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# The Impacts of Cost Sharing in Health Services in Geita Distrct, Tanzania

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## ABSTRACT

A study on the impact of cost sharing in health services was carried out in Geita District focussing on health service provision. A sample size of 96 respondents includes 24 health workers and 72 households' heads. Household heads were chosen to represent the community receiving health services. Health workers were chosen to represent health service providers who are providing health services in the study area. A cross sectional research design was adopted involving administration of structured questionnaires to both primary and secondary partners, complemented by relevant documentation. Statistical Package for Social services (SPSS) software was employed in data coding and analysis. The study revealed that the aim of cost sharing on health service is good. But the nature of the Tanzanians of being poor among the poorer and poor government procedure for sensitizing its policies before implementation impend the target and objectives of cost sharing on health service. More than 67% people earn less than 50,000 per month and more than 10% do not attend hospital services if they become sick. Also, more than 58% of people are not aware about cost sharing on health service. The study makes the following recommendations to improve health service provision under cost sharing policy. The spirit of working very hard in production activities should be done by all Tanzanians to reduce poverty. The government should educate its people at all levels such as villages, wards, division, district, region and national to make them aware on any policy like cost sharing on health service. Capacity building should be done to health workers to follow all the guidelines and conditions of cost sharing on health service provision.

**Key words:** Cost sharing, health services, poverty, willingness and ability to pay for health service

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## Introduction

### Background Information

The health of every human being is the major factor that determines power of someone to think and act upon a piece of work. A human being is the centre of all development; the human condition is the only final measure of development in any society (The 1988 Khartoum Declaration). Governments are responsible in making sure that citizens in their respective countries are provided with social services. These services may be provided to people using two ways; free provision through public subsidization or through the contribution from both citizens and respective governments for the purpose of bringing about community development.

Considering that governments in Sub-Saharan Africa, including Tanzania, have the social responsibility to assure the availability to their population of quality and affordable social services including health. Tanzania used to provide basic social services to all citizens free of charge. The government was the major provider of all health care services, and non-governmental (voluntary) agencies like missionaries were running a substantial number of health care units in rural areas on token fee. But following serious economic difficulties, which faced Tanzania during the 1980s, traditional

donors acquired a new habit of asking for the stamp of good economic conduct. This forced Tanzania to devalue her currency, reduce government expenditures, control credits, raise interest rates and remove subsidies. Due to this almost all government owned health centres and dispensaries had no drugs or diagnostic equipment and maternal mortality rates were on the increase (UNICEF, 1990); health workers' morale was at its lowest while attrition was at its highest. In an attempt to arrest the crisis the government introduced National Economic Survival Program (NESP) in 1981 for exploitation of local resources and then Structural Adjustment Program (SAP) in 1982 in which under the economic reforms, the cut backs on social sector expenditure were affected. NESP and SAP of 1982 were internal initiatives and they failed due to lack of resources. The SAP which began in 1986 was imposed by the World Bank and IMF which carried with it various conditionalities including cost sharing in major social services: health and education (Kiwara, 1994). Later in 1991, private practice was officially allowed and government accepted to introduce user fee in all health care providing units under the cost sharing policy.

According to Mujinja and Mabala, (1992) 59% rural population were in extreme poverty in the 1990s while health services are worse in rural than urban areas. In rural areas, they found that 42% failed to meet the need for cost sharing. Therefore, it is important to examine the impacts of SAPs policy instruments such as cost-sharing. Such an analysis is timely in the light of rising poverty levels in the country as well as Geita District.

**Problem Statement**

Cost sharing in Tanzania started in 1991, it intended to reduce government spending and encourage self-reliance (Abel-Smith and Rawal, 1992). This study is going to see what is done to those who cannot afford cost sharing (children of the poor, disabled, the elderly and poor). According to UNDP (1995), more than 50% African population including Tanzania constitutes children under 15 and old people of over 64 years. Also 44% had no access to health services (Mujinja and Mabala, 1992)).

Since the current cost-sharing plan is based on the assumption that with improved finances, the supply of drugs service will improve and the public system will win back patients. This fact is contrary to the current situation in Geita District in which drugs service, the public system does not win back patients, and finances have not improved. Hence, discrepancy or gap of the study, since the aim of this study is to assess the impact of cost sharing in access to health care. Also, there are inadequate data about this in Geita District and Tanzania in general.

