



**METHODOLOGY FOR AN
EQUITY AND COVERAGE OF
HEALTH CARE PROVISION STUDY**

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1. The Background and Purposes of the Study

A tradition of free public provision of all health services has existed in many developing countries since their independence. However, as these countries have seen severe downturns in their economies and government revenues in the last decade, the need for additional sources of revenue to operate the public sector health system and its services has become more acute. The result has been increased interest and implementation of cost recovery schemes. As noted by Gilson, the policy debate has shifted from the issue of whether or not to introduce cost recovery to how such systems should be introduced. Many cost recovery systems have been designed with the sole or primary objective of generating revenues to replace or supplement government funds. In designing such systems, little consideration was given to the potential negative impact of user fees on the population's demand and utilization of services. As the introduction of such schemes have become more widespread in developing countries, some unintended negative effects have been observed. This has resulted in uneasiness about the equity implications of these systems: How have cost recovery systems affected the access to and utilization of health services for the poor and other vulnerable groups? These concerns are based on the belief that health care is a basic right and its receipt should be based more on need than on one's ability to pay.

The result of these concerns has been the development of various mechanisms, such as means testing and exemption systems, aimed at protecting the poor from the full impact of such user fees. These systems are designed to ensure that cost recovery efforts do not create serious financial or opportunity cost barriers for the poor, or other groups such as those with certain illnesses, which would unduly reduce their access to care. Such assessments of access may compare changes in utilization of a particular group to their past utilization or to changes in utilization of the population as a whole.

It is these concerns which caused Health and Human Resource Analysis for Africa (HHRAA) of the USAID Africa Bureau to seek to have better understanding of the issues and the experience of protection mechanisms, such as means testing. HHRAA and a number of countries sought to answer their concerns about the present and the future by obtaining (1) a more formal evaluation of the equity implications of cost recovery schemes, (2) a review of which systems meant to maintain equity work the best, and (3) a series of options for policy makers in developing cost recovery schemes which ensure equity. The basic questions posed by HHRAA were:

- How to ensure the poor have access to health facilities under cost recovery?
- What means testing systems are most effective and under what conditions?
- How can means testing in the health sector be combined with similar tests carried out for other sectors?

At the meeting where these issues were raised with HHRAA, a number of countries indicated that there was interest in not only the rural and primary health care settings but also in hospitals and

in urban situations. While there was particular interest in public sector health facilities, there was also interest in the private, non-profit facilities and how they had dealt with this issue.

This paper is to address these questions by designing a methodology to undertake five country case studies. The purposes of the field case studies are to:

1. Develop a practical methodology for assessing the effectiveness of means testing systems;
2. Use the methodology to carry out five country case studies;
3. Describe the approaches taken to develop protection mechanisms for the poor;
4. Assess the effects of the various protection mechanisms used to ensure equity in the five countries;
5. Synthesize the lessons learned from the country case studies; and
6. Provide guidance, options and tools for other countries establishing or redesigning their mechanisms to protect the poor.

This document presents a framework for examining the basic issues of equity and coverage of health care provision to the poor under cost recovery through various protection or targeting mechanisms.¹ It proposes a methodology for undertaking the country case studies and assessing the conceptual and operational issues of means testing systems. The country case studies will document practical experience in the design and implementation of such systems.

2. A Framework for the Study²

The basic questions of this study are, in situations where some form of cost recovery has been introduced, how effective have the protection mechanisms been in ensuring equity? What has been the cost of these systems? How have the systems worked in reality compared to the design of the system? Equity, in the health context means "equal financial and physical access for equal

¹A companion document, commissioned for this study, "Literature Review: Equity in the Health Sector in Developing Countries" by H. Waters reviews much of the background which will not be repeated here, such as the concepts, issues, types of mechanisms, advantages and disadvantages, and experiences with different targeting programs.

²In the course of developing the framework and identifying the issues for this study, the authors relied upon the recent substantial works reviewing existing experience with targeting:

- Gilson's forthcoming works on targeting and user fees in the health sector, "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy" with Russell and Buse and "Cost Recovery in Government Health Services -- Is Equity Being Considered: An International Survey" with Russell;
- Grosh's broader work for the World Bank on targeting in various social sectors Administering Targeted Social Programs in Latin America (1994),
- Willis' examination of the concepts and economic basis for means testing, "Means Testing In Cost Recovery of Health Services" (1993), done under the USAID Health Financing and Sustainability project, and
- Waters' "Literature Review: Equity in the Health Sector in Developing Countries" completed for this study.

need", according to Vogel, or equal opportunity of use of health services for equal need (Gilson).

Targeting is the umbrella term used to describe protection mechanisms for, not only health, but all the social sectors. As outlined in Waters' literature review, Grosh defines targeting as the "identification of those who will or will not be eligible for a social program." The goal of targeting is to concentrate limited resources on those in greatest need. The benefits for an individual who is included in a targeting program in the health sector is the eligibility to receive or consume health services without paying the standard fee or paying only a portion of the fee (discounted fees).

Direct, characteristic, and self targeting are the three basic forms of targeting. Direct targeting describes the provision of benefits or services to those of the population who cannot pay because of a low income level. This form of targeting uses some form of means testing because identification of need is based on income. Characteristic targeting, by contrast, provides benefits to individuals with certain attributes, special circumstances or a special need regardless of the income level of the individual or their family. The third form of targeting, self-targeting, involves an individual's self-selection for participation or lack thereof in a program. Gilson points out that the relevance of self targeting is not clear for the health sector so this form of targeting will not be explored directly in this study.

Direct targeting, characteristic targeting, self targeting, means testing, exemptions, and waivers are all terms used to describe the "protection mechanisms" used to ensure equity. Table 1 summarizes the classification of the targeting terms.

