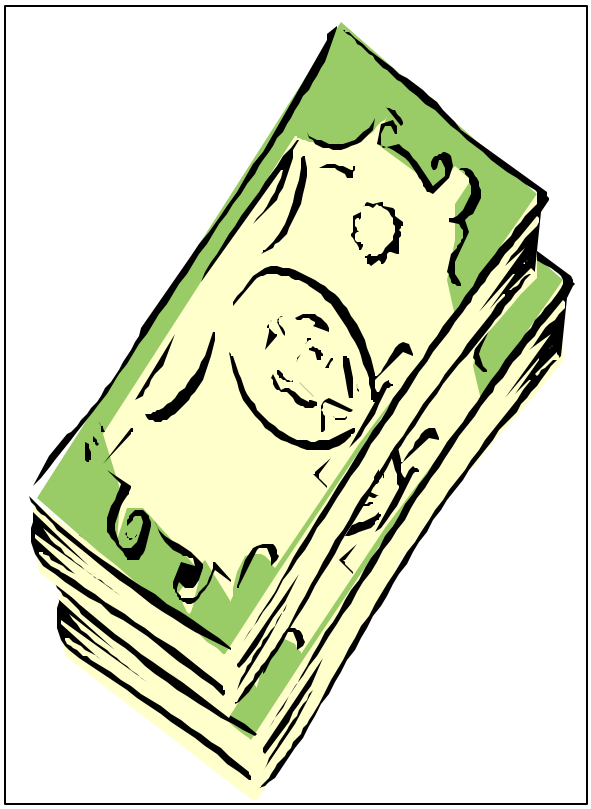
"We are still paying…"

A study on factors affecting the implementation of the exemptions policy in Ghana



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CHAPTER ONE: INTRODUCTION

Global Context

In the late 1970s the Word Bank began collaborative work with the WHO and governments of developed and developing nations in the late 1970s, to endorse the Primary Health Care Approach as a consumer-centred, participatory and equity approach to health care. In the early 1980's the World Bank advocated, among other economic policies, Structural Adjustment Programmes (SAPs) and pushed for cost recovery or user financed oriented health services (World Bank, 1987).

The user fee system has since become widely accepted and is a prioritised health financing policy in many countries. The system is viewed as a means of ensuring better incentives and improvement in the quality, efficiency and equity of health services (Goodman & Waddington, 1993). By direct implication, the establishment of equity in fees involves a critical targeting of the poor and the provision of subsidised or free care to this group. Despite the rapid implementation of the user fees globally since the 1980s, few countries have developed clear policies on fee equity. There is very little information on the critical processes involved in targeting and supporting the poor and on other factors that improve the effectiveness of the user fee system by ensuring equity and quality of health care provision. Within the context of developing and poor countries, these issues have been linked to declining health budgets arising from the global economic recession in the 1980s against the backdrop of an upsurge in population growth.

Ghana is one of the few countries with experience in implementing a national health exemption policy as a mechanism of addressing inequity in health care.

Ghana Context

A hospital fee system has been in operation in Ghana since pre-independence when the first colonial hospital was built in 1868 (Dakpallah,1988). Although a commission on health within the newly established Ministry of Health recommended a free health system in 1951, the pre-independence fee system still operated at independence in 1957. Between 1960 and 1969 hospital visits incurred a flat charge of 20 pence (The Ghanaian Pound was then at par with the Sterling). In 1969 the first attempts were made to introduce cost recovery in the health system (as well as the education system) (Dakpallah, 1988). A health system evaluation committee, the Konotey-Ahulu Committee, recommended full cost recovery as a means of improving the health system. For a number of reasons, chief among which was a fear of political and social upheaval, the cost recovery recommendation was not implemented. By 1980 funds targeted at diverse services had dwindled or were non-existent and the health system had experienced marked deterioration.

A unilateral action by the health providers under the guise of the Hospital Welfare Funds (HWF) led to the establishment of increased fees at health facilities. The HWF was unregulated and fees varied between facilities. These changes in the fee system faced no overt challenges however, firstly because the cost of living at the time was moderate, but also because for the majority of users fee increases were acceptable as long as this translated into improved quality and accessibility of health services.

In 1981 the Ghana Medical Association advocated the introduction of user charges as a means of sustaining the health services. While this was accepted in principle at policy level, implementation could not take place due to the ousting of the government by the 1981 coup. The PNDC in 1983 issued a Legislative Instrument (LI 1277) on hospital fee regulation as an interim measure towards introducing hospital user fees. During this period the hospital fee was raised from 0.5 cedis (50 pesewas) per visit to between 5 and 20 cedis per visit.

In July 1985, the LI1313 (The New Hospital Fees Regulation) was established which instituted a range of user fees. Subsumed within this regulation was an exemption clause targeted at selected user groups, diseases and at healthcare professionals. Whole or partial exemption from user fee payment was targeted first at the poor and those unable to pay fees, but also at selected service user sub-groups which included psychiatric patients, lepers, malnourished children and pregnant women. Specific diseases of public health concern such as TB, Yaws and Cholera (see appendix 1) also fell under the exempt category. Finally, health staff and their immediate family (limited to spouse and up to and including four children) were also exempted from user fees. In subsequent years the target groups and conditions requiring exemptions have been broadened through policy changes made in response to critical emerging issues in healthcare. Groups added to the list of the exempted are the under five-year-olds and the aged, while conditions added are snakebite, rabies and buruli ulcer.

Introduction of the exemption Policy

The exemption policy was introduced primarily because the government realised that a rigid imposition of user fees would affect healthcare access for many and particularly the poor and certain vulnerable groups in the society. This concern was somewhat validated by the 50% drop in out patient attendance at the Korle-Bu teaching hospital in the introductory year of user fee payment. During this period there was parallel commitment to reduce the threat of communicable diseases and overall mortality in the country.

Funding for exemptions

Funding for exemptions is sourced from the consolidated fund and is provided in two main ways. First there is a general budget ceiling provided for each BMC targeted at all activities of the BMC including exemption of user fees for paupers, disease categories and for Health providers. Amounts allocated for exemption activities are determined by the head of each BMC.

Secondly, there is an allocation of "earmarked funds" for the aged, the under fives and for antenatal care which is specific to each region and is distributed to the various regional BMCs based on relative and prioritised emphasis. The amounts allocated for this source of funding are usually fixed.

To date the estimated amount required per annum to cover the exemption categories (the aged, antenatal and under five year olds) is about forty-four billion cedis (¢44,000,000,000), an amount that strains the country's health and economic budget. In 1999, for example, the government could only provide 22% of this amount (Coleman, Larbi & Dakpallah, 2000).

1.1 Rationale for the study

Although the Government of Ghana has enacted the exemption policy the extent to which targeted groups have gained access to health services is unclear.
In 1995 a study was conducted to examine the impact of user charges on health services utilisation (Adjei and Aryee, 1995). The aim of the study was to establish criteria by which the poor could be identified and categorised and also determine the levels at which exemptions were required. The researchers also focused on the issue of decision-making by beneficiaries. Although this study focused on critical issues impacting on effective implementation of the exemption policy it yielded few definitive answers.

Problem Statement and Analysis

There is some consensus that the exemption mechanism is often abused. There is also under coverage of the system, resulting in members of exempted groups often paying fees when they should not. Generally there is a clear indication that the implementation of the exemption policy of the Ministry of Health is not uniform both within and between regions and districts. Several factors have contributed to non-uniformity in service coverage. These include:

- difficulties in identifying the poor;

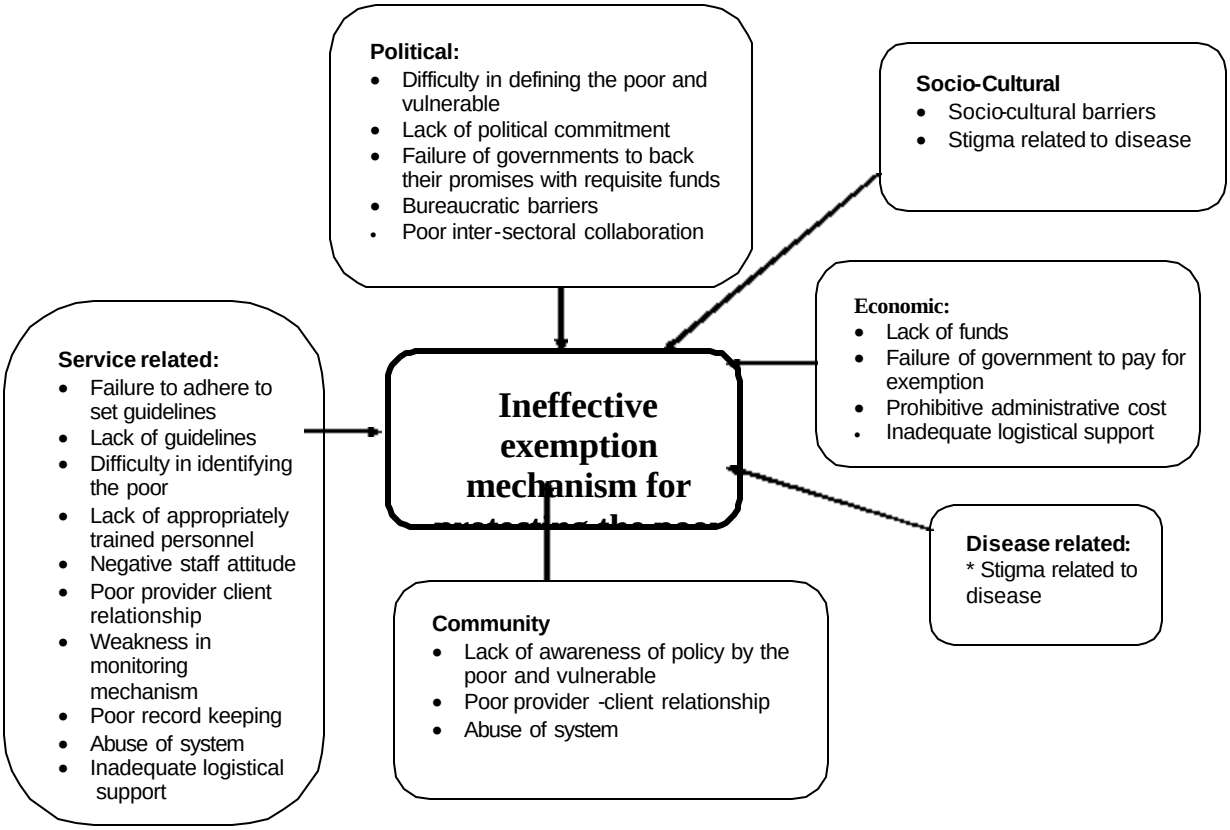
- problems with flow of funds for exemptions;
- excessive administrative barriers;
- failure to adhere to set guidelines;
- socio-cultural barriers;
- negative staff attitudes; and
- lack of awareness of the policy by beneficiaries and possibly some health providers.

(See Figure 1 for a problem analysis diagram)

An independent review of the Ministry of Health's 1998 health sector 5 year Program of Work (POW), concluded that there was a need for carefully designed policy oriented studies focusing on the implementation of the exemption policy to determine its effectiveness.

This study examined factors affecting effective implementation of the exemption policy. The study formed part of a larger four-part study, which examined various aspects of health inequalities in the country. The first study examined the exemptions policies, estimating the cost of exemptions and the implications on access to health care. The second study engaged in a 'mapping' of health inequalities through a community-centred examination of factors hindering access to and utilisation of health services (Agyeman-Amekudzi, 2000). This study focused on health seeking behaviour and on methods of improving service delivery through the use of the Participatory Rapid Appraisal (PRA) method. [The fourth study mapped out inequalities in health service access in the country based on secondary data analysis (Bosu, 2000).