**Problem Justification**

There is a need for this research because of the following reasons:

- The change from free medical service to cost sharing system might bring about changes on availability, composition, conduct and improved health services to the people.
- So far Tanzanian society, specifically the community in Geita District there are poor and rich people; cost sharing might influence differently the utilization of health services by different classes. Since cost sharing started in Tanzania in 1992, no study has been undertaken to determine its importance on health service delivery in Geita District.
- Results will be useful for different policy makers, planners and programme managers on health care programmes which seek to develop guidelines for health care improvement as to prevent big loss of manpower.
- Also, the study is in line with Millennium Development Goals number 4, 5, and 6.

**Research Objectives and Hypotheses**

The main objective of the study was to assess the impact of cost sharing on access to health care services in Geita District

**Specific objectives**

- To identify accessibility and affordability of the people on health service under cost sharing
- To find out if there are people who are denied health service under cost sharing for lack of funds
- To identify preferential treatment if any; for the old, children, and disabled on health service under cost sharing
- To establish if cost sharing has improved health care delivery (availability of medicines, equipment, personnel morale and improved health facilities)

**Null hypothesis**

Cost sharing is not significantly associated with accessibility and affordability of health service delivery.

## Literature Review

**Cost Sharing in Health Services**

Cost sharing is the portion of project or programme cost not borne by the sponsor. The "cost share" pledge may be either a fixed amount of money or a percentage of the project costs. The term "cost matching" often refers to cost sharing where the amount from the sponsor is equal to the amount from the cost-share partner. This is also known as a dollar

for dollar cost sharing or cost matching (UW, 2007). It is the community share of the cost of running any project. Cost sharing typically takes the form of in-kind resources includes contributed project personnel effort, manpower and cash. In Tanzania, establishment of cost sharing on health services was commenced in 1991 in higher – level health facilities like district, region and referral hospitals with the intent of reducing the financing gap, improving availability and quality of health services and increasing ownership/demand/community participation. Services at lower level health facilities like health centres and dispensaries were free until 1998, when the user fees were introduced in phase in conjunction with a community health fund, where a fixed annual membership fee entitled the household to fee health services. By the end of 2003, a community health fund was introduced in 36 out of 121 districts in Tanzania. Geita District was one of them, Community Health Fund as the means of generating fund for running health services aim to collect the fund and being utilized at district health facilities.

According to the Community Health Fund Regulations of 2004, the money accrued to the fund shall be used for payment of health care services provided, procurements of drugs, medical supplies and equipments based on health plans, health promotion and preventive measures, minor rehabilitation works in pre-selected government health care facilities in accordance with the approved plan and any other essential health purposes or activities as may deem relevant and approved by the Board. CHF is implemented differently from district to a district and it continues to evolve of many changing secondary objectives to core objectives. Geita District is charging Tsh. 10,000 per household per year (GDMO, 2011).

**National policy of cost sharing in health services**

According to the economic crisis in the 1980s, costs for health services were increased. However, shortage of budget of the government and high population growth caused the government budget especially of the health sector to be dependent to the donors. This caused the health services to be not sustainable, and the community failed to own them properly. For this situation, in 1993, the government decided to participate its community in cost sharing for their health services. The aim of this policy is to expand source of fund for health services in order to stabilize and develop source of revenue for the service provision and minimize dependent of the government on donors (URT, 2011).

**Exemption of cost sharing policy in health services**

The government of Tanzania determines the presence of people who cannot afford the cost sharing in health services, people who are in special community groups such as old people who are 60 and above years old, those who have no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income. Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases (URT, 2011). The aim of this policy is to enable all people to receive the quality and quantity health services equally.

**Willingness and ability of Tanzanians to pay for cost sharing in health services**

The Human Development Survey of 1994 on willingness to pay for desired quality health care at low – level health facilities to assess potential regressiveness of user fees has disproportionately higher negative effect of user fees among the poor compared with the rich (URT, 2003).

Nevertheless, report on program review and strategy development by U.N.F.P.A (June, 1996) claims that, Tanzania is one of the world's least developed countries and poverty profile in December, 1993 shows that approximately 50% of all Tanzanians live in Households classified as poor and more than a third of the total population live in the households categorized as hard core poor. This is an often used, even though at times problematic technique in this field. Studies in Tanzania (Abel-Smith and Rawal (1992)) suggest that typically people are willing to pay relatively modest sums for health care in return for better quality health services. They were willing to pay most for increased availability of drugs. It showed also that 42 percent of users had found it very difficult to raise the money to pay for mission services; another 43 percent had found it difficult to meet the need of cost sharing due to their low-income status.

