for the same care.

People will go to the private hospital although expensive because of the quality of care that is offered by these facilities. McPake and Normand (2008a) says private hospitals operate as in a model of a simple "free" market and therefore the amount out-of-pocket fee is controlled by demand and supply. In many poor countries the supply factor is not under government regulation. Financing of health system in Tanzania as described in chapter two is British system mixed with private system (Morris et al., 2007). This means the public health care services are financed by the government through tax and there are some other health care facilities that are owned privately or NGO and FBO.

For example the cost for caesarean in Makete government district hospital is provided for free while the same service is charged Tsh. 40,000 (approximately US$ 40) at BLH a church

owned hospital. Apart from paying the fixed amount of Tsh. 40,000 ($ 40) the patient that goes to BLH will have to buy gloves plastic covers to put on bed for lying on during delivery.

According to McPake and Nomarnd (2008a) such a sub system exist in many poor countries and by their existence creates groups of people that have no access to any of these. The out-of-pocket health system can be pictured in many different angles. For example the selling of drugs that are not necessarily to be prescribed exists almost in every country although not always there is a regulation and control by the government.

In this study the results showed that people who used other means of health care such as going to spiritual healers, buying medication from the medical store and using medication from their remains in the house were influenced by distance factor.

Table 0-5 Type of hospital-based health care chosen as compared to the reason for choosing

Type of hospital	The Reason for choosing the type mentioned.			
	Distance	Good quality	Cheap	Total
Government Hospital	38	10	106	154
Private hospital	0	49	0	49
Dispensary	76	22	0	98
Other specify	50	4	6	60
Total	164	85	112	361

There is strong relation between the type of the health facility people choose and the reason for choosing it with (chi-square of 351.169, df =6, $P < 0.05$).

The amount of people that have access to other means of health care apart from the hospital care becomes big because of lack of knowledge and inability of sharing the cost.
Prata et al., (2004) in their research on women utilization of maternal clinic realised that there were two reason why hospital-based health care were underutilised for mother and child health care programs. They mentioned the two reasons; one, the lack of education among women and people in the community. Because many women have no education and knowledge regarding how the health care works helps they fail to understand and appreciate the meaning of the formal hospital-based health care as well its importance. Poverty was

another reason that was identified as an obstacle toward proper utilisation of health care, poverty makes the ability to pay limited and hence affects the associated willingness to pay.

Table 0-6 what is discussed by members of the household when one member is sick

	Frequency	Percent
Which type of care should be sought	259	72.8
For how long will the patients need care	5	1.4
How much will the care cost	77	21.6
How will the cost relate to care be covered	15	4.2
Total	356	100

4.5 Health status

Self-assessment of health status of members of the household was determined. Some of the respondents reported having poor health status. Health status of the respondents was computer against the trend of people in using or not using hospital-based health care. the respondents with poor health had a number of reason of their poor health status from HIV, Chronic diseases (Cancer, Hypertension, Heart failure, Epileptic, Asthma), gynaecological and women related diseases, obstetric and infant clinics, curable and diseases (malaria, fever, dental, flue)

3.6. HIV/AIDS and stigma

The HIV prevalence rate in the district was between 12-13% (2006)When the prevalence rate from the documents is compared to the 70 people from members of the households involved in the survey that were able to disclose their HIV status it was possible to notice that the HIV the two rates matched. In many studies it shows that people were not free to disclose their status contrary to this study. Many PHLA were free to disclose their HIV positive status. The tendency where many people are free to tell their HIV positive signifies that the rate of stigma is very low. The research suggests the reason that would have made the rate of stigma to go down could either be due to high awareness among the people in the place which could be due to investment in education and training of the inhabitants. The other reasons could be due to the fact that almost everyone in the place has been affected with HIV directly or indirectly and that might have made them to be acquiring the required knowledge and courage to handle and deal with HIV/AIDS. The research would suggest further research on the possible reason to reduced stigma and the tendency of disclosing status for PLHA in the study area. According to Niehof and Price (2008) the way rural community talks about

individuals infected with HIV/AIDS helps in understanding how people view and their perceive HIV/AIDS.