Figure 1: Problem Analysis Diagram



CHAPTER TWO: OBJECTIVES

2.1 Main Objectives

The general objective of the study was to determine the factors that mitigate the effective implementation of exemption policy of the Ministry of Health and to make recommendations for effective implementation. Subsumed within this were a number of specific objectives.

2.2 Specific Objectives

The specific objectives were:

To identify and describe different cost sharing mechanisms at the different levels of the health delivery system.

To determine awareness of the exemption policy among health providers and users.

To describe the structures, mechanisms and procedures for the implementation of the exemption policy by health managers and providers in all ten regions.

To outline existing management and administrative practices that played a direct role in the implementation of the exemption policy.

To determine the strengths and weakness in the implementation of the exemption policy.

To determine the characteristics of beneficiaries of exemptions at the health facility level.

To make recommendations to policy makers, health managers, and providers as well communities on the effective implementation of the policy

CHAPTER THREE: METHODOLOGY

3.1 Preliminary work

Consensus building meeting
A two-day consensus-building meeting was held in Kumasi with three representatives from each of the ten regions. Each of the three member teams had been engaged in an examination of health inequalities in their respective regions prior to the meeting. The objective of the meeting was to review the exemption proposal that had been developed by the national team and to solicit the input of the various regions. It aimed also to ensure that regional concerns regarding the exemption policy were included and addressed in the proposed study.
A presentation of the study proposal was made after which the group worked on modifications. Areas of the proposal modified included the objectives, the dynamics of the sample population, and data collection techniques and instruments. These modifications formed the basis of a revised final proposal that informed this study.

Training and pre-testing
A four-day meeting was held in Ho as a follow-up to the consensus-building meeting. Fifty participants, made up of five representatives from each region, attended this meeting. This included the team that attended the consensus-building meeting. The objective of the meeting was to:

- Review the data collection tools.
- Pre-test the tools to ensure their adequacy in gathering the relevant data.
- Finalise the tools after pre-test, and
- Prepare the work plan and time schedule for fieldwork.

Pre-testing
With the collaborative support of the Volta Regional Health Administration eight prototype institutions were selected as pre-test sites. The results from fieldwork carried out in these sites were incorporated into a modification and finalisation of the data collection instruments.

3.2 Study Design
The design of the study was exploratory and cross-sectional and employed both qualitative and quantitative methods.

3.3 Sampling
The study was conducted in all the ten regions of the Country. In each region, the Regional Health Administration was selected as a study site.

In each region, two districts were purposively selected for the inequality study. The criterion for selection was based on the level of performance in delivering the expanded program on immunisation. The best and the worst performing districts in each region were selected.

The reason for selecting districts from the same region was to link community perceptions on the exemption policy to actual implementation practices of the health facilities serving the

communities. It was also expected that results from this study would feed into the broader national picture of health inequalities.

In each of the selected districts one District hospital, two Health centres and a private health facility serving the target communities were selected as study sites. A Maternal and Child Health (MCH) Centre or a Community clinic (where an MCH centre did not exist) operating at community level was also selected.

Where no district hospital existed, a Health Centre designated to become a district hospital or a quasi-government facility serving as a district hospital was selected.

In each region, both the District Health Administration and the District Assembly (the local government authority) were also selected as study sites. (The study design is illustrated in Figure 2).

Respondent Sampling

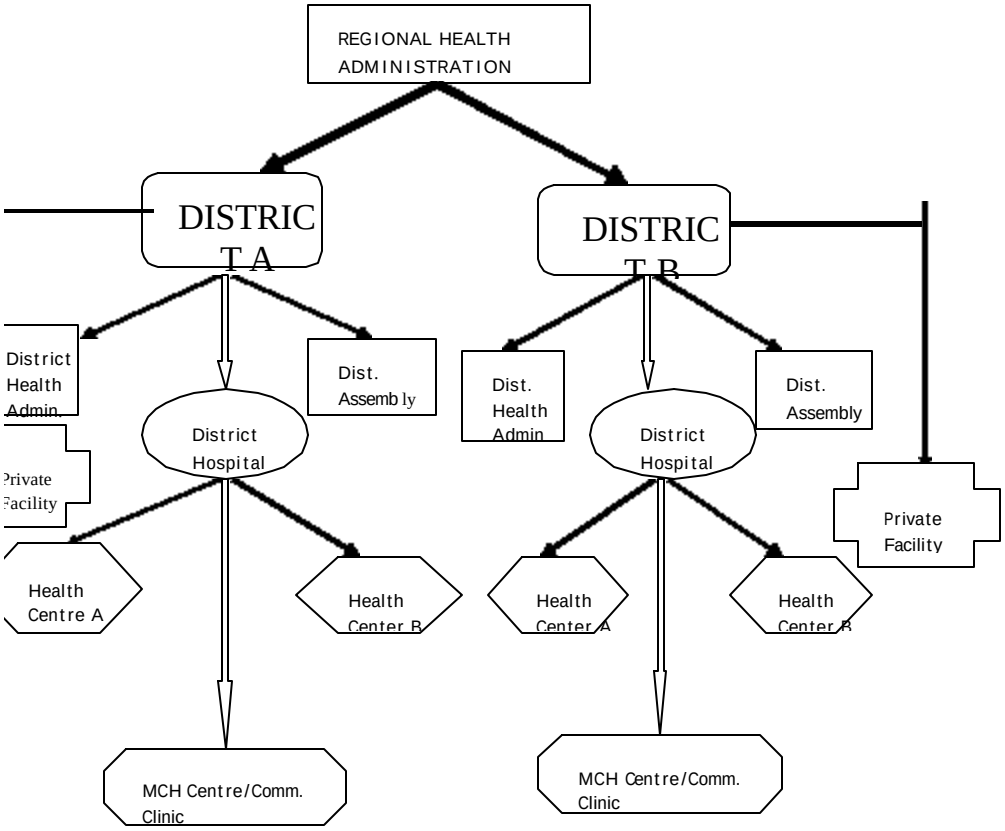
Members of the Regional Health Management Teams RHMTs) and the District Health Management Teams (DHMTs) were interviewed as regional and district participants respectively. In addition, the District Chief Executive, who is the political head of the district, was interviewed. Also recruited and interviewed as study participants were selected staff members of District Hospitals, 2 Health Centres as well as a private health facility serving the participant communities. The in-charges of Maternal and Child Health (MCH) centres or a community clinic also formed part of the health provider participant group.

Healthcare users who fell within the exemption categories were recruited from healthcare facilities and interviewed. The selection criteria per facility was as follows:

- 2 pregnant women attending antenatal clinic
- 2 children under five years
- 2 clients aged 70 and above
- 2 paupers
- 2 patients with specific diseases exempted from user fees e.g. TB, Cholera

Finally, interviews were carried out with 2 patients who had been recently discharged and did not necessarily fall into any of the exemption categories. These interviews were conducted to examine service delivery and the implementation of user fees at inpatient level.

Figure 2: Study Design



3.4 Data collection techniques and tools

Data was collected using both qualitative and quantitative methods.

The qualitative segment of the study included the use of in-depth interviews and focus group discussions. Individual in-depth interviews were carried out with health managers and in-charges, while focus group discussions were held with other health providers at the facility level.

The quantitative part of the study, involved conducting exit interviews with healthcare users who fell within the exempt categories.

In addition to these methods background information was gathered through a review of hospital and health facility records. The areas of review included amounts spent on exemptions as well as amounts reimbursed, the date of last submission of returns for re-imbursement, and a comparison between the number of exempt clients declared on the returns and actual OPD records. Guidelines on exemptions available at the health facility were also evaluated.

3.5 Research Variables

The following variables were investigated to collate the information required:

Variables	Indicators	**Data collection Techniques**	**Data collection Tools**	**Sourc**
Level of Health Service Delivery	• Regional Health Administration • District Health Administration • District Hospital • Health Center	Use of Available Information	Checklist	• M &I • Re • He
*Types of cost-sharing mechanisms in place	• Total Subsidy • User Fees • Community Pre-payment Scheme • Health Insurance Scheme (formal/private) • Rural Health Insurance	• Interviews • In-depth Interviews • FGD's	• Interview guide • FGD guide	• Al • Di • He • Di Ac • Re Admir
*Awareness of Exemption Policy	• Health Workers awareness of exemption policy • Clients Awareness of exemption Policy	*FGD's *Individual In-depth Interviews	*FGD guide *Interview Guide *Exit Interviews	*Heal *Clier

Structures, Mechanisms, & Procedures for Implementation of Exemptions Policy	• Presence or Absence of Structures, Mechanisms, & Procedures for Implementation of Exemptions Policy ♦ Availability of Guidelines on exemptions at Health Facilities ♦ Health Workers in HF with knowledge on Exemption guidelines ♦ Availability of inputs e.g drugs, gloves, syringes etc. ♦ No. of people responsible for deciding on who benefits from exemptions ♦ Duration of time before re-imbursement is made to health facility after submission of returns ♦ Availability of up-to-date exempted patient and financial records. • Proportion of the non-exempt people attending the Health facility who are exempted.	Interviews Individual In-Depth FGD's Observation Use of Available Information	Interview Guide FGD guide Checklist	Health of the Recor Health
Management and administrative practices that support or affect implementation of exemptions policy.	• No of points for payment for services • Who decides on beneficiaries • Communication between in-charges and other staff	Use of Available Information Interviews: Individual In-Depth FGD's	Checklist Intervi ew Guide FGD guide	All lev Distric Health Dist. H Admir Reg. H Admi

Strengths and Weaknesses of the Mechanism for Implementation of Exemptions policy	♦ Response to questions ♦ Health Worker Perception on who should be exempted	Use of Available Information Interview	Checklist	Health Med S Pharm Midwi Reven Hospit Med. A Dispe RDHS RHSA Reg. A DDHS Dist. A
Characteristics of beneficiaries: Age Sex Marital Status Income Educational level Occupation Reason for visiting Health Facility Pregnancy Status	 Age at last birthday Male, Female M, Non-M, W, Div, Household income/mth. Years of comp. Schooling & last grade Farmer, etc ANC, Curative care etc.	Exit Interviews	Questionnaire	Client

CHAPTER FOUR: FINDINGS

4.1 Profile of study sites and respondents

The total number of study sites were twenty (20) district hospitals (including 5 mission hospitals), thirty-seven (37) health centres, nineteen (19) MCH centres/community clinics, and twenty-four (24) private facilities (see Table 1 in Appendix 2 for a distribution of health facilities across regions and districts).

For the qualitative segment of the study, a total number of seven hundred and twenty-three (723) health service providers were interviewed. Table 2 in Appendix 2 presents the profile of health service providers interviewed in various regions by service category and level and by numbers. In addition, 48 focus groups were held with health providers in various institutions across the country.

For the quantitative segment, five hundred and twenty one (521) exit interviews were held with healthcare users across the country. Tables 3, 4 and 5 provide information on the total sample of clients interviewed by region, by type of facility and by exemption category, respectively. Table 6 in Appendix 2 presents a demographic profile of users, which includes sex and age distribution, educational and marital status, religion, occupation and economic status (weekly expenditure).