Table 1

CLASSIFICATION OF TERMS USED TO DIFFERENTIATE TARGETING MECHANISMS

| TARGETING | | |
|------------------------|----------------------------|------------------------------|
| BASIS OF QUALIFICATION | Income based determination | Individual's characteristics |
| TERMS | Direct targeting | Characteristic targeting |
| | Means testing | Exemptions |
| | Waivers | |

Adapted from Grosh, 1994, p. 34.

The distinction between direct and characteristic targeting is important in the health sector because it may influence which services people seek out and demand despite the imposition of user fees in the health system. Direct targeting seeks to benefit only the poor so they may receive necessary health services and not have any access barriers. By contrast, characteristic targeting identifies people who should receive health services free or at a subsidized price because they

- have certain illnesses which the government desires that they seek treatment for because of its contagious nature (such as tuberculosis) or the financial burden it creates (e.g. AIDS);
- belong to certain employment groups (e.g. civil servants or health workers); or
- fall within particularly vulnerable groups, such as children under 5 years of age, which are the focus of concern with characteristic targeting.

Characteristic targeting is often used for those health services which have positive externalities, such as immunizations, or groups which the government wishes that they seek treatment, as illustrated below. The groups selected for characteristic targeting may be due to public health concerns or simply chosen for political reasons.

An example from Kenya will serve to distinguish between direct and characteristic targeting (Quick and Musau, 1994). Direct targeting, allowing the poor to have access to health care by excusing them from paying fees, is termed a "waiver". Waivers are discretionary releases from payment based upon inability to pay or income levels. Waivers are synonymous with the term "means testing". Waiver programs may incorporate considerable variation. Gilson points out that in most countries, waivers are granted for all charges. While waivers, in general, are a release from paying any fees based on one's income level there are variations on the waiver system, such as sliding fee scales, in some countries. In Guatemala, for instance, the waivers are graduated fees depending upon ability to pay. Based upon different income thresholds, people are classified into different groups with different payment obligations: those in group A have sufficient income that they pay the full fee; people in group B pay half the fee; those designated as level D are poor but not indigent and pay 10% of the fee; and those in level C are considered the poorest and pay no fee.

The characteristic targeting program in the health sector in Kenya are referred to as "exemptions". An exemption is an automatic excuse from payment. Exemptions may be granted for a variety of reasons. The categories of individual characteristics which may qualify for exemption and some examples are:

- **employment group or status:** those belonging to a particular occupation group (e.g. military, civil servants, or health workers) or the unemployed.

- **age group:** children of certain ages or the elderly may be exempted.
- **illness:** patients with certain illnesses, such as tuberculosis or AIDS, are exempted.
- **certain health services:** patients seeking care for certain health services which are deemed to have externalities, such as immunizations, family planning or prenatal clinic visits for pregnant women, are exempt as a means of promoting use of that type of health service.
- **economic hardship:** even if a patient does not qualify for a waiver, the economic burden of a particular health situation may dictate an exemption, such as in Kenya where no further inpatient charges are made after 14 days of inpatient care.
- **geographic origin:** patients residing in certain geographic areas.
- **special groups:** students or prisoners.

In the health sector characteristic targeting is often used because of the externalities of people using certain health services, such as leprosy patients which receive their treatment and drugs free. The public benefits from this by not having a contagious person spreading the disease further.

The primary distinction between direct and characteristic targeting is that the former waive fees based on income while the latter waive fees based upon the characteristic of the patient, regardless of the patient's income level. This distinction has important implications for the administration of such targeting programs. The determination of someone qualifying for an exemption from fees due to characteristic targeting is straight forward: the patient either has one of the qualifying characteristics and is therefore eligible or is ineligible because he does not have one of the qualifying characteristics. Direct targeting, however, is more complex and difficult to determine eligibility because it involves an assessment and decision concerning the patients income level or economic status by some external evaluator. The decision by the evaluator usually has a discretionary element. There can obviously be overlap: the poor may be covered by an exemption from paying fees because they have certain characteristics or they may qualify based upon their low income level.

3. The Issues of the Study

From the work reviewed (see footnote 2) and other experiences from the field, a number of important issues on achieving equity under cost recovery emerged. These issues have been categorized: impact issues, criteria issues, administrative issues, subsidy issues, and issues of how direct and characteristic targeting systems interact to achieve equity. This section presents various questions and issues which are to be addressed by these studies.

3.1 Effectiveness issues

A basic issue is the effectiveness of a means testing system in achieving its objective of exemption the poor from paying for services so they may readily access basic health services. Some of the basic questions of this issue are: What is the effect of the cost recovery scheme with a means test? Are these systems effective? Do they ensure that there is equity in access to health services?

The effectiveness or impact of targeting mechanisms may be measured by undercoverage and leakage. Undercoverage, which Willis describes as a Type I error, is the classification of a truly poor person as non-poor. Leakage, a Type II error, occurs when a non-poor person is classified as poor and thereby eligible for a waiver. There is a tradeoff between these two types of problems: stringent application of eligibility requirements may reduce leakage but may also increase undercoverage. Likewise, the loose application of eligibility guidelines may minimize undercoverage but is likely to increase the number of non-poor being classified as poor, or leakage. Willis' chart to illustrate undercoverage and leakage is reproduced below.

Table 2

Undercoverage (Type I error) and Leakage (Type II error)

| | | ACTUAL STATUS | |
|---------------|----------|---------------------------------|---------------------------------|
| | | Poor | Non-Poor |
| CLASSIFIED AS | Poor | Correctly Classified Benefit | Type II Error |
| | Non-Poor | Type I Error | Correctly Classified Benefit |

For those who do receive care but do not receive a waivers, what is the source of funds used to pay for services? It is also important to know about those in the community who did not receive care who were eligible. Is it a lack of information about eligibility? Are the providers extremely stringent in providing waivers?

3.2 Criteria issues

Several criteria may be used to judge eligibility for exemption from user fees. The ones reviewed below are income, client or patient characteristics, the health services sought, and health condition of patients.