For the patient to benefit from the free service provided by the care and treatment clinic needs to be tested for HIV and be registered in the care and treatment clinic. Unlike BLH, when a HIV positive patient comes to the MDH for other health related care which are not directly provided by the CTC he will be attended for free with a condition that he will have to provide a proof of registration in the clinic by showing a card.

The patient will be seen by a regular doctor on duty at that moment and receive all the medication prescribed. After the treatment the patient will be asked to see the cashier whereby he will provide his CTC card. The cashier will not ask the patient to pay instead he will document the CTC card number for the patient.

The patient with HIV regardless of the clinic of registration they will be treated for free in Makete district hospital. What is always important is the cashier to collect the number of the patient from their CTC card, the cost is then calculated for all patients that have attended treatment in the hospital and who are HIV positive. The bill will then be sent to the ministry of health which in turn will recover the cost incurred.

In the Makete district government hospital all the care services to people living with HIV are free. However the situation is different from that at Bulongwa Lutheran Hospital whereby the patient that is HIV will be asked to pay an amount equalling the type of care he has received. The use of hospital by people living with HIV - AIDS is good, children has gone as far as starting AIDS awareness clubs. People tend to bring PLHA to hospital whenever their health is deteriorating. The cost sharing exemption to the PLHA at MDH has helped in making them use more hospital services.

There are many efforts to ensure that people use health care hospital-based care. When hospital staff goes on mobile services they talk to people about all the insurances and the services provided and therefore there are people who are willing to join health care.

For both hospitals, when a patient comes in the night or a time when there are no staff in the finance department, the treatment and care will be initiated without putting into consideration

whether the patient will be able to pay or not. The nurses with clinical officer in charge at that particular time will see the patient and offer the treatment accordingly. What is important is to see the situation of the patient.

3.7 Conclusion

A household is an important unit studying behaviours and trends in the community. Many organised activities such as income generating activities are organised at household level. The resources collected are also dispersed and utilised at the same level. Every day a patient spends in the Bulongwa Lutheran hospital will cost Tsh 300- as occupation fee. There is no occupation fees charged at Makete district hospital. The cost was not a primary factor for household members to take their patients out of the hospital.

Apart from the hospital-based health care provided in the study area there were other alternative health care available of which the inhabitants of Makete district were able to choose and access. The alternatives to hospital-based health care includes traditional healers, home-based care, medical shops and spiritual healers.

The hospital-based health care was more favoured and more used by the respondents followed by other means which included the buying of medication from the nearby medical shop and visiting the spiritual healers.

Traditions healers provides another alternative to health care when members of the household owes the hospital. Traditional healers had an impact on which is significant to willingness to pay. People that have an access to traditions healers would have less willingness to pay for the hospital-based health care.

Who should be regarded as HBC provider was a contradicting phenomenon. In the research area people that have been trained by various organisations to assist patient at home were called the HBC service providers or volunteers. However the care that is provided by the relative, family members, household members and neighbours was not regarded as home-based care. This research took the definition of the home-based care as the care that is given at home and therefore it found that home-based care was very important as alternative to hospital-based care. Most of the time people have used both the hospital-based and the hospital during the same time frame.

Spiritual healers provide a psychological support. The spiritual help was immediately available when sought by consumers and therefore reduced the inconvenience to the needy.

Although the literature says the decision at household level in many patriarchal societies is gender biased i.e. all the decisions are left to be handled by male partners, but in this study the trend was not the same the decision were done by both the head of the household and the spouse. The decision on health issues involved both women and men; there have been cooperation between women and men in making decision. The important decisions to be taken among others comprised what type of health care should be given to sick member of the household, and how much will it cost.

People from outside the household have little influence in the household in determining issue that are concerned with health care. Trained home-based care providers as well as relatives and neighbours have little interference on what kind of care should be provided and the way it should be offered. Nongovernmental organisation had little interferences in decision making too but their assistance in helping people seek and access hospital-based health was highly appreciated.