Table 3: Number of Health service users interviewed by Region

Region	Number
Ashanti	50
Brong Ahafo	46
Central	41
Eastern	48
Greater Accra	54
Northern	65
Upper East	55
Upper West	50
Volta	52
Western	60
TOTAL	521

Table 4: Number of Exit Interviews conducted by type of Facility

Type of facility	Number of facilities visited	Total no of clients interviewed
District hospital	15	259 (50%)
Mission hospital	7	147 (28%)
Health centre	38	56 (11%)
MCH centre/ community clinic	18	59 (11%)
Total	**78**	521 (100%)

Table 5: Distribution of Exit Interviewees by exemption category and admissions

	No./% of Respondents	No./% of Respondents	I
Paupers	5 (3%)	15 (5%)	20 (4%)
Antenatal clients	-	149 (45%)	149 (29%)
Child Welfare Clinic	19 (10%)	20 (6%)	39 (7%)
Under fives curative	61(33%)	64(19%)	125 (38%)
The aged curative	56 (29%)	48 (15%)	104 (32%)
TB patients	26 (14%)	13 (4%)	39 (12%)
Other specific diseases	16 (9%)	12 (4%)	28 (8%)
Admissions	21(11%)	29 (9%)	50 (10%)
Total	**185**	**330**	**521(100%)**

Background of Users interviewed

Age and sex distribution

Out of the total of 521 users interviewed, 185 (36%) were male and 330 (63%) were female. The remaining six excluded from the total tally had missing data in their medical files. More women than men were sampled because of the focus on the antenatal category. The age distribution of the users was as follows:

- Under fives - 31%(n=161)
- Women of childbearing age [15 –44 years] - 40% (n=208)
- Age 70 -19% (n=99) (21 users aged between 60 and 70 were categorised as aged).

Sex and age distribution was fairly even across the regions. In the Upper West and Northern regions, notably, the aged category included those between 60 and 70 years.
The target numbers for women accessing antenatal services and for children aged under-five were achieved. Numbers of aged interviewed feel below the target set for that group. No clients were recruited and interviewed at the private facilities.

Educational status

65% (334) of adult respondents were educated while the remaining 35% (180) of adult respondents had had no education. Approximately 20% (48) of respondents within the educated group had been educated up to JSS or middle school level or JSS education while 0.6% (3) had had university or polytechnic level education.

Economic status

A proportion of respondents had more than two jobs. Approximately 24% (n= 126) were farmers, while 15% (n=82) were traders. 14% (n=77) of respondents were unemployed.
Only 306 (59%) respondents provided information on their weekly expenditure. The median amount spent was ¢14,000; 76% of the respondents spent less than ¢25,000 per week and 96% spend less than ¢50,000. For 37% of respondents weekly expenditure ranged between ¢0 and ¢10,000. Half of the respondents classified as paupers spent less than ¢10,000 per week; one spent over ¢25,000 a week. There was negligible gender difference in weekly expenditure, with almost equal percentages of men and women (75.6% and 75.7%

respectively) spending less than ¢25,000 per week. In terms of amounts allocated for health service payments, respondents visiting hospitals spent more money (28% spent ¢25,000 or more) than those visiting health centers (23% spent ¢25,000 or more) or MCH centers (17% spent ¢25,000 or more).

Parental status

Childbearing age was determined as age 15 and above. Few (17%) respondents older than 15 years of age had no children. The remaining had children. Out of these 41% had 1 – 3 children, and 32% had 4 – 9 children. The maximum number of children recorded for men was 25, while the maximum for women was 12 children.

Religious status

The majority of clients (70%, n=368) were Christians. Moslems made up 18%(n=96) of the respondent group. 8% (n=44) belonged to African traditional religions. There was a greater distribution of Moslems in the Northern and Upper West Regions. Christians were more concentrated in the remaining regions, with the exception of the Upper East Region where a third of respondents belonged to African traditional religions.

Health seeking practices

The majority of respondents (83%) were attending their regular hospitals and health facilities at the time of the interviews. In the case of one particular respondent, a TB patient, up to 60 visits were recorded within the year preceding the interview. The high level of visits was due to attendance for Directly Observed Treatment Short Course (DOTS). Almost all the respondents could afford to pay for their healthcare; only 3%(16) had had to forego health services in the past due to a lack of money.

4.2 Respondents' Level of Awareness Of Exemption Policy

Provider level

With the exception of health providers in the mission health facilities who had poor knowledge of the exemption policy, there was generally a high level of awareness of the policy among the majority of health providers interviewed.

The predominant exemption categories cited by respondents in this group, were the aged, pregnant women and the under fives. With some prompting, other categories such as paupers and patients with specific diseases like TB and cholera were cited. Other respondents cited government workers as another category exempt from user fees. Although there was a high level of awareness of the policy among providers, very little was known about the specific target services aimed at the various exempt user and disease categories.

When probed on specificity of target services covered under the exemption policy, different interpretations of the guidelines were given across and within facilities. In the area of antenatal services, for example, interpretations ranged from exemption from drug payment solely to exemption of payment of all services. A selection of responses from one facility is presented below:

"pregnant women are to be exempt from paying for their card, routine drugs and consultation only"

" pregnant women are to be exempted from laboratory services, consultation and routine drugs only"

"pregnant women are exempted from paying for routine drugs like fersolate, calcium, B co and folic acid only"

In another area, the exemption of payment for various animal bites, responses on exemption guidelines varied between different respondents. Table 7 presents variations in interpretations of treatment guidelines for dog bites and snakebites by different healthcare providers at the same facility.

Table 7: Variations in Interpretation of Guidelines on a treatment category in the same Facility

Respondents	Dog Bites	Snake Bites
Medical Superintendent	No exemption	No exemption
Pharmacist	Exempt	Exempt
Matron	No exemption	No exemption
Accountant	Exempt	Exempt

In some cases a lack of knowledge of exemption guidelines was linked to a general lack of knowledge of the range and specificity of services offered in other departments of a respondent's health facility. A nurse respondent, for example, offered information on services she had a direct or adjunct role in, but could offer no opinion on other services in her facility:

" ….since I am not at the laboratory I can't say much but I know that card , consultation and drugs are free." Nurse

User level

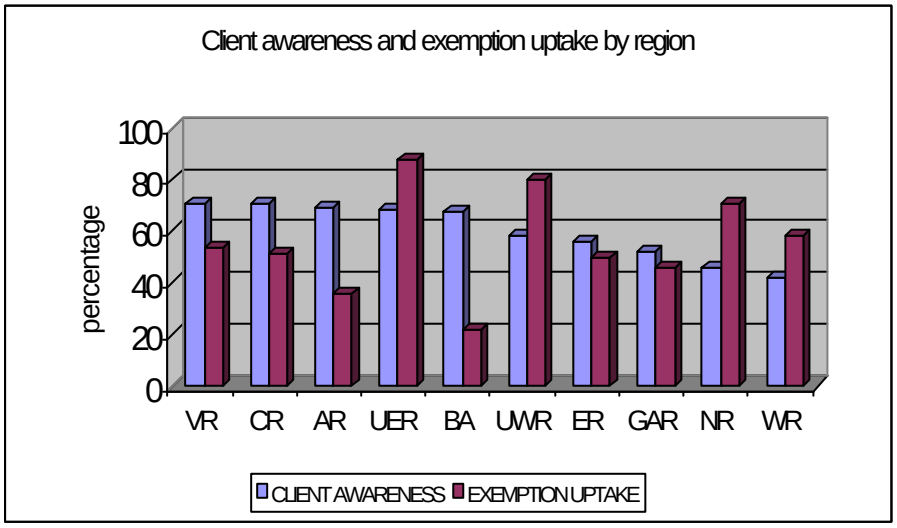
Of the total number of users interviewed, 59% (n=307) had some knowledge of the exemption policy and guidelines, although the level of awareness varied across types of exempt categories. Predominantly cited exempt categories were pregnant women, under-fives and the aged. Table 8 presents a profile of level of awareness across a range of exempt categories.

Table 8. Users' level of awareness of Exemption Categories

Categories	NO (%) AWARE OF CATEGORIES
The aged over 70 years of age	193 (37%)
Pregnant women	160 (31%)
Children under 5 years of age	142 (27%)
TB patients	50 (10%)
The poor	32 (6%)
Leprosy patients	17 (3%)
Buruli Ulcer patients	10 (2%)
Snake bite victims	7 (1%)
Cholera patients	5 (1%)
Children with psychiatric disorders	3 (1%)
Dog bite victims	2 (0%)

Users also cited a range of user categories not covered under the exemption policy. These included the disabled, HIV/AIDS patients, accident and emergency cases, blind people, orphans and relatives of government workers.

Figure 3: User Awareness and Exemption Uptake by Region



Private Health Provider Level

The majority of private providers were aware of the existence of the policy and of some exempt categories, but knowledge was not detailed.

4.3 Respondents' Sources Of Information On Exemptions

Health Providers' Sources

Sources of information on the exemption policy, for the majority of health providers were formal and informal. Formal sources, particularly for senior health staff, included health circulars or proceedings of various regional and district meetings. For junior health staff other formal sources included verbal instructions from superiors, educational meetings and seminars held at their health facilities or information disseminated by the District Director. Informal sources included information circulated among colleagues and media reports. A few respondents cited sessional addresses by the president as an informal source of information.

Users' Sources

Approximately 20% of the total sample of user respondents cited health providers as a major source of information on exemptions. The second most common source of information was family and friends. Generally the range of sources of information cited by respondents included health workers, family members, friends, radio and television progammes, and notices at health facilities. Other sources cited by a minority of respondents included other patients, community announcements, newspapers, assemblymen and the church. Table 9 presents data on the common sources of information cited in order of citation frequency.

Table 9. Users' sources of information on Exemptions

Source of information (N=307)	No. (%) citing source
Health providers	109 (20.4%)
Family	63 (11.7%)
Friend	49 (9.1%)
Radio	42(7.9%)
Notice board in health facility	13(2.4%)
Other patients	21(4%)
TV	6(1.2%)
Newspapers	3(0.6%)

While some clients were aware of their rights of exemption they rarely communicated their knowledge to their health providers. The primary reason given for this lack of communication was a fear of confrontation with health providers, although the health state of the patient at the time of visit also contributed to diminished communication with providers.

District Chief Executive source

District Chief Executives act as district representatives of the government are charged with enacting all government policies at district level. The sources of information within this group of participants were primarily the President's Sessional address and the media.

4.4 Respondents' Perceptions on the Exemptions Policy

Public Health service provider perceptions

The majority of health providers agreed on a need for exemptions. However, perceptions differed on the types of user groups and disease categories that required exemption. For some respondents the selection of exemption targets had to be informed by socio-cultural dynamics:

"Exemptions should be limited only to the aged. Women abuse the exemption policy for under five and pregnant women. They now become pregnant and deliver more often than before. They also come to the health facility even when the situation does not demand it just because they get free treatment." Health provider

"Only under fives should be exempted. The aged have enjoyed the world and have very little or nothing at all to do on this earth again." Health provider

" The exemption for pregnant women should not be encouraged if we do not want a population explosion" Health provider

" Areas should be declared as living below the poverty line And such places should have free medical care." Health provider

For others, financial status had to be a critical factor in the definition and choice of exemption categories:

" Yes, for now the exemption is necessary, but there is the need for review. The financial status of the client should be the determining factor but not flat for everybody." Health provider

"ANC clients should pay because they have husbands. A lot of small [small] girls are rushing for ANC because government is paying for them and encouraging them to get pregnant." Health provider

"*People who can pay for health services should not be exempted simply because they fall in the category of exemptions."* Health provider

"What are we trying to promote? Are we encouraging people to have more children they cannot take care of? People should be made to live up to their responsibilities" Health provider

A third group of respondents suggested an expansion of the policy to include other user groups such as the disabled and mentally handicapped, as well as users who opted for long-term or permanent surgical family planning methods like vasectomy and mini-laparotomy.
Concern was expressed about the way in which the exemption policy operated for health workers. A majority of respondents complained that the pay-refund system was problematic, in that health workers often had to wait for long periods before their refunds came through.