**Impact of cost sharing in health services (research gap)**

An introduction of cost sharing for health sector, therefore, might have more impact on health status of Tanzanians who have to pay for treatment of various health problems that face them. According to Semboja (1994), it is widely believed that implementation of Structural Adjustment Program from which cost sharing policy was introduced has negatively affected social services provisions.

Bagachwa (1994) stated that reduction of government expenditures would have the effect of increasing poverty and its associated aspects of environmental degradation. The increase of poverty and environmental degradation will have impact on the public health status. With this fact, it is obvious that an introduction of cost sharing policy might have an impact in health care services delivery to Tanzanians. This study is intended to determine these impacts of cost sharing policy in health care services in Geita District whose inhabitants are mostly peasants, small miners and street vendors who generally get low income from their activities.

## Methodology

### The Study Area and Rationale for Choice of the Study Area

The study was conducted in Geita District rural and urban areas. Geita District has been chosen in this study to select divisions, wards, villages and health facilities from which sample respondents was selected. The following factors were considered in reaching the decision to choose this District: (a) cost sharing was introduced in this district as pilot study area (b) logistical support.

### Research Design and Justification

Non – experimental design was employed where a cross-sectional design was used in this study. The design allows data collection at a single point in one time (Babbie, 1990). Also, the design has the greater degree of accuracy and precision in social science studies than over design like observation (Casley and Kumar, 1998). Limited resources and time had been the criteria to justify the use of the selected design.

### The Sample Size and Sampling Procedure

The target populations were different actors such as household heads and health workers. According to Bailay (1994) minimum of 30 respondents is the bare minimum for studies in which statistical data analysis can be done. The study selected a sample size of 96 respondents, includes 24 health workers and 72 households' heads. Household heads were chosen to represent the community receiving health services. Health workers were chosen to represent health service providers who are providing health services in the study area.

Stratification and simple random sampling methods at different stages was employed; rural and urban strata were chosen, while the choice of 2 Divisions, 2 Wards from each Division, 1 village from each ward, 4 health facilities, 18 heads of household from each village and 6 health workers were chosen by using simple random methods to make a total of 96 respondents.

### Data Collection

**Primary data:** Primary data related to health services provided to community, impact of cost sharing on health service delivery, people who denied health service under cost sharing for lack of funds, accessibility and affordability of the people on health service under cost sharing, public attitudes toward cost sharing in health service provision, health providers improvement delivery owing to cost sharing (availability of medicines, equipment, personnel morale and improved health facilities) and other related information was collected using a structured and pre-tested questionnaire, checklist and informal discussion for sampled individuals.

**Secondary data:** Secondary data from different sources such as government offices, library, institutions, web site and live participants observations were collected and then used to complement the information obtained from sample respondents.

### Data Processing and Analysis

Data were coded and analyzed using the Statistical Package for Social Sciences (SPSS) version (12) computer programme. Descriptive Statistics (Means, frequencies and percentages) were computed. Also statistical inferences (linear regression) were computed for hypotheses significance test. Finally, data were analysed using the linear regression model so as to determine the impact of cost sharing on health service.

Formulae: $Y = A_0 + B_1 X_1 + B_2X_2 + B_3X_3 + \ldots\ldots\ldots\ldots + B_nX_n + e$

Where, Y = Dependent Variables (improved health service such as availability and accessibility of quality health service provision)

$X_1$, $X_2$, $X_3 \ldots X_n$ = Independent Variables (Health service users under cost sharing with relation to belief, income, education, perception, demographic, geographic)

$A_0$ = Constant (no health provision improvement)

$B_1$, B2, B3……..$B_n$ = Constants (there is improvement of health service provision due to cost sharing policy) e = is an error term