The hospital-based health care remains the main health care that is trusted and depended on by people in the rural area.

Care services such as spiritual healing or buying medication from nearby medication shops, has greater contribution in the care package. The spiritual healing, buying drugs from the medical store act as an immediate alternative to hospital-based health care,

Following the limited resources available to people living in the rural areas the government health hospital-based health care services is an ideal services for the people that are living in the village rural area.

People are more concerned with what type of care should be given to sick members of the household rather than the cost involved.

Stigma hinders people from utilizing the available health care services such as the preventive care, VCT and CTC. There are a number of possibilities that the patient can be helped in

covering their cost as related to treatment. People living with HIV that are registered under CTC, pregnant women and the children of less than 5 years old are exempted from paying the related cost. There has been no arrangement between the hospitals and the mutual groups. That is there is no mutual group that has come into agreement with the hospital in such a way that they will bring their patient and the patient should not be charged instead the group will cover all the costs after treatments.

The doctors helps the patients t control the cost by matching the diagnosis with the most affordable drug to treat the patient.

3.8 Recommendation

Need to identify a proper and right definition for the home-based care and the people that provide the home-based care at home should be recognisable and appreciated. By not being able to identify and make and the right definition understood by people at the grass root will make people fail to benefit from the service. The providers will be ignored from being trained and equipped and the patients will not recognise the care the providers could offer.

Education for people at household level on how to help patients especially those with chronic diseases or HIV/AIDS should be given.

Further study has to be sought to see if people that access spiritual help replace the hospital-based health care for the spiritual help.

Chapter 5

Conclusion and recommendations

5.1 Conclusion

People in the village gain their income from the farm works. From the farm produce people do sell crops, animal and animal products. The gains obtained from these selling are used for paying for health bills and other social obligation.

The women whether they are the spouse of the head of the household or they are the old enough they will be responsible for home activities like cooking, cleanness and care of small children and sick people in the household.

Whether men are the head of the household or they are the sons at home without fathers they will find themselves subjected into making decisions in all the matters that are facing the household including supplying the family with daily needs and also deciding what and how sick people should be cared for.

The health insurance fund was appreciated by people that are enrolled and use it. The members of the national health insurance fund are governmental employees. The insurance fund has failed to attract people that are not employed by the government to buy the premium. People in the villages have no knowledge regarding with the Insurance.

The concept of insurance is not well understood by health care users in the community
More awareness is needed to be created and sensitization programs need to be initiated
A good study need to be conducted to determine how much will people be willing to buy the premium so as to avoid the possibility of people choosing to pay user fees as compared to higher premium price. If the government will set higher membership fee it will act as a block towards enrolment to the Community based health insurance fund.

Staff attitude towards patients, the quality of the service provided and medication availability in the hospitals affect the willingness of people in sharing the cost. Number of items were identified as contribution to the low quality as seen from the eyes of patients, lack of drugs in the hospital, lack of qualified staff, lack of essential equipment, lack of proper diagnosis and lack of a proper referral system.

Information on the availability of waiver and how poor people can benefit is not known among the health care users. There is a possibility of those who deserve to fail obtain a waiver because of lack of information.

According to Hargreaves, Bonell et al. (2007) income is the major factor determining people accessing health care as well as from enrolling with CBHIF. Care as well as from enrolling with CBHIF. Whether it is the user fee paid as out of pocket or the buying the premium for any type of insurance the consumer need to have an income that will help him to have enough money to be able to pay for the service. Therefore it is important to understand the importance of income in accessing health care. For the poor inability to pay the membership contribution fee will be an obstacle in joining the CBHIF.

Apart from willingness to access health being affected by income of the household, also the type and kind of health household would like to access will be affected by income too. The decision of the household is affected by income. Members of the household will decide whether they should seek health care or not depending on income and saving they make in the household. People would look for health care which would be more affordable. This means that people will categorise health care according the price and costs involved.