User perceptions
Some respondents suggested an expansion of the policy to include other categories of health service users and diseases. Specific user categories suggested included patients undergoing surgery, women undergoing caesarean surgery, single mothers, people with large families, students and school children, the disabled, national service personnel, newly qualified teachers posted to other regions (due to the 2 year lag between transfer and payment of first post-transfer salary), 60year olds, members of Institutional Management Committees (IMC) of health facilities. Disease categories cited included diabetics, hypertension and HIV/AIDS.
Other respondents suggested that private and mission health facilities should be provided with funds to enable them offer exemptions to users falling under the exempt categories.
A minority of respondents argued for free healthcare for everyone.

Private health service provider perceptions
Generally, private providers spoke in favour of the exemption policy. However there was general consensus that proper planning and increased consultation with stakeholders was required to improve its implementation. They also stressed the need for building systems for monitoring, feedback, resource allocation, and human resource development. The majority of

private providers expressed a willingness to play an active role in the implementation of the exemption policy.

Specific issues were raised regarding existing methods of policy implementation. Providers highlighted the financial burden of implementing exemptions on drug costs for example. A workable solution for the private sector in this particular area would be for the government to provide drugs for exemptions or to reduce the cost of drugs making them affordable for all. Additionally a referral system could be developed which allowed private providers to refer private patients who could not afford specific services to public facilities that provided such services for free.

The lack of active collaborative links between the public and private sector was highlighted as a critical issue. The majority of private providers expressed that while they provided services for a large and growing section of the population, their experiences and knowledge were consistently excluded from the development of health policies and decisions. There was an erroneous notion that the private sector was only out to make money and was therefore uninterested in policy matters.

To appropriately address the inequalities and inadequacies of the healthcare system there was a need to improve the relationship between the two sectors and particularly to incorporate a private sector perspective at all levels of health decision-making.

As one private provider asserted:

'Since both sectors are working towards one goal I think we need to work together'.

Perceptions of District Chief Executives

Major concerns expressed by District Chief Executives centred on health providers' abuse of the guidelines of the exemption policy.

" There is corruption by health staff in the implementation. People are diverting resources for the policy into private use." District Chief Executive

"Public education of the policy to the population is inadequate this makes it open to abuse by Health providers" District Chief Executive

4.5 Dissemination of Guidelines On Exemptions

Availability Of Guidelines

None of the regions had copies of the actual policy document, although the majority of study sites possessed a variety of guidelines. These included:

- **National circulars copied to Regions, Districts and facilities, in that order**
- **Regional circulars or guidelines focused on exemption categories and target services.**

Most study sites had either national or regional guidelines, while a few had both. At some study sites, health providers were unable to present their guidelines for inspection although there were claims to the existence of guidelines. At other sites guidelines were kept by the in-charges and were very rarely offered to or consulted by other health providers. In the OPD facility in one region, the guideline was pasted on the notice board.

Information provided in the guidelines focused on exemptions for pregnant women, children under five years, adults over 70 years, health providers, and on free treatment for snakebites and dog bites. There were no circulars or guidelines available at any of the study sites that included exemptions for paupers and other user and disease categories.

4.6 Respondents' Interpretations Of Guidelines

Health Provider level
Health providers' interpreted guidelines in terms of the types of free services available to select health service user groups:

" ***The circular is asking us to give free treatment to exempted category of patients mentioned in the circular for both outpatient and inpatient services. This is to encourage people to attend the health facilities"*** Health provider

"The circular is asking us to ensure that children under five are attended to and provided with basic drugs free of charge, antenatal patients are not charged anything for the first four visits to the clinic, the elderly above 70 years are not denied health care." Health Provider

Some health providers misinterpreted the guidelines available in their facilities, citing less than the full range of services exempt from user fees or citing exemptions for service areas not covered by the guidelines. A typical example of misinterpretation of the guidelines by health providers in one region is presented in Table 10.

Table 10. Variations in Interpretation of Guidelines on exempt user categories in One Region

User Category	Content of guideline	Providers' interpretation of guideline.
Aged above 70 years	Free consultation including card, free basic lab tests, basic drugs for acute illnesses	OPD card, malaria drugs
Children under 5 years	Malaria, measles, diarrhoea, URTI for **only 4 visits.**	OPD card, Drugs for diarrhoea & malaria, URTI
Pregnant women	Free consultation, basic lab tests.	OPD card, Routine drugs, and consultation
Orphans	No information	Exempted from all services
Paupers	No information	OPD card, Consultation, Drugs on malaria

Use Of Guidelines

The majority of study sites claimed active use of the guidelines available to them. It was generally observed and confirmed that for many of the institutions visited, the guidelines were re-worked to facilitate greater understanding across all staffing levels and to guide effective implementation. There was also some level of re-adaptation of the guidelines to reflect particular dynamics of the patient population served. Typical issues guiding re-adaptation of the guidelines included estimated cost of implementation, the perceived financial standing of the facility and the perceived economic status of the population within which the facility operates.

4.7 Implementation Issues

Facilities Implementing Exemptions

The majority of public sector facilities were actively engaged in the implementation of the exemption policy.

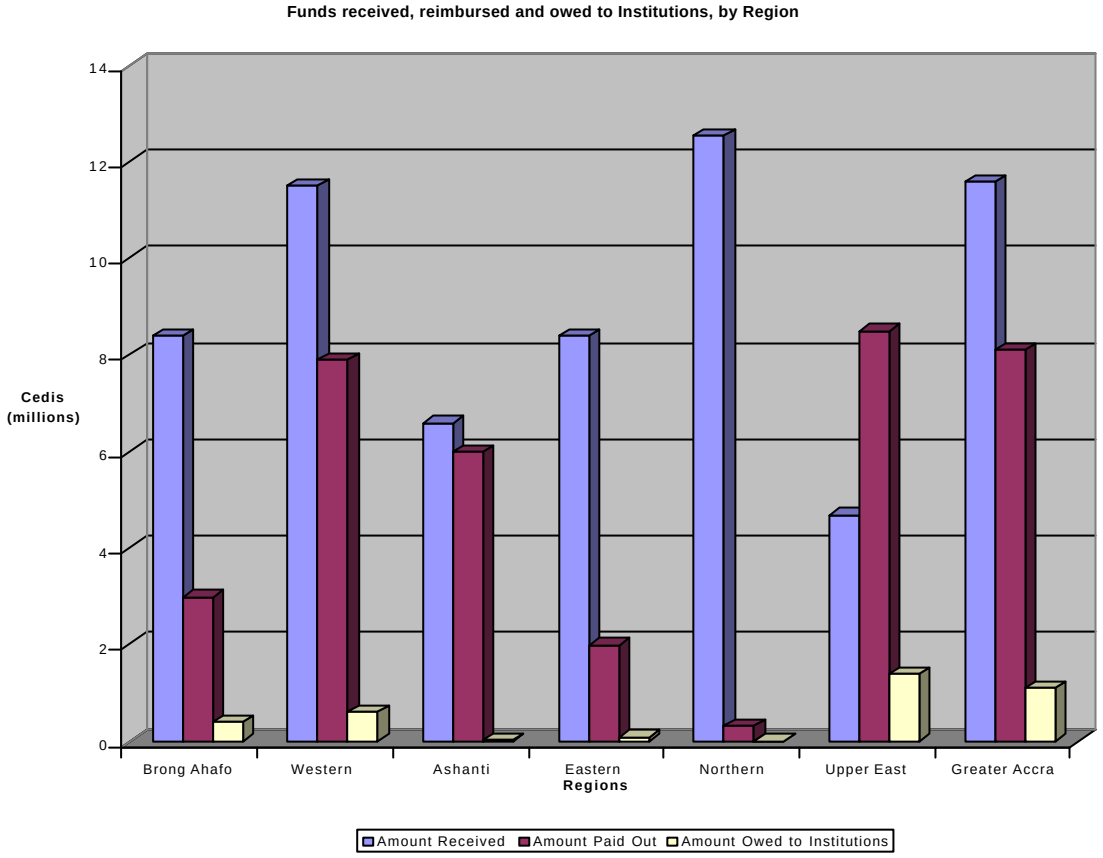
In some regions the mission hospitals played a role in implementation, although in other regions such as the Brong Ahafo Region where mission hospitals outnumbered public sector hospitals and facilities, very few mission hospitals offered exemptions to users. At the time of the study, mission hospitals in the region only offered exemptions to antenatal patients. The possibilities of incorporating the services provided by private midwives in the implementation scheme was being explored.

Disbursement / Reimbursements

The system for disbursement from and reimbursement of the exemption fund varied across regions. Three kinds of systems were in place. The first involved providing advance allocations to all district BMCs who then used the funds and submitted returns on their expenditure. The second involved district health administrators disbursing funds as specified by submitted returns from health facilities or BMCs. The third system involved disbursement of funds at regional level. In this case facilities submitted their returns to their districts where all returns were collated and submitted to the regional level. The reimbursement followed the same procedure in the reverse order.

For the majority of regions, actual amounts that were paid out to various facilities to fund their exemptions practices fell far below the amounts budgeted and allocated to the regions for this purpose. In the Brong Ahafo and Eastern regions for example more than double the amount allocated to fund their health facilities remained to be paid out. In other regions, the profile of reimbursement and disbursement varied. The Ashanti Region for example had matched its payments to facilities with amounts received to fund exemptions. The Upper East Region had paid out almost double what it received for exemptions and still needed to reimburse its health facilities. To a large extent, all the regions still owed some amount to their institutions although there appeared to be enough money in regional coffers to settle their debts.

Figure 4: Fund Received, Reimbursed and Owed to Institutions by Region Jan-Dec, 1999



There was no standard re-imbursement procedure across the regions. According to regional, district and facility staff in charge of financial management, the delay in receiving funds for exemptions at both regional and district levels ranged between 1 and 12 months, while delays in transfer of funds from district levels to various facilities ranged between 3 and 9 months. In the Volta Region key informants at regional, district and facility level had little knowledge on the financial arrangements and procedures relating to the exemption policy. No information was provided on the average duration of disbursement at different levels.

The problem of delays in re-imbursement was attributed to bureaucratic processes such as the unnecessarily prolonged checks on submitted returns by at different managerial levels. In the Brong Ahafo region, for example routing returns through the regional Audit Department created a bottleneck in the reimbursement process. According to health providers, delays in reimbursement affected stock levels and the quality of care given to user groups targeted in the exemption policy.

Figure 5: Average Duration of Fund transfer at various levels Jan - Dec 1999

Ashanti	5	4	3
Greater Accra	12	12,75	4,5
Eastern	10	4	4
Western	6	7	6
Brong	1	3	4
Volta	0	4	5
Central	0	0	2,4
Upper East	3	2	3
Upper West	0	0	3,1
Northern	1	2	4

AVERAGE DURATIC

In the Ashanti region it took a shorter time for Districts and facilities to receive reimbursement of exemption funds than it took for the region to be reimbursed by the national headquarters. This was the reverse for the Brong Ahafo, Volta and the Northern Regions.

For the majority of health providers and managers at facility level the delays in receiving reimbursements for exemptions, was problematic. There were complaints that delays resulted in dwindling drug stocks that often had to be replaced by purchasing on credit. This increased the cost of drugs for patients. MCH units and community clinics were affected more acutely by delays in reimbursement, since they did not receive direct funding from the government for general services.