## Results and Discussion

### Ability of People to Pay Cost Sharing

Income means a regular flow or addition to one's stock of wealth and generally one considers a person to be poor if his income is low (Hanson, 1996). According to Ellis (2000), income comprises both cash and in-kind contributions to the materials welfare of the individual or household deriving from the set of livelihood activities in which household members are engaged. Information about household income in the study was very important as they could reveal if the community can afford and access the health service under cost sharing. During the study the respondents were asked to mention their income per month. The results indicate that the 67 percent of household respondents earns

below Tsh 100,000 per month or below Tsh 20,000 per month per person/individual which are equivalent of US $ 80 per month or US $ 18 per month per household member or below US $ 0.6 per day per person (see Table 1) in which respondents were asked to estimate amount of money they earn per month. The results imply that the majority of respondents are still below poverty line i.e. below one dollar (US) per day per person. The findings are in line with the report by World Bank (2000) which pointed out that 50 percent of Tanzanians live in poor household with an income equivalent of less than US $ 0.75 per day per person. It also reported that in the year 2000 income in Tanzania was US $ 242 per capita per years. Furthermore, about 50 percent of Tanzanians live below the poverty line of Tsh 73,877 per adult equivalent per year in 1995 prices which are about the US $ 0.5 per capita per day.

**Table 1:** Ability of people to pay cost sharing (N = 96)

| Monthly earned income (Tsh) | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| 100,000 and below | 48 | 67 | 0 | 0 |
| 100,001-200,000 | 10 | 14 | 10 | 42 |
| 200,001-300,000 | 4 | 6 | 6 | 25 |
| 300,001-400,000 | 3 | 4 | 2 | 8 |
| 400,001-500,000 | 4 | 6 | 2 | 8 |
| 500,001-600,000 | 1 | 1 | 2 | 8 |
| Above 700,000 | 1 | 1 | 2 | 8 |
| **Total** | **72** | **100** | **24** | **100** |

**Attendance of people at public health service under cost sharing**

Table 2 indicates, 90 percent of heads of household respondents do not attend at public health service because of lack of funds for paying for the health service under cost sharing. This meant that the majority of people in the study area do not attend at hospital for health service, but they use traditional medicine for their treatment. Many people opt to go to traditional healers for treatment that is very much cheaper and payment procedure done after recovery that is contrary from health service treatment, whereby people pay before treatment take place to the patients. During the study more respondents complained about this, for example Masalu said that "*his grandmother died at Geita District hospital due to late treatment that was to be done after completion of payment cost sharing process at reception step"*.

**Table 2:** People who are denied Health services due to lack of funds (N = 96)

| Attendances of people at health service | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| I do attend | 65 | 90 | 24 | 100 |
| I don't attend | 7 | 10 | 0 | 0 |
| **Total** | **72** | **100** | **24** | **100** |

Source: Survey data.

**Preferential Group for Health Service under Cost Sharing Availability of the old, children and pregnant women preferential for health service under cost sharing policy at Geita District**

The Tanzania national policy of exemption different special group of people from cost sharing in health service states that people who are in special community groups such as old people who are 60 and above years old, those who have no ability to generate income, children who are under five years old, children who are at risk environment of life, pregnant women and all people who do not have power to generate income. Also, people who have the following diseases; cancer, HIV/AIDS, diabetes, blood pressure, asthma, sickle cell, TB, leprosy, and psychiatric cases should be exempted from cost sharing in health services. The aim of this policy is to enable all people to receive the quality and quantity health services equally (URT, 2011).

According to health workers in the study area, 29 percent indicated that, disabled people are not treated free at hospital because not all disabled do not have the ability to pay while 42 percent indicated that the old people are not treated free. This is because not all old people have no fund to pay for health service. It meant that, procedures for exempting

preferential group are not clear to the community as well as health workers. Lack of exemption of preferential group from cost sharing on health service is evident as shown further in Table 3.

**Table 3:** Preferential treatment identification (N = 96)

| Variables | Head of households (n=72) | | | | | Health workers (n=24) | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | YES | % | NO | % | Total | YES | % | NO | % | Total |
| Disabled treated free | 29 | 40 | 43 | 60 | 72 | 17 | 71 | 7 | 29 | 24 |
| Children treated free | 60 | 83 | 12 | 17 | 72 | 24 | 100 | 0 | 0 | 24 |
| Pregnancies women treated free | 60 | 83 | 12 | 17 | 72 | 24 | 100 | 0 | 0 | 24 |
| Old people treated free | 23 | 32 | 49 | 68 | 72 | 14 | 58 | 10 | 41.67 | 24 |
| **Total average** | **43** | 60 | **29** | **40** | **72** | **20** | **82** | **4** | **18** | **24** |

**Health Service Delivery Improvement Availability of the medicine at government health service**

**Table 4:** Availability of medicine at government Hospital health service (N = 96)

| Availability of medicine at Hospital | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| Available | 7 | 10 | 6 | 25 |
| Most of time not available | 65 | 90 | 18 | 75 |
| | **72** | **100** | **24** | **100** |