From this study it was found that health costs are divided into two categories, the direct cost and the indirect costs. When consumers at household level consider costs for health care they include both. Therefore the willingness to access hospital-based health care is affected by both direct costs and indirect costs.

There is low motivation and awareness on alternatives to covering health care costs such CBHIF, NHIF, NSSHIF, Mutual groups. The indirect costs are not covered by insurances and other schemes too yet they have great impact on people from accessing health care.

However the alternatives to covering health care costs have no significant impact on willingness to pay for health care.

Formal health insurance covers a very small proportion of health users especially in the rural areas and the people that are enrolled in the program governmental employees, and therefore the schemes are not giving chances to farmers who make up the large population of the villagers.

When health becomes a commodity to be purchased the concept of right for all becomes questionable. When health care becomes a pay service there will be two groups of people that have the access and that have not. There is an issue of inequality between the people who can afford to pay and those who cannot afford.

The government of Tanzania had a good intention and plan to ensure that there is no one is discriminated from health care as per WHO constitution by putting an exemption and weaver program in place, however the program are not implemented by the government officials at lower levels. This makes the many people fail to access hospital-based health care because due to fear of user fees.

5.2 Recommendation

The mutual and women's groups are serving a very vital role in ensuring that people in the rural area received health care as they deserve, the Mutual and women's groups removes the financial obstacle and henceforth people receives their health care. Since the women's groups are playing such a vital role there is need to be assisted so that they should reach many people and work effectively. The groups are very important as they have been helping women with solving the problem of user fees in accessing health care. The mutual groups lack enough capital and skills to organise operate much better to reach many and more people in the rural areas. There should be an assistance t mutual groups to make them more sustainable and functional through number of angles as identifies also by other researchers stewardship (e.g., Regulation and monitoring); creating an enabling environment (e.g., the rule of law); and resource transfer (e.g., Subsidies) (Mladovsky and Mossialos, 2008) empowering of the mutual groups should include enrolling more members for the community. According to De Weerdt et al. (20062006) the government should intervene by assisting the groups to broaden and extend their activities into more development ones, empowering them with skills and ability to mobilize resources and organization.

Giving proper health education and training to people who are providing home-based health care. The education should not only be limited to NBO volunteers but it should be disseminated as far as to family members who most of the times are with patients at home.

There is a guide for home-based care which has been developed by the MHSW. The guideline is used by all NGO that are involved in providing home-based care activities. The guideline tool that has been developed by ministry of health is brought down to community to be used as a tool. There should be initiative to learn the means whereby people from the grassroots organize and conduct a home-based care on household. The home-based care system and procedure should be owned by the people themselves.

Further study is needed to learn the local initiative by the Lutheran church of Tanzania south central diocese in starting a local community based health insurance fund. Lesson on how the fund was organised and run, how it helped people and its pitfall and reason why it did not survive longer should be studied.

People in the rural areas needs to be more informed about health insurance schemes, exemptions and weaver. More awareness should be created among people in the rural areas. People do not have any knowledge regarding with insurance and they also do not know the benefit and advantages of the insurances. Awareness needs to be created so to help people to be able to decide whether they would like to join or not. Information given to people will help users to understand

There are other districts have already organised and worked with CBHIF. The Makete district council has to identify other councils that have been successful in the waiver program and get a time to learn how they organised and run it. This will make sure that the waiver is given to the one who deserve it. Since the decision making for people that have to qualify for the waiver is centred to the community, and the community through its committee has the mandate to decide who qualify and who does not. Then the committees at village and ward level very important. Therefore increase management capacity building to Ward development committees and decision making committees at village level, the committees that are involved in decision making needs to be equipped with technical knowhow and mean to be able to organise and supervise the fund. The district and the Lutheran church to have an independent audit firm that will audit and produce audited report that will be open for public viewing so as to build trust among members of the community that are buying the premium. Important area where needs to be effectively organise includes to mobilise, administer, criteria for selection etc.