INCOME: For waivers from fees, the criterion for eligibility is often income. The proportion of the population which are below the poverty threshold are not to pay fees for health services because of their low income. The primary implementation difficulty is how eligibility is determined. It may either be a formal income assessment or an informal, subjective proxy measure such as the ward nurse's assessment of how well off the family members, who visit the patient, appear to be. Formal income assessments are more difficult where the employment sector is small and documentation of income is minimal. It is usually more costly than systems based on characteristic targeting described below.

CLIENT CHARACTERISTICS: For other forms of targeting, client characteristics are the criteria to establish eligibility for free or subsidized care. Exemptions, the foregoing of payment of fees applies to all patients with certain characteristics. The variety of characteristics which may make a patient eligible for an exemption includes: (1) employment group or status, (2) age group, (3) illness, (4) use of certain health services, (5) lengthy and costly illness episodes create economic hardship for the patient, (6) geographic origin, or (7) belonging to a special group. Individuals with a qualifying characteristic are either exempted from paying or given a discount in fees for health services received. How are the characteristics eligible for exemption determined? Was it a centralized or decentralized decision process? Were special interest groups involved in promoting exemptions for their members? Gilson refers to this as the political context.

HEALTH SERVICES: Exemptions may also apply if certain services are being promoted. Anyone using family planning services, for instance, may be exempted from payment for those services. Services with positive externalities, such as immunizations, are often exempted. This is slightly different than individuals qualifying for exemptions based on their health condition. Exemptions for patients in this group are provided because of the desire to have certain services used, such as prenatal services for pregnant women.

HEALTH CONDITION: There may be a public interest in ensuring that certain communicable illnesses, such as tuberculosis, are treated. To facilitate patients seeking treatment, there may be no fees for certain illnesses. Other health problems, such as AIDS, may be exempted because of public concern over the financial burden of the illness or seeking to provide incentives for seeking treatment, such as or those with sexually transmitted diseases where it is a public health concern.

3.3 Administrative issues

With any form of targeting there is the need to administer the program. This raises issues about how the program is run. The paragraphs below deal with the three major issues of who and where is responsibility assigned for determining eligibility, the systems in place to carry out the

program, and the extent of public information or education about the program and policies for exempting patients from fees.

RESPONSIBILITY:

Certifying eligibility. Who is responsible for determining whether a patient qualifies? For characteristic targeting it is not difficult, generally, to determine eligibility. The health facility staff determines if the patient has a certain characteristic which places him or her in an exemption category. Means testing, however, is income based and involves more discretion and subjectivity in making the eligibility decisions. The question is whether it is the hospital administrative staff such as the admissions clerk, a nurse on the ward or in the outpatient clinic, a social worker, or by some arm of government, such as a Ministry of Social Welfare or a local district council or administrator who determines eligibility, prior to seeking care.

Verifying eligibility. In addition to certifying eligibility, there is the issue of how the assessment is verified. These are important issues which will have an impact on the amount of leakage and undercoverage, depending upon the stringency with which the standards are applied. This also relates to how long a certification for exemption from paying is valid for. Is the exemption valid for a single treatment, for an episode of illness or for a specified period of time? The longer the period of validity the lower the administrative costs for that system but the greater the opportunity for abuse.

SYSTEMS: What are the means for assessing eligibility for a waiver? Is it a card issued by a ministry before care is sought or is it made when the patient presents at the health facility? How often does the assessment have to be made or verified? How long is the waiver good for?

PUBLICITY OR EDUCATION: How do people learn about eligibility for waivers? A key issue is whether there is public education or if people learn by word of mouth or accidentally. This will affect undercoverage if there is little education effort or leakage if there is much publicity so the non-poor seek waivers to receive free care as the poor.

3.4 *Subsidy issues*

What are the costs of the waivers? This is both the cost of administering the program and the cost of revenues foregone. Administration costs include staff time to administer the waiver system, such as time to explain it, grant waivers, and monitor compliance with the program provisions, and the supplies necessary, such as cost of forms. Revenue foregone are those revenues which would have been generated if those same services had been used if there had been no fee waiver. These may be substantial, for instance, if 30% of the patients receive waivers from paying fees due to their income level and an additional 20% receive exemptions because of their various characteristics, the effective revenue expected is only 50% of the potential total

revenue under cost recovery if there were no waivers or exemptions. Thus, cost recovery systems which are intended to provide revenues for operation of facilities to increase quality or expand services, in most cases, may experience a shortfall in revenues from those originally envisaged due to the granting of exemptions and waivers.

There may also be a cross subsidization of costs. The charges for services for paying patients may have to be increased or exceed actual costs in order to subsidize the costs of those patients receiving waivers or exemptions. For instance, hospitalized patients who have insurance or a self paying patient may pay more than actual cost of their treatment in order to subsidize the cost of outpatient MCH services for mothers and children to encourage their use of those services.

3.5 Interaction of direct and characteristic targeting system issues

Another consideration of effectiveness is the overlap of direct and characteristic targeting. This relates to the efficiency of these targeting mechanisms for achieving equity goals of covering the poor. For example, poor families may receive free services for their young children from an under-5's exemption. The remainder of the family members receive care without paying fees under a waiver. Are both needed? Is one easier to administer and achieving the equity goal, for the most part? If so the waiver system may only be relevant to ensure access to the members of that family who are over 5 years of age.

A summary comparison of differences in administrative and cost aspects of waiver systems (direct targeting) and exemption systems (characteristic targeting) is provided in Table 3. This table is reproduced directly from Gilson, Russell, and Buse's forthcoming paper "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy" in the Journal of International Development.