Availability of medicine is the key determinant of improved health service under cost sharing. According to the Structural Adjustment Programme, donors left medicine for the government in relation with cost sharing. Table 4 above shows that 90 percent of the head of households indicated that, medicine is always not available at government health delivery while 10 percent only said that medicine is available in which most of them were found in urban area. In rural areas medicine is not available most of the time the study realised and observed. This was supported by health workers in which 75 percent indicates that medicine at government health service is not available while only 25 percent shows that medicine is always available. Moreover, act of further discussion by respondents, findings revealed that one person required to pay Tsh 1500 before being given any treatment and he was discovered suffering from malaria, incredible enough a person was dispensed with *panadol* with an equivalent to Tsh 200. A person complained a lot and promised that he will never attend again at government hospital because of lack of medicine under cost sharing.

**Poor health service at public health service**

Table 5 shows that, 36 percent of respondents said that poor health service at public health service are due to complicated procedure at hospitals. Further discussion revealed that, a person may be serious sick but a very long process will be taken before treating him/her. Also 33 percent indicated that, nowadays at any public service there is a passive resistance by workers. Moreover, findings discovered that, government is not considering its workers in terms of paying them satisfied salaries in relation to their demand, also lack of motivation in paying extra duty for health workers who work in village and those who have low position.

**Table 5:** Reasons for unsatisfactory/poor public health services (N=96)

| Reasons for unsatisfactory public h/services | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| Passive resistance | 24 | 33 | 1 | 4 |
| Salary is not enough | 1 | 1 | 5 | 21 |
| Complicated procedures | 26 | 36 | 1 | 4 |
| **Total** | **51** | **71** | **7** | **29** |

**People willingness to pay cost sharing for health service**

**Table 6:** Willingness to pay cost sharing for health service (N = 96)

| Willing to pay cost sharing for health service | Head of households | | Health workers | |
|---|---|---|---|---|
| | Frequency | Percentage | Frequency | Percentage |
| Yes | 38 | 53 | 10 | 42 |
| No | 34 | 47 | 14 | 58 |
| | **72** | **100** | **24** | **100** |

During the study respondents were also asked whether they like and are willing to pay in cost sharing for health service. Results in Table 6 above show that, 53 percent of head of households are willing to pay cost sharing for health service while 47 percent indicate that they are not willing to pay for health service. But 58 percent of health workers respondents do not like to pay for health service through National Health Insurance Fund (NHIF) which is automatic contribution for any government employee while 42 percent they like to pay cost sharing for health service. Further discussion by respondents, findings revealed that community contributed a lot for health service but improvement of health service is very low compared to objectives of cost sharing policy.

**Determinants of Health Service Accessibility and Affordability**

Multivariate regression analysis and T-test were conducted to ascertain factors that influenced significantly health service accessibility and affordability by health user under cost sharing (see Table 7). Access and affordability of health service under cost sharing was regressed and tested against age, education level, income status, belief, availability of medicine, enough health workers, motivated health workers, and occupation.

**Age:** The results indicate no significant relationship between cost sharing and age, the probability was 0.204 which is greater than 0.05. Beta was -0.04, this implies that as age increases an ability of people to access and afford health service decreases (Table 7). This finding implies that older people have poor chances to afford cost sharing on health service. This is because older people always risk averse, they can not work and be paid as they used before in case of retired.

However, rural older people can not work effectively for income generation. Therefore, cost sharing for the old people is not in position. Hence, the older people should be excluded from cost sharing for their health service.

**Occupation for income generation:** Occupation activity was thought to be significant because farming which was the main occupation of the majority respondents could influence a person to run income generation. However, the results show that there was no significant relationship between occupation and accessibility of health service, since probability was 0.41 which is greater than 0.05. The Beta statistic was -0.09, this implies that those who have good employment any where can always be treated in private hospitals and not in public hospitals. They always fear to waste their time while they have money to choose whether to be treated in public or private hospital (Table 7).