Further study is needed to see if people who are members are more willing to access health care than the non-members. Also more study if the people who are insurance members have a financial protection.

Ensuring that there is maximum participation from the members of the community and that the members of the community feel owning the program, the increase in the participation of the government official will limit the feeling of owning the project by the members of the community.

To integrate the microcredit banking into the community health insurance fund will help the insurance fund to run sustainably. The interest that will be obtained from the loans will add up to the health insurance fund.

The implementation of the community based health insurance fund should include simple process that will not obstruct people from accessing it. Hence the coordinators of the program need to reduce bureaucracy to the health funds members.

The CBHIF should give great participation and involvement of Villagers and encourage the villagers to give opinion on how the fund should be organised and maintained. They should be more involvement of the local and the indigenous people from the village level, this has also been supported by Dercon, De Weerdt et al. (2006)with a reason that the groups are more strong, they have a list of members already to target, written rules and regulations.

Hospital-based health care users need to be informed regarding with the right to waiver and exemption. They should be educated that they entitled to hospital based health careless of their economical statues and position in the community.

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Appendix I Questionnaire.

The Impact of cost sharing policy on Peoples' ability and willingness to pay for health care services in rural Tanzania

Household number_____ Date of interview_____ Name of respondent/s _____
Village of the respondent _____ Household size _____

A. General socio-demographic information

1. Table 1. General Information

1.A Serial Nr	1.B Name of the household number	1.C Sex Codes Male 1 Female 2	1.D Age	1.E. Marital status Codes Single 1 Married 2 Separated 3 Divorced 4 Widow/ Widower 5	1.F Relation to the house hold head	1.G Educational level	1.H Working status	1.I Professional

1. Table 2. General Information

1.A Serial Nr	1.B Name of the household number	1.J. Health status	1.K Used hospital based care in the past 12 months	1.L Health care accessed	1.M Paid user fee Yes 1 No 2	1.N Source of money	1.M Type of complain / symptoms (Mantion)

Codes for question 1. F

Head	1	Step son/step daughter	6	Sister/brother in-law	11
Wife/ husband	2	Step father/ step mother	7	Nephew/nice	12
Son/Daughter	3	Grand child	8	Uncle/aunt	13
Father/mother	4	Grand parent	9	Cousin	14
Sister/Brother	5	Father/mother in-law	10	Other (specify)	15

Codes for question 1.G

Illiterate	1	Secondary education	3	University	5
Primary education	2	Vocational training	4	Adult education	6
				Others (Specify)	7

Codes for question 1.H

Not applicable	1	employed	3	Unemployed	5
School/studying	2	Self employed	4	Retired	6

Codes for question 1.I

Farmer	1	Private sector employee	3	Business	5
Government employee	2	Faith based	4	Housewife	6
				Other (specify)	7

Codes for question 1.J

Excellent	1	Fair	3	Very Bad	5
Good	2	bad	4	Not Sure	6

Codes for question 1.L

Hospital	1	Home based	3	Others (specify)	5
Traditional healer	2	All	4		

Codes for question 1.N

Saving	1	Selling crop or animal	3	Insurance	5
Selling asset	2	Borrowed	4	Not paid	6

B. Assessment on willingness to pay

2. When sick would you be willing to pay for hospital based health care
    a. Not at all
    b. Sometimes
    c. Yes
    d. Absolutely yes
3. If you are willing to pay how much will you be willing to pay _____
4. If you have to pay what would be the reason to make you pay
    a. Good quality and satisfaction
    b. Cheap price
    c. Feel owning health care
    d. Gives power to demand for more quality
    e. Others_____
5. What is reason will let you not to pay for hospital based health care

Poor Quality, not satisfied with the service as compared to the amount paid	YES	No	Not Sure
Cannot afford too expensive			
I need money for other social obligation			

6. What kind of payment would make you feel easy and cheap to pay for health care
    a. Cash
    b. Assets
    c. Crops
    d. Animals
    e. Other means (mention please) _____