4. The Methodology of the Study

4.1 The Structural Design

The study will involve learning how equity is addressed in cost recovery systems from the experience of various public and private sector health facilities in five countries. The process will involve gathering data in each of the five countries, analyzing it for each country, synthesizing the data and information from the five countries, and identifying policy options and systems which promote equity under conditions of cost recovery. The data sources for all country studies will include information from local health facilities and central ministries. The information will be from primary and secondary data sources. The process of gathering data will involve reviewing existing and secondary data, visiting health facilities, gathering original data,

Table 3

COMPARISON OF ADMINISTRATIVE AND COST ELEMENTS OF
DIRECT AND CHARACTERISTIC TARGETING

| | Direct Targeting | Characteristic Targeting |
|--|------------------|--------------------------|
| Decision-making criteria | ←—————→ | |
| Ability to cover all of eligible | Lower potential | Greater potential |
| Leakage to non-eligible | Lower potential | Greater potential |
| Informational requirements | Higher | Lower |
| Administrative costs & capacity required | Higher | Lower |
| Invasive costs & dangers of stigmatisation | Higher | Lower |
| Behaviourial/incentive costs | Higher | Lower |
| Self-selection possibilities | Lower | Higher |

Source: Figure 2 in L. Gilson, S. Russell, and K. Buse's (1994) "The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy", forthcoming paper, p.46.

surveying patients, providers and the poor, and conducting household interviews with the poor. The sample of facilities in each country will include public and private facilities, urban and rural facilities, and hospitals and health centers.

The data to be gathered for these studies were selected to serve two purposes: to provide descriptive and evaluative information. The descriptive information will provide a description of the various approaches which have been used to protect the poor and ensure equity as well as provide insight on the factors which have contributed to the success or failure of such protection mechanisms for the poor.

The evaluative information from the studies will enable an assessment of the effectiveness of the protection mechanism: Is equity assured by protecting the poor from the effects of user fees so

they continue to have access to basic health services? The descriptive information relates primarily to the operational issues of the system while the assessment process evaluates the effectiveness of the systems in achieving equity. Effectiveness is evaluated from assessments of the leakage and undercoverage of the system. Information from undercoverage will be obtained from household surveys among the poor who have not used the health facilities. Patient exit interviews will capture the poor and non-poor who do use the health facilities. The following section describes the basic descriptive and evaluative information which is to be gathered in the country studies.

4.2 *The Sample*

Countries

The examination of these questions and issues of equity and the development of guidelines and options for ensuring equity under a cost recovery scheme will occur through synthesis of five country case studies sponsored by HHRAA and BASICS. BASICS, in consultation with HHRAA, will identify potential countries for this study and obtain the necessary approvals. Three of the countries of this study will be from Africa. The other two countries selected to participate will be from outside Africa. This selection of some countries from regions other than Africa will ensure that the results, lessons, guidelines and policy options selected will have broad applications than just Africa.

Facilities

Within each of the countries which participate in these studies, there will be a sample of facilities. The sample of facilities will be selected by each primary investigator after arrival in the country in consultation with the AID mission, the Ministry of Health, and NGO hospital or health associations. The sample of facilities in each country will include the public and private, non-profit sectors. For-profit health facilities and private practitioners will not be included in the sample because while these facilities may provide some free care, it is minimal in quantity and value and it is not likely that these examples will provide useful or transferable lessons to the other categories of facilities.

For types of facilities, hospitals, in urban and rural areas, are to be included, as well as health centres. Urban hospitals will also need to be included in the sample. The participants at the HHRAA meeting which spawned this study indicated that the interest in user fee systems and effect on the poor was particularly relevant to them in urban, hospital settings. So these facilities will be included in the sample. The sample will include facilities along three dimensions. A particular facility will meet more than one of the elements identified in Table 4. The various

combinations lead to eight possible cells when all the combinations of characteristics are considered.

Table 4

CHARACTERISTICS OF THE SAMPLE OF FACILITIES

| Descriptive Element of Facilities | Characteristics to be Sampled |
|--|--------------------------------------|
| Type of facility | hospital and health centers |
| Ownership | public and private |
| Location | urban and rural |

The objective in selecting a sample is to facilities with operational means testing systems. The desire is to identify those facilities where these exemption systems are working so lessons may be learned and shared. Such facilities may be identified, in part, through discussions with AID, the Ministry, and NGOs. In addition, there may be other indicators which are suggestive of well managed facilities: select facilities which regularly report their statistics and information on services provided to the poor.

Another objective in identifying the sample of facilities is to find those facilities which are part of the referral network, if possible. A network of facilities would be a district hospital with inpatient and outpatient services and having a network of health centres and dispensaries reporting to it. For example, a sample of a government district hospital and one of its health centres as well as an NGO facility in the area would provide information on the health seeking behavior and facility choices people make in a particular area. There are several reasons for having networked facilities representing three levels of the health system included in the sample:

1. This will facilitate seeing an overall means testing system in operation rather than a number of individual facilities.
2. The means testing system may be assessed in relation to referrals.
3. The health seeking behavior of people in the area may be identified through the choices they make for the health facility they visit, if any.
4. This will enable the investigators to see how the systems work from the patients' point of view of the entire referral system for health facilities.

The investigators will also sample a government tertiary facility and, if possible, a private referral hospital.

4.3 Sources of data

Site visits will be made to government and private health facilities that have implemented a means testing system. In addition to the facility site visits, some information and statistics will be obtained from central sources.

Data from sampled facilities

Descriptive information will be gathered at each facility surveyed through observation and interviews with health staff and patients. Evaluative information to ascertain the effectiveness of the system requires information from:

- (1) examining the facilities' records and interviews with health staff, both administrative staff (e.g. hospital secretary, medical superintendent, cashier) and health providers and ancillary staff (e.g. physicians, outpatient and ward nurses, pharmacists, laboratory and radiology staff),
- (2) exit interviews with patients, inpatient and outpatient, receiving care at that health facility, and
- (3) interviews in the community with individuals and households who are poor and which are not receiving care from the health facility.

The patient exit interviews will help determine the extent of leakage, that is, the number of non-poor who are classified as poor and receive free treatment. The household interviews will help determine the extent of undercoverage or the poor who are eligible for free care but are not receiving it.

Information and local data on waivers systems will be gathered during site visits. Review of the policies, procedures, systems, records and statistics, interviews and observation will be the sources of data. Observation of the actual operation of the exemption and waiver systems can provide valuable insights on how they truly operate. Conducting household surveys is beyond the scope of work feasible under this activity. Existing household survey data will be examined, if available.