Some health providers gave accounts of problematic effect of the reimbursement process on effective implementation of exemptions:

'When we were implementing it, we used to send the reports. The government owed us about 20 million Cedis so we decided to stop. I was then the administrator'. Private Provider

Another mentioned that *'the government asked us to give exemptions and they will refund we later found that the money was not coming so we stopped. The laboratory charge for ANC was 5000cedis and routine drugs 4000 cedis"*

Other health providers complained about the impact of the delays on the quality of service provision:

" It affects our purchasing power. Consumables and drugs sometimes get out of stock" Health provider

"The procedure is too cumbersome, there is a lot of delay at the regional level before reimbursement is made" " Health provider

" In fact if we broadcast this exemption people will flood in at the clinic and we cannot give every one" " Health provider

"***If the delays continue, we may have to call it quits. My stock is getting finished and I'm not getting money for restocking" "*** Health provider

" Funds are available but under utilised in the region" Health provider (Regional Level)

Delay in reimbursements was also attributed to the delay in submissions of return forms by various health institutions and facilities as one regional manager asserted.

Identification of exempt clients

There were very wide variations in the structures, procedures and mechanisms for the implementation of the exemption across facilities, some within the same district. In some facilities the identification of beneficiaries for example, was the responsibility of the records officer subject to approval by the in-charge, while in other facilities it was the sole responsibility of the in-charge. In the former set up there were often instances of patients making part payment for services they were exempt from before consultation with the in-charge.
In larger facilities committees had been set up to determine exemption categories. The identification and authentication of paupers was a complex issue for the majority of health providers. In many facilities there was no clear system for definition and identification. A few facilities that employed social workers as adjunct staff referred pauper cases for evaluation. In two facilities the watchman and the security man who happened to know most of the community members served by the facilities, acted as informal evaluators of pauper status, and assisted the screening of users requiring exemptions. The majority of health staff tended to be sceptical of people who claimed pauper status and developed diverse methods and criteria for identifying this complex group of health care user.

" A pauper is somebody whose relatives cannot be traced, he has no source of income. We have never met such person at this health centre" Nurse

"Formally social workers were assisting but had to be left out because of malpractice. Now nurses investigate the background of the clients and when satisfied that they cannot pay they inform the medical superintendent who then decides finally for free service". Nurse

"When a patient comes with the OPD card and you ask for money and the person looks as if he had not heard or after treatment when the cost of the drugs are mentioned, he will say that 'I cannot pay now I will go home and come." Nurse

Here, what I usually do is to put the drug down initially. However, when he goes home and comes the next day insisting he cannot pay, I give the drugs to him." Nurse

"You ask about the background of the person age, place of work and dependants. His appearance will also show. Sometimes they tell you they have not eaten the whole day" Nurse

"We know those who are poor" Nurse

Private health providers found it easier to identify users who could not pay. Most cited strong community links as a factor. They offered partial or whole exemption to specific categories of users such as family members, poor patients and employees. They also offered credit facilities. One private health provider summarised his exemption strategies:

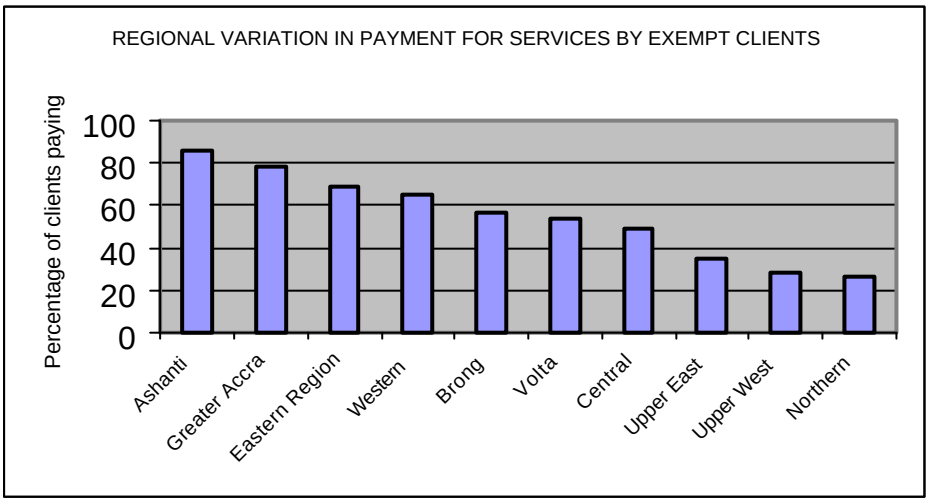
"Sometimes you only identify them after you have treated them. When we are sure they cannot pay we give them a start treatment so they will go and look for money and come back for full treatment. For those who have little money less than we have charged we allow them to make part payment I give them drugs worth the money they have on them. For those we know, we allow them to go home and come back to pay in a week or a months time. Some come, some do not come. There is nothing we can do. It is really not easy" Private provider

While the identification of other categories such as the under fives and the aged was straightforward, there was some confusion regarding the full range of free services targeted at these groups. In the case of under fives, the road to health chart was usually used as a guide to determine actual age.

Payment For Services By Users in Exempt Categories

Out of the total number of clients interviewed 54%(281) had paid for services, while 56%(292) had been exempted from paying for services. The total amount paid by users at the time of the interviews was ¢3,372,150.00, worked out as ¢12,000.00 per paying user.

Figure 6: Regional Variation in Payment for Services by Exempt Clients



A number of factors contributed to inadvertent or enforced payment of full or partial fees by users in exempt categories. These included:

- **Late identification of exemption status of patient (eg. user pays for the card is then identified as an exempted user and is exempted from paying for other services.)**
- **Users are exempt from some but not all services (e.g. antenatal patients are exempt from antenatal services, often including basic laboratory tests and some specified drugs, but have to pay for other services/drugs)**

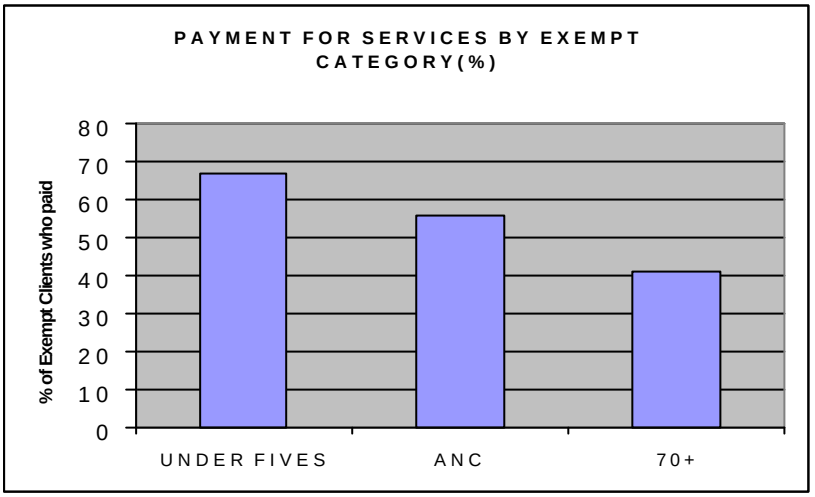
Con formato: Numeración y viñetas

- **Exemptions are made on available but not scarce drugs (e.g. users having to but unavailable or scarce drugs from the private sector or open market)**
- **Enforcement of illegal fees** (see **section** on administration of payments).

Con formato: Numeración y viñetas

Free services that usually ended up being partially or fully paid for by users in exempt categories were registration, drug prescriptions and laboratory services. The latter two services in combination with X-ray services formed the most expensive set of services provided by health care facilities. There was some variation in levels of inadvertent or enforced payment of free services across exemption categories. Thus 65% of under-fives were recorded as paying for free services compared to 55% of pregnant women and 40% of the aged (Fig. 7).

Figure 7: Payment for Services by Exempt category



** Under fives include both Child welfare clinic and curative care clients*

Table 11. Services paid for and amounts paid by users in Exempt Categories

	exempt users paying for s	paid per user
Drugs	187 (36%)	C 8,700
Card	129 (25%)	C 1,300
Laboratory	53 (10%)	C 3,700
Dressing/inj.	39 (8%)	C 1,400
Nurse consultations	33 (6%)	C 2,300
Doctor consultations	19 (4%)	C 2,000
Tetanus injection	16 (3%)	C 1,500
X-ray	8 (2%)	C 12,000
Other[a]	40 (8%)	C 27,900

a. The category Other Services includes some clients who only knew the total amount paid for all services, and operations etc.

Table 12. Average amount paid for services by users in exempt categories

	No (%) that was exempted		
Paupers	9 (45%)	8 (40%)	C 111,500[+]
Pregnant women	**93 (62%)**	83 (56%)	C 6,300
Child Welfare Clinic	**13 (37%)**	18 (51%)	C 1,400
Curative Under 5*	**58 (45%)**	92 (71%)	C 7,900

The aged	70 (68%)	42 (41%)	C 18,200
TB patients	31 (80%)	11 (28%)	C 18,600
Other specific diseases*	18 (64%)	10 (36%)	C 22,900
Total (paid by any category)	292 (58%)	281 (54%)	C 12,000

+Amount includes outstanding bills.

Data presented in Table 12 indicates that implementation of exemptions varied across user and disease categories. Exemptions for patients seeking treatment for TB and other specific diseases covered by the policy, as well as exemptions for the aged were most likely to be enforced, compared to exemptions for children under five which were least likely to be enforced. This profile varied across regions however as Table 13 indicates. Regions in the northern sector for example enforced a wider range of exemptions compared to other regions. Regions such as Ashanti, Greater Accra and Brong Ahafo were least active in implementing exemptions (see figure 6).

Table 13. Payments for services by users in exemption categories across region[a]

Regions	Paupers N=20	Pregnant women N=149	Child Welfare Clinic N=35	Curative under fives N=129	Aged over 70 years N=103	TB N=	
Ashanti	-	100%	4 / 4	100%	60%	2 /	
Brong Ahafo	-	50%	5 / 13	100%	5 / 8	0 /	
Central	-	50%	1 / 1	75%	1 / 8	2 /	
Eastern	0 / 3	82%	2 / 2	50%	73%	0 /	
Grt. Accra	1 / 4	93%	3 / 3	94%	5 / 8	3 /	
Northern	1/3	18%	0 / 4	24%	8%	-	
Upper East	1 / 2	24%	0 / 2	56%	4 / 9	0 /	
Upper West	2 / 4	42%	0 / 1	31%	9%	1 /	
Volta	0 / 1	56%	-	100%	31%	0 /	
Western	3 / 3	40%	3 / 5	100%	4 / 8	3 /	
Total	40%	56%	51%	71%	41%	28	

a. Payments are indicated as percentages or proportions, where numbers are low (le

Paupers

Paupers, when they were appropriately identified, often cut across the various categories targeted for exemption at disease and also age level.

The actual payments made by users identified as paupers were small, but a large amount was still recorded as outstanding indicating the health facilities intention to collect this debt.

Pregnant women

56% (84) of pregnant women paid for services. Payments made were mainly for registration and registration cards, drugs, laboratory tests and consultation with the nurse. Each user paid an average amount of ¢6,300 per visit.

Child Welfare Clinic

Only 18% of respondents attending these facilities made any payments. These payments usually covered drugs and consultation with the nurse. Average payment was ¢1,400. Respondents did not discuss their rights of exemption or their experiences of being exempted from user fees. It is likely that since the Child Welfare Clinic was generally perceived to be a free service, the issue of fee exemptions was irrelevant in this context.

Curative services for children under five

This is the group that had the highest percentage (71%) of respondents making full or partial payments for some or all services. In Ashanti, Brong Ahafo, Volta and Western regions all respondents in this group had made some payments for services. Average payment per user in this group was ¢7,900. Payments generally covered registration cards, drugs, dressings and injections and laboratory tests.

The aged (70+)

Exemptions for this group were most likely to be implemented across all regions, although the Northern and Upper West regions taking the lead with consistent comprehensive implementation. Only 42% of this group had made some form of payment for services, which usually covered cost of registration cards, drugs and laboratory services. Average payment tended to be higher within this group compared to other groups, at ¢18,200 per user.