**Table 7:** Linear regression factors influence accessibility and affordability of health service under cost sharing (N = 96)

| Variables | B statistic | T statistic | Probability |
|---|---|---|---|
| Age | –0.04 | –1.08 | 0.20 |
| Availability of health workers | 0.37 | 3.59 | 0.00 |
| Education | –0.03 | –0.2 | 0.84 |
| Peoples' perception on cost sharing | 0.22 | 2.22 | 0.03 |
| Employment | –0.09 | –0.82 | 0.41 |
| Belief on traditional healers | –0.12 | 1.28 | 0.04 |
| Availability of medicine | 0.35 | 3.23 | 0.00 |
| R square = 0.508 | | | |
| Significance P<=0.05 | | | |

**Education**

Education was found to be not significant variable that determines ones to attend and afford public health service under coast sharing, since probability was 0.84. Beta statistic was -0.03 (Table 7). These meant that increased level of education does not make people attend public health service under cost sharing, as educated people have increased awareness on prevention to various diseases and they know that at public hospital, health service provision is poor compared to private hospital. Therefore highly educated people are not likely to get diseases and if they become sick they prefer private health service while people without education are at risk of becoming sick and if they become sick they prefer public health service if not traditional healers.

**Availability of Medicine**

Availability of medicine was found to be a significant variable that determines accessibility and affordability of health service under cost sharing, the probability was 0.003, Beta statistic was 0.35 (Table 7). Moreover, when medicines are available, the attendance of patients at public health service increased also, the vice verse is also true.

**Health workers at public health service**

Health service delivery is determined by personnel. Results in Table 7 show the most significant relationship between health workers and accessibility/affordability of health service under cost sharing, the probability was 0.001 and Beta statistic was 0.37. This meant that at any health service if there are enough, motivated and qualified health workers, health service users or customers will also be increased.

**Belief on witchcrafts/traditional healers**

The results indicate a significant relationship between access and beliefs on witchcrafts, the probability was 0.04 while Beta statistic was -0.12 (Table 7). This finding revealed that as the number of believers in witchcrafts increases, the number of people to attend at health service decreases. Therefore, most people choose for witchcrafts service provision rather than health service. This is due to the number of reasons include cheap treatment; use of natural trees and some diseases can not be treated at the hospital.

**Perception of people on health service under cost sharing**

The results indicate a significant relationship between access/affordability and perception of people on health service under cost sharing, the probability was 0.03 while Beta statistic was 0.221 (Table 7). This finding revealed that as the number of people perceives that cost sharing is for everybody and is, therefore, the purpose of improving public health service increases, the number of people to attend and afford health service under cost sharing increases also.

**Testing the hypothesis**

Null hypothesis stated that, there is no significant relationship between associated factors/variables of cost sharing (age, education level, income status, occupation, availability of medicine, enough health workers, and belief) and accessibility/affordability of health service. More variables tested above show there is a significant relationship between associated factors/variables of cost sharing and accessibility affordability of health services. Therefore, from these evident results by the linear regression model, the alternative hypothesis is true, which states that there is a significant relationship between associated factors of cost sharing and accessibility/affordability of health services.

## Conclusion and Recommendations

**Conclusions**

The following are aspects of the conclusion made from the findings.

- The information on cost sharing policy does not reach well the health service users especially rural people. Therefore, the lack of good procedure for sensitizing any policy before starting implementation is a big problem in the study area.

- The majority of people do not have an ability to pay for health service. This is due to an adverse poverty situation that is dominating the majority of Tanzanians.
- Many people have the negative attitude on cost sharing for health service. This is because they do not see an expected highly positive improvement of health service delivery.
- People have started to deny health service provision under cost sharing. This is due to an unavailability of medicine most of the time and low health workers with low education level and low morale to work.
- Both heads of household and health workers appreciate traditional healers since they conduct traditional medicine services by natural herbs and at low cost compared to cost sharing in health services.
- Exemption policy treatment for preferential group i.e. the old and disabled people is not well known to some health workers and the community.

**Recommendations**

From the conclusions of this study, the following recommendations are made.

- The government especially health policy makers should aim at making extensive sensitization of any new programme to all stakeholders before implementation takes place.
- There should be a survey to determine people who are very poor to exclude them from cost sharing for their health service. Nevertheless, a big loss of people may happen because of failing to pay for their treatment at the hospital.
- Health workers especially leaders in collaboration with government should make sure that money obtained through cost sharing reflects the objectives of improving health service delivery and not otherwise.
- There should be a simple procedure to identify the old and disabled people to exclude them from cost sharing in health services. Findings revealed that majority of the old and disabled people are not simply excluded because of complex procedure existing at public health service facilities, but also the policy for exempting them from cost sharing in health service is clearly defined and stated by the government. It seems that the policy actors such as health workers management are the source of the problem. Therefore, the government should work on this to serve its people.

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