Data from central sources

Centralized sources of information will be reviewed for information which may be collected from all or a group of facilities on a regular basis. For example, organizations representing church health facilities may have information on some of the facilities to be included in the sample. Ministries of the government may also have information collected regularly from all public facilities, such as the numbers of waivers resulting from means testing systems and the revenues foregone from such waivers. Information on the poor may be available from household surveys conducted by or for the government. Examples of where centralized data may exist are listed here:

- Ministry of Health
- Mission hospital or health facility associations
- Organizations representing NGOs
- National statistical office
- National or local household surveys

Information gathered from these sources may be of marginal use as it may not specifically address the questions of interest of these studies. It can provide supportive data in confirming findings done through the field surveys.

4.4 *Collection of data*

Variable specification

The information needed for each country and facility is listed in Table 5 under various categories. The questions may be asked of several of the data sources. For example, information on the process by which patients request and receive approval for a waiver may be asked of the hospital administration but also of the health provider and ancillary staff to determine what happens in reality compared to the administration's perception of the application of the policy.

The basic information sought relates to:

- The Community and Facility
- Fee Structure
- The Targeting or Exemption System
- Administration of the System
- User and Non-user Experiences with the Targeting System
- Historical and Cultural Situation

Survey instruments

Examples of survey instruments are shown in Annex 1 to 4. These are for each group of interviewees: administration, health staff, patients, and households. These questionnaires are illustrative of the basic survey instrument and data to be gathered from each information source. The data from patients and households needs to be discrete in order to allow it to be entered in a data base. It is suggested that researchers use EPI Info version 6.0 to design the questionnaire and enter the data from the interviews to facilitate analysis and allow the data from the various country studies to be combined and integrated at a later date.

5. In-Country Work

5.1 *Work plan*

The case studies in countries will require accomplishment of several logistical and administrative tasks in addition to the research and data gathering component. The case studies are aimed to not only gather the data for this study but be a tool which may be used immediately by the ministry and USAID mission of the host country. Table 6 provides a guideline for use of time to complete the in-country activities for the study. It is based upon a 24 day work plan (4 six day work weeks).

This methodology was revised based on the first country case study in Kenya. This methodology reflects the observations and comments of the Technical Advisory Group (TAG) for improving the methodology as well as the experience from the first country case study. The methodology reflects modifications based on problems encountered in the field. The modified methodology is to be used subsequently for the other four country case studies.

The product of each country study will be a report based upon what is learned from the information gathered and analyzed. This report will be completed in-country by the primary investigator prior to his or her departure. This will enable the Ministry of Health and the AID

Table 5

DATA SPECIFICATION AND SOURCE

| DATA CATEGORY | TYPE OF DATA | DATA SOURCES | | | |
|------------------------|---|--------------|-------------------|---------------------|----------------|
| | | HEALTH STAFF | PATIENT INTERVIEW | HOUSEHOLD INTERVIEW | CENTRAL AGENCY |
| Community and Facility | What is the catchment area? | XX | | | XX |
| | What is the socio-economic status of the community? | XX | | | XX |
| | What type of health facility is this? Public or private, hospital or health center? | XX | | | |
| | What network of health facilities is this institution a part of? | XX | | | |
| | What is the referral system within this network? | XX | | | |

| DATA CATEGORY | TYPE OF DATA | DATA SOURCES | | | |
|---------------|---|--------------|-------------------|---------------------|----------------|
| | | HEALTH STAFF | PATIENT INTERVIEW | HOUSEHOLD INTERVIEW | CENTRAL AGENCY |
| Fee Structure | What fee system is currently in place? | XX | | | XX |
| | What is the relation of fees to income level and cost of living for the area (such as fee as a proportion of average daily wage or as a proportion of a pack of cigarettes or bag of rice)? | XX | | | XX |
| | What are the fee levels? Are they graduated by type of service or type of facility where the service is provided? | XX | | | |
| | What services are covered by the fees? | XX | | | |
| | What are the fees in the network (e.g. for referred patients, do they pay a fee at each level or only if they have bypassed the referral system)? | XX | | | |

| DATA CATEGORY | TYPE OF DATA | DATA SOURCES | | | |
|-----------------------------------|---|--------------|-------------------|---------------------|----------------|
| | | HEALTH STAFF | PATIENT INTERVIEW | HOUSEHOLD INTERVIEW | CENTRAL AGENCY |
| Means Testing or Exemption System | Who is eligible for a waiver? (the criteria) | XX | | | XX |
| | Who determines eligibility for a waiver? | XX | | | XX |
| | How is eligibility for a waiver determined? | XX | | | XX |
| | What information is required to determine eligibility ? | XX | | | XX |
| | When is eligibility for a waiver determined? | XX | | | XX |
| | What is the form of the waiver? Full, partial or sliding scale waiver? | XX | | | XX |
| | How long is the waiver valid? | XX | | | XX |
| | Where is the system administered? (e.g. At point of service, local government or central government?) | XX | | | XX |
| | What system is used for recording and reporting of waivers? (e.g. utilization and revenues foregone) | XX | | | XX |
| | How many waivers were granted during the last full month? What proportion of total patients does that represent? | XX | | | XX |

| DATA CATEGORY | TYPE OF DATA | DATA SOURCES | | | |
|------------------------------|--|--------------|-------------------|---------------------|----------------|
| | | HEALTH STAFF | PATIENT INTERVIEW | HOUSEHOLD INTERVIEW | CENTRAL AGENCY |
| Administration of the System | What are the administrative costs of the system? (e.g. cost per waiver) | XX | | | XX |
| | Is there any education of the public or information campaign explaining the targeting system eligibility? | XX | XX | XX | |
| | What training of staff is required for the operation of the system? How much training has been provided to staff in the past year? | XX | | | |
| | Do health workers understand how the targeting system works? | XX | | | |
| | What are the total revenues foregone under these targeting systems? | XX | | | XX |
| | What is the level of undercoverage? (Those who should receive care through targeting system but do not) | XX | | XX | |
| | What is the leakage of the system? (The noneligible or non-poor who receive benefits from the targeting system). | XX | XX | | |