TB patients

Only 28% of TB patients had made any form of payment for services received. 80% had been exempted from payment during their visit on the day of interviews. For the group that had made some payments, the average cost per user was ¢18,600, however. It is difficult to extrapolate regional differences from such small numbers, although it was clear that this was one of the critical disease categories for which exemptions were likely to be consistently enforced.

Patients with other specific diseases (ages between 5 and 70 years of age)

Implementation of exemptions for this user group was also fairly high and consistent across regions, with only 36% of users making any payments. Average payment for users within this group was comparably high at ¢22,900.

In-patients

Data on the payment profile of in-patients was gathered to provide some knowledge on levels and rates of charges for admissions services. Within this group 70% had made payments for services received, while the remaining had received exemptions. Payments covered cost of cards, drugs and laboratory tests. Other users had paid for surgeries and x-ray services. Payments ranged from ¢15,000 for X-ray services to ¢35,000 for other services. Average cost of drugs was ¢18,000. The total cost for a full range of services was averaged at ¢40,500.

Relationship between Points Of Payment For Services and effective implementation

Points of payment for services varied from facility to facility. In the majority of facilities however payment was made at a designated central collection point in. In some facilities, particularly those with no system of revenue collection, the central collection point was manned a medical assistant or a consulting room nurse. In one facility the dispensary doubled up as a central collection point. In two facilities payment points were split, with card payments

made at the records office, and remaining payments made at the central collection points. In such facilities where two or more payment points were in operation, users in exempt categories would often make initial part payments (for registration cards, for example) before their exempt status was recognised and were provided with free services. Recognition of exempt status did not guarantee automatic exemption from all services however.

Table 14. Points of Payment for Services by Region

Region	% Central point	% Multiple Service points	% Both
Ashanti	80%(4)	20% (1)	0%
Brong Ahafo	86%(6)	14%(1)	0%
Central*	-	-	-
Eastern	29% (2)	57% (4)	14% (1)
Greater Accra	83% (5)	-	17% (1)
Upper East	80% (8)	-	20% (2)
Upper West*	-	-	-
Volta	71% (5)	29%(2)	-
Western	33% (2)	50%(3)	17% (1)
Northern	37.5% (3)	62.5%(5)	-

Data not available

Table 16. Receipts for payments[ab] by Exempt Users for Various Services

Services paid for	All health personnel		Cashiers/revenue coll.	
	Receipts given %	Payment conform receipt[c]	Receipts given %	Payment conform receipt[c]
Drugs	47%	98%	88%	100%
Card	34%	95%	86%	100%
Laboratory	51%	89%	100%	90%
Dressing/inj	14% (5/37)	100%	83%	100%
Mw / nurse	6% (2/32)	0%	0% (0/2)	--
Doctor/ MA	53%	80%	100%	100%
X-ray	63%	100%	100%	100%
Other	50%	87%	93%	92%

a. Percentages are given as proportion of total available information.
b. There were no receipts for TT injections.
c. In cases where payments were not conform receipt – with few exceptions -the payments were higher.

In table 14 the points of payment are indicated, where users interviewed had paid for the different services, at either a central point or at multiple payment points. Multiple payment points were usually manned by staff in charge of the various designated health facility levels, for example a laboratory technician would be in charge of collecting payment for laboratory services, or the doctor or Medical assistant in charge of collecting payment for consultations (see Table 15 in Appendix 2). In table 16 the frequency of handing out of receipts across different payment points is recorded, comparing cashiers/revenue collectors' frequencies with that of the collective group of health facility staff. It is clear that there was not a strong habit of handing out receipts, although cashiers/revenue collectors seemed to do better than health facility staff.

Fate of Paupers

The status of paupers and other users who were unable to pay for services varied across facilities. Generally investigations would first be carried out to confirm a user's inability to pay for services. Following confirmation of pauper status, full or partial fee exemption would be carried out in a number of ways depending on type of facility.

1. Partial exemptions

For genuine cases facility heads would a waiver of fees owed. In cases where users' pauper status could not be proven health staff resorted to detentions and threats of exposure to get such users to pay fees owed.

"*On one occasion we had 11 patients who claimed they were paupers, we informed them that we would publish them as paupers by the following day. After all of them were photographed 4 of them came to settle their bills in full. This is an indication that there are those who can afford to pay and yet will refuse to pay."* Medical Superintendent

2. Drugs per amount paid

In cases where users were unable to pay full cost for their drugs, providers either dispensed partial amounts of drugs that users could afford or gave users prescriptions to purchase their drugs from outside sources.

3. Assistance by Sympathetic Health providers

In a number of facilities, users unable to pay for the cost of care received partial or full assistance from sympathetic health providers.

4.Poor and Sick Fund of the Catholic Hospital

The poor and sick fund instituted by the Catholic Church in its Mission Hospitals offered financial assistance to proven paupers. In the Brong Ahafo region, the poor and sick fund was a key source of funding for users unable to pay service costs.

5. Payment by Instalment

In some facilities users were allowed to settle their bills in instalments. In one institution in the Brong Ahafo Region an instalment facility was set up for a beneficiary only if the beneficiary had a credible guarantor.

Absconding

The issue of patients absconding from health facilities after accessing services was raised by health care providers. As one health worker stated:

" Especially with the in-patients, when they are admitted, a few relatives follow to pay up but as the charges go up the number of relatives reduce and finally they end up with no one visiting them to help settle their bills. In the end, they abscond.

Submission of returns

Most facilities compiled monthly returns on numbers of users exempted from payment which were submitted to the district level. Some districts had standardised formats for compilation of returns, while others had no standardised methods. Some districts vetted the returns by cross checking with records at the facility level whilst others did not.

The districts in turn submitted returns to the regional level. In some regions submitted returns would undergo some form of vetting, which usually involved examining the average cost per person.

4.8 Challenges to the Implementation Of Exemptions

Health providers cited a number of challenges they faced in the implementation of the exemptions. These included:

- **Delay in reimbursement and inadequate refund.**
- **Increase in workload and stationery cost.**

"**We have only one typist and one typewriter for everything and this makes compilation of returns very difficult."** Health Provider at Facility

- **Problems in identification of pauper status and determination of patient age.**

"Determining the actual age of the above seventy is a problem, the few who are aware of the free treatment package of the aged even if they are not seventy years they claim they are and ask for free treatment" Health Provider at Facility

"Because mothers know about the exemption they try to reduce the ages of their children to qualify for the package" Health Provider (at Facility)

- **Abuse of the healthcare system.**

"A mother will bring her child for treatment and within three days she is back asking for more drugs when the previous supply is not yet completed, just because is free." Health Provider (at Facility)

- **Burden of documentation and lack of trained staff to carry out role.**

"Sometimes the executive officer has to leave her work and go to the ANC unit to help in recording before compilation and typing." Health Provider at Facility

"There is extra work of recording exemptions in the lab. It is extra work so someone should be employed to be doing it. We sometimes have to stay longer to work on the recording at the lab, no one pays us for it and I haven't told anyone to pay for that" Health Provider at Facility

- **Unclear policy and guidelines**

Some of the health providers found the exemption policy and guidelines unclear and difficult to implement.

" ***For cholera cases, we were told that services were free. Later, they said it was only free during epidemics and not isolated cases"***

" if a patient is exempted on one occasion and comes again with a different disease and he is not exempted, he gets annoyed; especially the elderly with chronic diseases."

4.9 Respondents' Suggestions For Improving The Implementation Of The Exemptions

Suggestions and recommendations given by the various categories of respondents are summarised below:

Users

- **Increase public education on the policy and guideline.**
- **Encourage health providers to implement policy**
- **Impose penalties on health providers who wrongly charge people**
- **Monitor staff practices**
- **Improve availability of drugs**
- **Clarify policy**
- **Introduce a user Identification card system**

Health providers

- **Revise policy to make it clearer**
- **Simplify record keeping**
- **Funds to be disbursed to the facilities up-front and not after submission of returns.**
- **Funds for exemptions to be kept at the DHMT.**
- **The implementation of the policy should be based on affordability.**
- **There should be a limit on amounts spent on exempt users.**
- **Reimbursement should be fast, regular and adequate to cover the cost of service.**
- **A good monitoring system should be put in place to check and verify the authenticity of the returns.**
- **Health providers and their dependants should be exempted from paying for services at any MOH facility.**
- **A health insurance scheme should be instituted to gradually replace the exemptions.**
- **Step up education of health providers to aid effective public education.**
- **MOH should decentralise the exemption funds and send funding directly to the district level.**
- **Auditing of returns should be carried out at the DHMT instead of the Audit service**
- **Monies should be sent directly from the Regional Health Administration into the institutional drug account.**
- **Credit facilities should be instituted at the regional medical store so that we can get our drugs and supplies whilst awaiting reimbursement.**

District Assemblies

- **Intensify public education on exemption policy.**
- **Involve district assemblies in the dissemination of information on the exemptions and monitoring.**
- **Exemptions to be targeted at deprived areas.**
- **Community members, church leaders and government appointees to be encouraged to be part of the exemption categorisation process in their capacity as key community informants.**

Private Providers

- **Include private providers in the implementation of the exemptions, organize workshop to disseminate specifics of the guidelines to improve knowledge across all provider levels. Carry out repeated assessments to evaluate problems.**
- **There should be an effective system of identifying private providers who qualify to be part of the exemption policy implementation**
- **Policy should be clear-cut with no ambiguities**
- **Reimbursements should be carried out promptly.**
- **Ensure regular supply of drugs and other inputs.**
- **Government to provide special pharmacy shops for the exempted.**
- **Create public awareness about exemptions.**
- **Prioritise sustainability of the exemption policy**
- **Phase out mass exemptions and introduce part payment of drugs for users in exempt categories.**
- **Provide exemptions in the deprived areas.**
- **Financial status, rather than age, to be key determining factor for setting up exemptions categories. Potential users exempt from payment to be determined by their community members, church elders and government appointees.**
- **ANC should not be free - more money to be allocated to family planning education.**

CHAPTER FIVE: DISCUSSION

Problems with existing Exemptions

Previous studies carried out to evaluate the effectiveness of the exemption policy found problems with the process of implementation (ref?). Primarily implementation was inadequate and a significant number of users with exemption rights paid for health care services. Little has been done in the past to improve the effectiveness of the policy following the findings of this group of studies. Instead there has been an expansion of the policy to include two additional vulnerable user groups – the aged and children aged under-five – as well as a redefinition of the exemption profile for pregnant women.

Implementers Evaluation of the Exemption Policy

Firstly, a majority of health providers felt they needed a consultative role in the development and modification of the exemption policy. As active implementers they acted as a critical source of empirical knowledge on how the policy translated to practice. First they were the group most likely to identify correctly, categories of users and diseases that required financial support or exemptions. Second, they could suggest ways in which exemptions could be implemented with attention and flexibility to constantly shifting socio-cultural economic and public health contexts.

Many disagreed with the rigidity imposed on implementation, arguing that in some cases it was necessary to adopt flexible methods of accessing genuine need for exemptions across patient and disease categories. For the majority of health professionals who worked at community level, collective socio-economic status was a critical issue that needed to assume prominence in future modifications of the policy. In the Upper West Region for example, which had the second highest rate of exemption uptake, implementers opined that there were entire communities that could not afford any type of healthcare. The majority of community members were low-income peasant farmers, and relied solely on seasonal subsistence farming as a source of income. For many heads of households, who were in charge of all financial matters, the responsibility of the extended family system placed an additional burden on the health costs.

Secondly, implementers expressed concern at the effect of delays in reimbursement of exemption funds. In the majority of facilities, prolonged delays caused depletion in drug and other consumable stocks and directly affected the quality of service.