7. If there was no fee to be paid how would you have reacted
    a. Happy
    b. Very happy
    c. Nothing
    d. Not happy
    e. Disappointed

C. Ability to pay

8. How can one be able to use hospital based services without paying (specify)
    _____
9. Do you see fee you pay at the hospital as impediment to use the hospital services
    a. Very much
    b. Much
    c. Neutral
    d. Not much
    e. Not at all
10. What will be done when one household member is sick at time when the family owes the hospital

	Yes	No
a. Not applicable		
b. Go to hospital and explain		
c. I do not care the last debt just go to hospital		
d. Go to another hospital		
e. Seek care at home		
f. Seek help from the traditional healer		
g. Do not go to the hospital at all		
h. Other (specify) _____		

11. When a member of house hold is sick and have no money what would you do

	Yes	No
a. Sell a family asset		
b. Find a pay job		
c. Keep the patient at home		
d. Take the patient to the traditional helear		
e. Take the patient to the spiritual healer		
f. Other (specify) _____		

12. Will you be willing to pay the same amount for the child as the same amount as that is pasid for an adult person
    i. Yes
    ii. No

D. Alternative to reduce cost related to health care

13. Do you know any existing scheme that can help in covering costs related to health care?
    a. Yes
    b. No

c. I am not sure

14. Have you or any member of your family considered any way mentioned below as means to reduce costs related to health care apart from borrowing
    a. No
    b. Joining the community insurance funds
    c. Joining the national health insurance fund
    d. NSSF health insurance fund
    e. Applied for poor patient
    f. Mutual groups (cost sharing groups)
    g. Other mention ……
15. What could be a reason for joining the scheme
    a. The employer
    b. Personal initiatives
    c. Friends and colleagues
    d. Not applicable
16. To what extend do you consider the initiatives to be effective
    a. Not at all
    b. Not much
    c. I do not know
    d. Much
    e. Very much
17. Do you remember if there have been any meeting by the community members or a group pf people in your village to discuss cost related to health care
    a. Not at all
    b. Not sure
    c. Yes
    d. Sometimes back (specify) ……..
18. On average how much did the household earned from various sales (crops and animals) last production year Tsh. _____
19. Please mention the total income received into household from wage employments of each household member in each month.

No	Household member (name)	Hours paid for per day	Amount earned per day/month (Tsh)
Total			

20. Please mention the other income received into the household from the various non-employment sources like pension payments, charity, grants and insurance in the last 12 months. Tsh. ☐

    Total House hold income ☐

E. Household decision to spend on health

21. What is important in discussion of the household members when one member is sick?
    a. Which care should be given
    b. How long will the patient need care
    c. How much will the care cost
    d. How is the cost going to be covered

e. Others (specify)_____

22. How long was the patient kept in the hospital the last member of the house hold to be given care as in-patient at the hospital (Mention the time) _____
23. What was the reason to bring the patient home?
    a. S/he recovered from sickness
    b. S/he was not getting satisfactory services
    c. S/he did not show any sign of improvement
    d. The cost was becoming too big following the daily charged fees
    e. S/he was shifted to a traditional healer
    f. S/he was brought home
24. Who decided to take the patients to the hospital
    a. Household head,
    b. Household spouse
    c. Household head and spouse
    d. The patient
    e. Doctor
    f. All
    g. Others (state)…….
25. Who decided to bring the patient home from the hospital
    a. Household head,
    b. Household spouse
    c. Household head and spouse
    d. Sick person
    e. Doctor
    f. All
    g. Others (specify) _____
26. What do people do when a member of the household who is HIV positive is sick
    a. Do nothing/keep her/him at home
    b. Bring her/him to the hospital
    c. Bring her/him to the traditional doctor
    d. Prefer not to say
27. When given an option to go for hospital based care which one would you choose
    a. Government hospital
    b. Private hospital
    c. Dispensary
    d. Other (specify) _____
28. Why would you choose the choice you have made above
    a. Close from home
    b. Good quality
    c. Cheap
    d. Other reason (please state)_____