| DATA CATEGORY | TYPE OF DATA | DATA SOURCES | | | |
|---|--|--------------|-------------------|---------------------|----------------|
| | | HEALTH STAFF | PATIENT INTERVIEW | HOUSEHOLD INTERVIEW | CENTRAL AGENCY |
| User and Non-user Experiences with the Exemption System | What are the patient costs of the targeting systems (e.g. time lost or travel). | XX | XX | XX | |
| | How well informed are patients or the community about the targeting systems for the poor and others? | XX | XX | XX | |
| | Do they know if there is a targeting systems for the poor? | XX | XX | XX | |
| | Do they know who is eligible not to pay for health services? For which health services? | XX | XX | XX | |
| | How is someone excused from paying? | XX | XX | XX | |
| | How did they learn about the targeting system? | | XX | XX | |
| | How many poor, non-users of the targeting system are there? | XX | | XX | |
| | Why do these people not use the targeting mechanism? What alternative care or providers do they seek out? | | | XX | |
| | How many people do not use health services because they do not know of the exemption system? | | | XX | |
| Historical and Cultural Situation | What is the history of direct targeting nationally? | | | | XX |
| | What cultural traditions exist for providing for the poor? | | | | XX |
| | What other sectors use a direct and characteristic targeting system? (education?) For what services? How is it administered? | | | | XX |

mission to be briefed on the findings of the review of existing government and private waiver and exemption systems. This will facilitate the usefulness of the report to the host country.

Table 6

WORK PLAN FOR IN-COUNTRY ACTIVITIES

| No. days | Activities / Tasks |
|----------|--|
| 3 | Briefing of USAID and MOH, identify counterparts and local researchers, selecting sample (identifying survey facilities), organizing logistics (transport, approval to visit, schedule appointments for site visits), pretest survey instruments |
| 2 | Gather background information from central sources on waiver policies and systems and records on waivers granted, finalize survey instruments |
| 10 | Site visits to rural government and non-government facilities (district hospital, rural health centre, rural dispensary), conducting household interviews |
| 5 | Site visits to urban government and non-government of facilities (referral and provincial hospitals) |
| 1 | Examine other social sector waiver systems |
| 3 | Report writing, debriefing with MOH and USAID |

5.2 Investigators

The country case studies are intended to strengthen local capacity for undertaking such investigations. Each primary investigator will attempt to have the Ministry of Health or an NGO association identify a counterpart to work with or select a local investigator or both. Local universities, institutes for medical, social or economic research, or local consulting firms will be the primary sources for identifying local investigators. The counterparts and local investigators will work with the primary investigators to choose a sample, make site visits, gather the data, analyze the data, and prepare a final report on the findings of the study.

6. Outputs of the Studies

To ensure that the five country case studies can be compared and contrasted as well as synthesizing similarities and lessons learned. A detailed outline is provided in Annex 5.

At the conclusion of the five country case studies, an analysis and synthesis of the data and lessons learned will be undertaken to compare the results of the case studies based on the various countries' experiences. This will serve as a basis for (1) preparing information on the conceptual problems and actual experience of exemptions and waiver systems which will be disseminated to policy makers, managers, NGOs, and donors; (2) developing a manual on the policy options and operational guidelines for developing exemption and waiver systems to ensure equity under cost recovery programs; and (3) having conference presentations concerning the studies and their findings. Another output of these studies is the development of an "assessment tool" for evaluating means testing policies and systems. This will be part of the manual for assessing such systems.

SCOPE OF WORK

EQUITY AND COVERAGE OF HEALTH CARE PROVISION KENYA

1. The Activity

To follow on the work from the Kenya Health Care Financing Project's (KHCFP) dealing with exemptions and means testing for receiving care at health facilities. Such systems are designed to ensure that cost recovery efforts do not create barriers for access to care for the poor.

The methodology will be developed by MSH in conjunction with KHCF Project team prior to the initiation of this activity. The work will involve learning from the experience of the KHCF Project by gathering data and conducting interviews during site visits to Government of Kenya and mission facilities that have implemented a means testing and exemption system. The product of this work will be a report based upon what is learned. The KHCFP will be able to use the report to modify the government system and validate earlier results if they are consistent. If the results vary from earlier project findings, KHCFP will be able to review the need for further modifications to the current system of exemptions and waivers. The sample will include facilities which are charging for family planning services. In the future the results will be able to be applied to the issue of charging for family planning and other MCH services. This work builds on the KHCFP and has continuity with its on-going work.

The experiences and information to be reviewed and gathered will come from several sources: central data and site data and visits.

Issues to be examined:

- a. Examine different exemption and waiver schemes at facilities in Kenya.
- b. Assess the successes and failures under the different schemes.
- c. Examine the non-fee costs of the systems (time, wages lost, travel, etc.).
- d. Determine how other sectors, such as education, deal with exemptions and waivers.
- e. Review the revenues foregone under such schemes.
- f. Attempt to assess the poor who do not have access despite these safeguards
- g. Attempt to assess the leakage of the system, that is the noneligible who receive exemptions and the non-poor who receive waivers.

Sources of information:

1. Centralized data and information
 - Ministry of Health
 - Christian Health Association of Kenya
 - Catholic Secretariat of Kenya
 - Review any household survey data available (KHCFP)
2. Decentralized data and information sources

Data will be gathered from as many of the following cells as possible to obtain a representative sample of information on exemptions and waivers. The data will be gathered by site visits to the facilities. Exit interviews with patients and their families, the staff of the hospital and health facility, and the institutions records. Observation of the practical application of the exemption and waiver systems.

| | Government | Private/ | Non-Government |
|------------------|------------|--------------------|----------------|
| | | Mission/Non-Profit | For Profit |
| Referral IP | | | |
| OP | | | |
| District Hosp IP | | | |
| OP | | | |
| Health Centre IP | | | |
| OP | | | |
| Health Station | | | |

Original data gathering of household survey information is beyond the scope of work feasible under this activity. Existing household survey data will be examined.