An evaluation of the data showed, however, that the rate of uptake of exemptions across regions occurred independent of the duration for reimbursement. Prolonged delays in reimbursement did not necessarily threaten the quality of care, particularly in settings where uptake of exemption was low. Generally the introduction of user fees created a culture of income generation for health facilities. For a proportion of health service managers, effective management is defined in terms of maintaining high levels of revenue generation. Within this group, offering free services to users in exempt categories without assurance of immediate refund constitutes ineffective financial management. Facilities managed in this way are often inconsistent with the implementation of the policy, imposing full or partial charges to users in exempt categories.

Finally, health providers expressed concern that they did not benefit from exemptions. It is worth noting in conclusion that the issue of health provider's abuse of the exemption policy exists and requires attention. In some facilities for example, monies paid by users in exempt categories went unaccounted for and were likely to be kept by providers who imposed charges.

Inadequate Dissemination of Information on Exemptions

There were problems with the formatting and method of disseminating the policy to stakeholders and implementers at district level. Firstly the policy had not been developed with sensitivity to different levels of understanding across different levels of health staff. Secondly, guidelines were not made widely available to the implementers who interacted directly with the beneficiaries and therefore required the guidelines as regular directive tools. Guidelines often remained in the possession of in-charges and there was generally a verbal trickle down of information from high to low level staff. This contributed to varied interpretations and misinterpretations of the policy guidelines.

Points of Payment for services in Health Facilities

Points of payment varied from facility to facility – some facilities had one central collection point, while others had two or more payment points. In facilities where a central collection point was in operation it was easier to streamline implementation of the policy. In such settings the central points were often the last point of call for patients thus allowing the crucial steps of identification and authentication of exempt status to be carried out before imposition of payment.

Identifying and authenticating exemption status

In cases where decision-making on exemptions was carried out by one person (usually the in-charge) or a cohesive team, the implementation of the exemption policy tended to be more effective. For example in the Upper West region where facility in-charges usually made decisions on exemption status, highlighting cards of beneficiaries with a bold 'Exempt' marker, users would receive free services at targeted points of treatment. However, in facilities where the role of decision-making was placed on staff managing different service points, decisions tended to be less clear and uniform and were often based on various and often clashing subjective criteria of authentication.

Impact of User Awareness of policy on Uptake of Exemption

Generally a high level of user awareness of the exemption policy did not imply a corresponding high rate of uptake of exemptions.

Ashanti Region, which had the lowest uptake of free services, had the highest level of client awareness of the exemption policy (69.4%). This level of awareness was just slightly higher than the percentage (68.1%) of knowledgeable users in the Upper East Region, where the highest uptake of free services was recorded. This worked in reverse also in that a high level of exemption uptake did not necessarily translate to high levels of awareness among users. In the Northern Region, which had one of the highest uptake records, only 45.7% of users were aware of the exemption policy. In some cases users were aware of their rights of exemption but did not discuss this knowledge with their health providers or exercise their rights for fear of negative confrontations.

Reasons for Variations in Exemption Uptake

The reasons for variations in the uptake of exemptions across regions were multifaceted. Generally high or low levels of uptake revolved around a cluster of factors that included:

- **Provider knowledge attitudes and practices regarding the exemptions policy**
- **Availability of guidelines or information on exemption for staff**
- **Flow and management of resources for carrying out the exemptions**
- **Management practices at the health facility e.g financial & drug management, organization of regular staff meetings etc.**
- **Clarity of Regional re-interpretation and re-definition of the policy**

Socio-economic status was a critical dynamic guiding implementation of the exemption policy by health professionals. Health professionals were more likely to provide free services to users who were poor, once identified. In the Upper West Region, where greater numbers of communities were classed as poor, there were strong collaborative links between the Health Directorate and the facilities. Detailed feedback on budgets and funding was provided to the facilities and they were actively encouraged to implement exemptions and request reimbursements. The primary aim of the Directorate was to encourage and facilitate the ability of facilities to reduce and remove barriers preventing quality of care to the poor in the region. In this region and also the Northern region, where uptake of free services was highest, the guidelines targeted at the aged had been modified to include 60 to 70 year olds in the aged category. The aim of this modification as health providers in these regions explained was to increase coverage for the regions' poor.

CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

Clarity of policy

One of the critical issues raised by health professionals was the fact that the exemption policy was complex and required simplification to aid understanding and appropriate application. To a large extent the effectiveness of implementation was compromised by a lack of understanding or misinterpretation of the policy by implementers.

Recommendation 1

It is critical that the policy is simplified and/or clarified for health providers at all levels. A systematic plan for packaging and disseminating key guidelines of the policy will help implementers understand better the purpose and need for exemptions and enable them implement the policy more effectively.

Reluctance by Health providers in exempting clients

Although a critical lack of understanding of the aims and methods proposed in the exemption policy was the primary factor in the inadequate implementation of the policy, there was also a general reluctance by health providers to provide free services to users in exempt categories. This reluctance was tied to two factors; first that the majority of health providers faced difficulties in obtaining entitled exemptions for themselves and their dependents and secondly, the fact that they often faced prolonged delays before their refund claims on hospital and other health service bills were paid to them.

Recommendation 2

Efforts must be made to address the felt needs of health staff in a holistic manner and to ensure that their claims are promptly attended to.

Payment points

There was no uniform system of payment in the health facilities. While some collected payments from a central collection point, others operated two or more points of payment collection. Usually in the latter setting, users in exempt categories ended up paying for one or more services to which they had free entitlement. Costs incurred by users in exempt categories were often for the purchase of registration cards and drugs. To a lesser extent costs could be incurred for hospitals admissions, surgery, X-ray and laboratory services. Costs for the latter category of services were comparably higher than the former.

At facilities operating multiple points of payment, financial accounting was inconsistent and inadequate at some points. Users who paid for services provided by nurses for example did not usually receive receipts. Laboratory, X-ray and dispensary services tended to have a better system of accounting and provided receipts to users.

Recommendation 3

It is important to examine the feasibility of establishing central payment points in all facilities to address and reduce the enforcement of unauthorised fees. The existence of such points will have to be extensively publicised to health service users to create awareness and facilitate a change in existing payment methods.

Awareness among beneficiaries of the policy

Although users had some awareness of the exemption policy, this was limited to a few target areas. Users did not know that paupers were exempt from payment, for example. A majority had little knowledge of the specifics of free services targeted across user and disease categories. A number of users who knew about their rights of exemption often failed to exercise these rights because of negative staff attitudes. Users stressed the need for public education and for improved provider-user relationships.

Recommendation 4

Negative health staff attitudes need to be addressed. Active ways of improving relationships between health care users and providers should be explored and recommended.

Documentation

Health providers complained of the added burden of preparing evaluation documents on exemption practices and the critical lack of staff trained to take on this role. While this task was key to making claims for reimbursements, it was perceived by the majority of health professionals to be a separate administrative task that required appropriate remuneration,

separate from regular salaries. There were additional complaints about lack of equipment and stationery to facilitate documentation.

Recommendation 5

Design simpler more user-friendly reporting formats to ease documentation process.

Recommendation 6

Managers at the health facilities to ensure that administrative work carried out on implementation of exemptions outside duty hours is catered for by the additional duty allowance set up by the government for health workers.

Delays in reimbursement

An evaluation of the financial status of regional health directorates showed that for the majority of regions, there were sufficient funds to reimburse facilities implementing exemptions. However there were often prolonged delays in reimbursements, which affected the effective implementation of the exemption policy as well as other critical service areas such as drug procurement. Health providers were reluctant to provide free services due to long delays in reimbursement of funds. The majority of health providers perceived the process of reimbursement as bureaucratic and in some regions corrupt.

There are gradual moves to incorporate mission hospitals into the exemption scheme although this remains a gradual process subject to an improvement in the disbursement and reimbursement system.

Recommendation 7

A workable and fast track system for re-imbursements must be put in place to reassure health providers of continuing funding for the exemptions and to reduce delays in reimbursement.

Targeting of clients for exemptions

One of the critical problems facing health providers is the identification and authentication of users in the pauper category. Identification of other user categories such as under-fives, pregnant women and the aged, are more straightforward. Exemptions for these categories are therefore comparatively easier to implement.

Recommendation 8

There is a need for prioritised focus on users with a genuine inability to for health services. Poor communities should be especially targeted. A community-based study with all stakeholders in the community may assist in clarifying indicators for appropriate identification of the poor.

Exclusion of private providers

The exclusion of private providers from the implementation of the exemption policy is problematic and results in the neglect of a large section of the population who access private healthcare services.

Recommendation 9

To ensure a comprehensive coverage of the exemptions policy for all specified targets private providers need to be included in the implementers. The modalities for collaboration in this area should be worked out with the full participation of the private sector.

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APPENDICES

Appendix 1: Various Interpretations of Guidelines from Some Regions

Region	Date	Guidelines	
Eastern	15/8/97	Limited to primary care facilities in the public sector • *Antenatal* – Free consultation, free basic laboratory services(Haemoglobin estimat sickling, Blood film for parasites, routine urine testing), Basic haematinics **to cover average of 4 visits** per pregnant woman • *Aged (above 70)* – free consultation, basic laboratory, basic drugs for acute illnesses • *Children under five* – **free immunisation, child welfare clinic services, subsidised schedule**	
	26/10/97	Limited to primary care facilities • *Antenatal* – Free consultation, free basic laboratory services (Haemoglobin estimat sickling, Blood film for parasites, routine urine testing), Basic haematinics • *Aged (above 70 years*) - **free consultation, basic laboratory, basic drugs for a illnesses** • *Children under five* – free immunisation, child welfare clinic services, subsidised fee sche	
	29/12/97	• Aged – entitled to free treatment **only for** the following acute illnesses**: Malaria, U respiratory tract infection, Diarrhoea, Urinary tract Infection, and Degener diseases**	
	23/2/99	• *Children under five* – entitled to free treatment **only for** the following diseases: **Mal Measles, Diarrhoea, Upper Respiratory tract infection or a combination of th diseases.** The exemptions are to cover **four (4) visits only.**	
	23/6/99	• *Antenatal* – Free consultation, free basic laboratory services(Haemoglobin estimat sickling, Blood film for parasites, routine urine testing), Basic antenatal drugs • *Aged(above 70 years*) - free consultation, basic laboratory, basic drugs for acute illnesse • *Children under five* – entitled to free treatment **only** for the following diseases: **Mal Measles, Diarrhoea, Upper Respiratory tract infection or a combination of th diseases.** The exemptions are to cover **four (4) visits per each of the diseases** mentioned ab The scope of the package is limited to free consultation (including cards), basic labora tests, and free basic drugs.	