2. Duration of Work

4 weeks

3. Funding

HHRAA and BASICS

4. Proposed Investigator

Dr. Bill Newbrander, of MSH, is proposed as the primary investigator. He has been part of the MSH TA team supporting the KHCFP. Bill was the team leader for review of the NHIF in 1993 and is currently involved with the Project's work with Chogoria Hospital and the Apollo Insurance on their insurance scheme. It is anticipated that Kenyan staff will also be part of this investigation effort.

ANNEXES

Annex 1 Example of Hospital Administration Interview Survey

Annex 2 Example of Health Staff Interview Survey

Annex 3 Example of Patient Exit Interview Survey

Annex 4 Example of Household Interview Survey

Annex 5 Example of Report Outline for Country Case Studies

HOSPITAL ADMINISTRATION INTERVIEW

1. Fee System:

- What fee system is currently in place:
- What services covered by fees?
- Are fee levels graduated?
- Are there fees for referred patients?

2. Policy:

2.1 Waivers:

- Are the poor exempted from fees? Yes No
- If so, how?:
 - Who is considered poor?
 - Who determines eligibility as poor?
 - How do they determine eligibility (criteria)?
 - What information is required to determine eligibility?
 - When and where is eligibility determined?
 - How long is waiver valid for?
 - What records are kept on waivers granted?
 - How many waivers were granted last month (February 1995)?

2.2 Exemptions:

- Are certain types of patients or services automatically exempted from fees? Yes No
- If so, what types of patients or services?:

| | |
|---|--|
| <input type="checkbox"/> Children under 5 | <input type="checkbox"/> Child clinic |
| <input type="checkbox"/> TB | <input type="checkbox"/> Family planning |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Antenatal |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Children under 15 |
| <input type="checkbox"/> STD | <input type="checkbox"/> Civil Service |
| | <input type="checkbox"/> Health workers |
- Other: (List)

- Who determines eligibility for an exemption?
- How do they determine eligibility (criteria)?
- What information is required to determine eligibility?
- When and where is eligibility determined?
- What records are kept on waivers granted?
- How many exemptions were granted last month (February 1995)?

3. Information to Public

Are patients informed that they are eligible for waivers or exemptions?

Yes

No

If so, how?

Signs posted in hospital or health centre

Information provided by health staff (ward nurse, education campaign worker, etc.)

Learn from relatives, friends, or other patients

Other

4. Training for Staff

Are staff trained on who is eligible for waivers (the poor) and exemptions?

Yes

No

If so, how and how often?

5. Costs of the System

What are the costs of waivers for the poor?

Revenues not collected

Training of staff

Supplies

Other

What are the costs of exemptions?

Revenues not collected

Training of staff

Supplies

Other

HEALTH STAFF INTERVIEW

Position of staff member being interviewed:

- Supervisor
- Ward nurse
- Outpatient nurse
- Physician
- Pharmacy, laboratory or radiology staff
- Social worker
- Other

1. Fee System:

- What fee system is currently in place?
- What services covered by fees?
- Are fee levels graduated?
- Are there fees for referred patients?

2. Policy:

2.1 Waivers:

Are the poor exempted from fees? Yes No

If so, how?:

Who is considered poor?

Who determines eligibility as poor?

How do you determine eligibility (criteria)?

What information is required to determine eligibility?

When and where is eligibility determined?

How long is waiver valid for?

What records do you keep on waivers granted?

How many waivers were granted last month (February 1995)?

2.2 Exemptions:

Are certain types of patients or services automatically exempted from fees? Yes No

If so, what types of patients or services?:

- | | |
|---|--|
| <input type="checkbox"/> Children under 5 | <input type="checkbox"/> Child clinic |
| <input type="checkbox"/> TB | <input type="checkbox"/> Family planning |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Antenatal |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Children under 15 |
| <input type="checkbox"/> STD | <input type="checkbox"/> Civil Service |
| | <input type="checkbox"/> Health workers |

Other: (List)

Who determines eligibility for an exemption?

How do they determine eligibility (criteria)?

What information is required to determine eligibility?

When and where is eligibility determined?

What records do you keep on waivers granted?

How many exemptions were granted last month (February 1995)?

3. Information for Patients and Community:

Are patients informed that they are eligible for waivers or exemptions?

Yes

No

If so, how?

- Signs posted in hospital or health centre
- Information provided by health staff (ward nurse, education campaign worker, etc.)
- Learn from relatives, friends, or other patients
- Other

4. Training for Staff

Did you receive any training on who is eligible for waivers (the poor) and exemptions?

Yes

No

If so, when and how often?

FACILITY: _____

PATIENT EXIT INTERVIEW SURVEY

1. Are you (is patient) Poor Non poor
2. Were you or your family member an Inpatient or Outpatient
3. How far did you come to receive care here? _____ (in kilometers)
 Did you go to any other facility before coming here? No Yes
 How long did you wait before you came here for care?
 Did not wait under 1 week 1 or more weeks
4. **Paying**
 Did you pay for the services today?
 Yes No
 If NO, why not? Exemption Waiver Other
 If YES, did you pay total amount of bill or partial amount
 What was the total you were asked to pay today? KSh _____
 How much did you pay for the service you received today? KSh _____
 How did you obtain the money to pay for today's care?
 Own money (a)
 Savings (b)
 From family (c)
 From friends (d)
 Some combination of (a) to (d) above
 Did not pay
5. **Waivers (Poor excused from payment of fees)**
 5.1 Do the poor have to pay for care at this facility?
 Yes No Partially
 5.2 If not, what do they do so they do not have to pay? _____ (Explain)