		• *Health providers* **–** Exempted from all categories of fees but laid down procedure mus followed strictly. • *Tuberculosis patients* **-** T. B patients after diagnosis are exempted from all categories of e.g **drugs, feeding, accommodation, consumables etc.**	
Western	12/3/99	Victims of snake and dog bites – **Free treatment**	
	No date	• *Antenatals* **–** Free registration and consultation, free basic laboratory services (Haemogl estimation, sickling, Blood film for parasites, Blood grouping, routine urine testing, stool Free routine antenatal drugs **{ Vit. B complex, Multivite, Fersolate, Vit. C, Folic A Calcium+ Vit. D, Mist Ferric Ammonium Citrate (if fersolate not available)}** • *Children under five* – free registration and consultation, free routine laboratory exa Haemoglobin estimation, sickling, Blood film for parasites, urine RE, stool RE) • *Aged (above 70 years)* **-** free registration and consultation, free treatment for a conditions only. **Acute conditions** such as **hypertensive crisis**, **malaria, home accidents (e.g bur acute asthmatic attacks etc. shall be treated free.** ***(Discretion of prescribers could be used in defining acute conditions)***	
Western	26/2/99	• *Antenatals* – Free registration and consultation, free basic laboratory services (As define the regional guidelines on exemptions), Free routine antenatal drugs (**As defined in regional guidelines on exemptions)** • *Children under five* – free registration and consultation, free routine laboratory exams. ***N.B They should however pay for drugs*** • *Aged (above 70 years)* **-** free registration and consultation, free treatment for a conditions only. ***Discretion of prescibers could be used in defining acute conditions***	
	No Date	• *Antenatals* **–** Free registration and consultation, free basic laboratory services (As define the regional guidelines on exemptions), Free routine antenatal drugs (As defined in regional guidelines on exemptions) • *Children under five* – free registration and consultation, free routine laboratory exams. ***N.B They should however pay for drugs*** • *Aged (above 70 years)* **-** free registration and consultation, free treatment for a conditions only. ***Discretion of prescibers could be used in defining acute conditions***	

		• *Antenatals* – Free consultation, free basic laboratory services (Haemoglobin estima sickling, Blood film for parasites, routine urine testing) and routine antenatal dr (haematinics). This covers four visits per woman. • *Children under five* – free registration and routine laboratory examination and consultatior ***N.B They should however pay for drugs*** • *Aged (above 70 years)* – with acute conditions e.g malaria, accidents, acute asthn attack, hypertensive crisis. In such conditions, the discretion of the Prescribers could be *so long as it can be defended.* • *Staff of Ministry of Health (including students of NTC)* – Fee free services apply to He providers and not their dependants. In case of referrals, the bill should be sent to the BM the staff in questions. **Their dependants must go to the Civil Servants Association to claim reimburser** until the Ghana Health Service is fully established. • *Disease Categories* – Leprosy, Tuberculosis, Psychiatric Patients. • *Paupers* • *Prisoners and National Service Persons*	
	15/8/97	**Limited to primary care facilities in the public sector** • *Antenatal* – Free consultation, free basic laboratory services(Haemoglobin estimat sickling, Blood film for parasites, routine urine testing), Basic haematinics **to cover average of 4 visits** per pregnant woman • *Aged (above 70)* – free consultation, basic laboratory, basic drugs for acute illnesses • *Children under five* – **free immunisation**, **child welfare clinic services, subsidised schedule**	
	6/8/97	• *Health providers* – Fee free services for Health providers but **shall not include tl dependants**	
Ashanti	10/8/99	• *Victims of snake and dog bites* – Free treatment • *Buruli Ulcer* – Free treatment	
Upper West	16/11/97	• *Pregnant women* – Drugs, lab, **admission and other services, all deliveries in hea centres** • *Elderly people **above 60 yrs*** - lab, drugs, **operations etc.**	

Eliminado:

18/6/98	• *Paupers* • *Health providers* • *Civil Servants* • *Specific Diseases of TB, Leprosy and Psychiatry* • *Malnourished children under 5 years* • *Elderly people above 60 years* - **Free Medical care for all the above (all services)** • *Pregnant Women* – Free consultation and routine drugs **only** • *Children 0 – 5 years* - Free consultation and **all** laboratory services	
4/8/98	▪ *Paupers* – All care ▪ *Aged 60+yrs* – **All care including in-patient care and surgery** ▪ *O – 5 yrs* – Consultation and laboratory ▪ *Antenatal Care* – **All care/services** ▪ *Normal Delivery* – **All Care/ services** ▪ *Difficult Deliveries* – **All care /services** ▪ *Emergencies* – **Deferred payment when necessary** ▪ *Referrals* – **Subsidised fees when necessary** ▪ *Malnutrition* – All care/services ▪ *Tuberculosis, AIDS, Leprosy* – All care/services ▪ *Caesarean sections* – **Surgery**	
6/10/98	*Snakebite and Dog bites* – Antisnake venom and antirabies venom **only**	
9/98	*Civil Servants* *Elderly* *Antenatal Care*	
3/6/99	Extension of exemptions to under fives, elderly over 70yrs, pregnant women and paupe mission hospitals	

APPENDIX 2: Tables 1,2,6,15

Table 1: Health Facilities Visited by Region and District

REGIONS	DISTRICTS	Dist. Hosp.	Health Centers	MCH/Comm. Clin	
Ashanti	Afigya-Sekyere	Asamang SDA	• Agona • Jamasi	Boanim	
	Ashanti-Akim South	Juaso	• Ofoase • Bompata	Dwedwenase	
Brong Ahafo	Berekum	Holy Family	• Jinijini • Akoroforo	Zongo	
	Techiman	Holy Family	• Tanaoso • Oforikrom	-	
Central	Assin	Assin Fosu Catholic Hosp.	• Fanti Nyankumasi • Bereku	Akropong	
	Abura-Asebu-Kwamankese	Dunkwa H/C	• Moree • Asuansi	Abakrampa	
Eastern	Yilo Krobo	Atua (Manya Krobo)	-	• Somanya (Ma • Nkurakan (Ma	
	East Akim	Kibi	• Apedwa • Anyinam	Jejeti	
Greater Accra	Tema	Tema General	• Ashiaman • Manhean	Tema Municipal	
	Dangme East	Ada Foah H/C	• Kasseh • Sege	Anyamam	
Northern	West Gonja	West Gonja Hosp.	• Yapei • Buipe	Busunu Comm. Cl	
	Savelugu/Nanton	Savelugu H/C	• Pong-Tamale • Nanton	Zoggu	
Upper East	Bolgatanga	Bolgatanga Regional Hospital	• Bolgatanga • Tongo	Bolgatanga MCH/F	

Upper West	Bongo	War Memorial Hosp. (Kassena-Nankana Dist.)	• Bongo • Bongo Soe ▪ Hamile	• Gowrie • Dua
	Jirapa/Lambussie	St. Joseph's Hospital	▪ Han	
	Sissala	Sissala District hospital	▪ Wellembelle ▪ Fielmuo	
Volta	Hohoe	Hohoe Govt. Hospital	• Akpafu-Mempeasem • Leklebi Duga	Ve Koloenu C Clinic
	Kedjebi	Mary Theresa Hosp.	• Ahamasu • Dzamlome	Dzamlome C Clinic
Western	Sefwi Wiawso	Sefwi Wiawso Gov't Hospital	• Anyinabrim Health centre • Akontonbra Health Centre	Bekyiwaa Comn Clinic
	Ahanta west	Nana Hemaa Dekyi Hospital	Agona Nkwanta	Apowa MCH Clinic

Con formato: Numeración y viñetas

Table 2. Number of Health Providers Interviewed by Region and staff level

	Regions							
Respondents	Ashanti	Brong Ahafo	Central	Eastern	Gt. Accra	Northern	Upper East	Upp Wes
REGIONAL HEALTH ADMINISTRATION								
Reg. Director	1SMOPH	1	1	1	1	1	1	1
Reg. Admin	1	1	1	1	-	-	-	1
Regional Accountant	1	1	1	1	1	-	1	1
DISTRICT ASSEMBLY								
DCE/Co-ord. Director	2	2	2	2	2	2	2	2
DIST HEALTH ADMIN								
DDHS	2	2	1	2	2	2	2	2
Dist.Acct	2	2	2	2	2	2	2	2
DIST. HOSPITAL								
Hosp. Supt	2	2	2	2	2	1	2	2
Pharm/Tech	2	2	2	2	2	1	2	2
Hosp. Admin	-	2	2	2	1	1	2	2
Acct./Rev Collector	2	2	2	2	2	1	2	2
Matron	2	2	3	3	2	1	2	2
HEALTH CENTRE								
Med. Asst	4	4	2	-	5	3	4	3
Matron	3	-	-	-	4	6	4	1

Acct/Rev Coll.	2	-	-	-	4	1	1	-
Disp.Tech/Att	2	-	-	-	4	1	3	-
No of FGD held with other staff	5	6	4	4	7	4	6	6
MCH CENTRE /COMM.CLINIC								
In-charge	2	1	3	3	2	1	2	-
PRIVATE FACILITY								
In-charge	2	4	1	1	2	2	2	4
Sub-Total	72	82	53	52	97	55	81	75
Clients	50	46	41	48	54	65	55	50
Grand Total	122	128	94	100	151	120	136	125

Table 6. Demographic characteristics of exit interview clients

Sex	No	Percentage
Male	**185**	**35.5**
Female	**330**	**63.3**
Missing data	**6**	**1.2**
Total	521	100
Age Distribution	No	Percentage
0-4	**161**	**30.9**
5-9	**5**	**1.0**
10-19	**29**	**5.6**
20-29	**105**	**20.2**
30-39	**70**	**13.4**
40-49	**20**	**3.8**
50-59	**11**	**2.1**
60+	**120**	**23.0**
Total	521	100
Educational Background	No	Percentage
None	**180**	**34.5**
Primary	**48**	**9.2**
Mid/JSS	**102**	**19.6**
O'Level/SSS	**16**	**3.1**
Voc/Tech./Comm.	**11**	**2.1**
University/Polytechnic	**3**	**0.6**
Child	**161**	**30.9**
Total	521	100
Marital Status	No	Percentage
Single	**52**	**9.9**
Married	**240**	**46.1**
Divorced/separated	**25**	**4.8**
Widowed	**43**	**8.3**
Child	**161**	**30.9**
Total	521	100
Religion	No	Percentage
African tradition	**44**	**8.4**
Christian	**368**	**70.1**
Moslem	**96**	**18.4**
None	**12**	**2.3**
Other	**2**	**0.4**
No response	**2**	**0.4**
	521	100
Occupation	No	Percentage
Unemployed	**77**	**14.4**
Farmer	**126**	**23.5**
Government worker	**11**	**2.1**
Artisan	**37**	**6.9**
Trader	**82**	**15.3**
Child	**161**	**30.0**
Student	**25**	**4.6**
Other	**17**	**3.2**
	536[1]	100
Expenditure per week (Cedis)	No	Percentage
0-10,000	**134**	**37.2**
11,000-20,000	**89**	**24.7**
21,000-30,000	**36**	**10.0**

31,000-40,000	**29**	**8.1**
41,000-50,000	**11**	**3.1**
70,000-150,000	**7**	**1.9**
No response/DK	**54**	**15.0**
Total	360[2]	100

1 - Multiple responses were allowed. Some clients had more than one job.

2 Information on expenditure per week were required from all clients with the exception of those under five s

Table 15. Points of payment for services by health facility and provider level

Services paid for	Cashier / rev. coll.	Record officer	Doctor / MA	Midwife	Nurse	Dispens. Assist.	Laborat. Technic.	C		
Drugs	66 (36%)	2 (1%)	13 (7%)	27 (15%)	15 (8%)	51 (28%)	1 (1%)	9		
Card	22 (17%)	71 (55%)	8 (6%)	13 (10%)	10 (8%)	-	-	5		
Laboratory	20 (38%)	1 (2%)	-	2 (4%)	1 (2%)	1 (2%)	28 (53%)	-		
Dressing/inj.	6 (15%)	-	1 (3%)	4 (10%)	26 (67%)	2 (5%)	-	-		
Mw / nurse	2 (6%)	-	3 (9%)	20 (63%)	6 (19%)	1 (3%)	-	-		
Doctor / MA	5 (26%)	-	13 (68%)	-	-	1 (5%)	-	-		
Tetanus inj.	-	-	1 (7%)	7 (47%)	6 (40%)	1 (7%)	-	-		
X-ray	3 (38%)	-	-	-	-	-	-	5		
Others	15 (43%)	1 (3%)	3 (9%)	5 (14%)	7 (20%)	-	-	4		
TOTAL PAYMENTS	139 (27%)	75 (14%)	42 (8%)	78 (15%)	71 (14%)	57 (11%)	29 (6%)	2		