6. **Exemptions (Automatically excused from payment due to patient characteristic)**
Do you have to pay for care at this facility if you are or have: (check those answered "yes")

- | | |
|--|--|
| <input type="checkbox"/> Children under 5 | <input type="checkbox"/> Child clinic |
| <input type="checkbox"/> TB <input type="checkbox"/> Family planning | <input type="checkbox"/> Antenatal |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Children under 15 |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Civil Service |
| <input type="checkbox"/> STD | <input type="checkbox"/> Health workers |
| <input type="checkbox"/> Others (code book) | |

7. **Information/Knowledge about system**

- 7.1 How did you learn that these people or the poor do not have to pay?
- Sign posted at facility
 - Information provided by health facility staff (ward nurse, education campaign worker, etc.)
 - Learned from relatives or friends
 - Other
- 7.2 Do you know of anybody who could not go the health centre/hospital because they could not pay?
 Yes No
- 7.3 Do you know of anybody who did not go the health centre/hospital for other reasons?
 Yes No
- Why didn't they go?
- Could not pay
 - Other:
 - Went to mission hospital
 - No drugs
 - No transport money
 - Distance
 - Poor quality or unhappy previous experience

8. This health facility is in a: rural area? urban area?

9. This facility is a: Government facility? Mission/private facility?

FACILITY: _____

SURVEY OF HOUSEHOLDS

1. Is the household ___ Poor ___ Non poor

Assessment of this household based on:

- ___ Living quarters/home
 ___ Property (Land, cattle, crops, other)
 ___ Educational level
 ___ Clothes
 ___ Other (list) _____

2. Did anyone in your household experience an illness in the last month?
 ___ Yes ___ No

If NO, stop here. If YES, continue survey.

3. Did you seek care or see a health provider?
 ___ Yes ___ No

4. Where did you go for care?
 ___ Government hospital
 ___ Government health centre or dispensary
 ___ Mission or church facility

Other:

- ___ Traditional medicine
 ___ Bought drugs at kiosk
 ___ Private clinic
 ___ Nowhere - stayed home

If other, why did you not go to a government or mission facility?

- ___ Lack of money
 ___ Inconvenience of location
 ___ Health facility not open
 ___ Not satisfied with previous experiences
 ___ Lack of money AND not satisfied with previous experience
 ___ Other (treated by relative doctor)
 ___ Less expensive than government facility
 ___ None

5. *Waivers (Poor excused from payment of fees)*

5.1 Do the poor have to pay for care at this facility?
 ___ Yes ___ No

5.2 If not, what do they do so they do not have to pay? (Explain) _____

6. Exemptions (*Automatically excused from payment due to patient characteristic*)
Do you have to pay for care at this facility if you are or have: (check those answered "yes")

| | |
|--|--|
| <input type="checkbox"/> Children under 5 | <input type="checkbox"/> Child clinic |
| <input type="checkbox"/> TB <input type="checkbox"/> Family planning | <input type="checkbox"/> Antenatal |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Children under 15 |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Health workers |
| <input type="checkbox"/> STD <input type="checkbox"/> Civil Service | |

7. Information/Knowledge about system

7.1 How did you learn that these people or the poor do not have to pay?

- Sign posted at facility
- Information provided by health facility staff (ward nurse, education campaign worker, etc.)
- Learned from relatives or friends
- Didn't know/never heard of waivers

7.2 Do you know of anybody who could not go the health centre/hospital because they could not pay?

Yes No

7.3 Do you know of anybody who did not go the health centre/hospital for other reasons?

Yes No

8. This health facility is in a: rural area urban area.

Annex 5

Example of Report Outline for Country Case Studies

Equity and Coverage of Health Care Provision

in (name of country):

A Case Study Carried Out Under BASICS and HHRAA

Acknowledgements

- 1. Introduction**
- 2. Objectives of the Study**
- 3. The Study Approach**
 - 3.1 Health facility information**
 - Health facility administration**
 - Health facility staff**
 - Patient exit interviews**
 - 3.2 Household information**
 - 3.3 The Sample**
- 4. Description of Waiver and Exemptions in (name of country)**
- 5. Findings**
 - 5.1 Government Facility Waiver and Exemption Systems**
 - a. Functioning of the systems and application of guidelines**
 - b. Number of waivers granted and cost of the system**
 - c. Use and non-use of the waiver system by the poor**
 - d. Public information about the waiver and exemption system**
 - e. Staff training and knowledge of the system**
 - f. Efficiency and effectiveness of the system**
 - g. Summary and Conclusions: What worked in government health facilities**
 - 5.2 Non-government Facility Waiver and Exemption Systems**

- a. Functioning of the systems and application of guidelines
 - b. Number of waivers granted and cost of the system
 - c. Use and non-use of the waiver system by the poor
 - d. Public information about the waiver and exemption system
 - e. Staff training and knowledge of the system
 - f. Efficiency and effectiveness of the system
 - g. Summary and Conclusions: What worked in government health facilities
- 5.3 Findings of patient exit interviews at health facilities
- a. Characteristics of interviewees
 - b. Distance to seek care
 - c. Alternative health providers or facilities
 - d. Waiting to seek care
 - e. How much did you pay for care?
 - f. Waivers and exemptions
 - g. Where do patients obtain their money to pay for care?
 - h. Knowledge about waivers
 - i. Knowledge about exemptions
 - j. Interviewees' knowledge of others not receiving care
- 5.4 Findings of Household Interviews
- a. Characteristics of household interviewees:
 - b. Seeking care:
 - c. Alternatives for seeking care
 - d. Why people use other health providers or facilities
 - e. Knowledge about waivers
 - f. Knowledge about exemptions
 - g. Knowledge of others not receiving care
6. Summary and Conclusions
- 6.1 What worked in government health facilities
 - 6.2 Formalizing Some Guiding Principles
 - 6.3 Improved definitions and procedures
 - 6.4 Improved information to communities and individuals
7. Recommendations: Application of study for national cost sharing program
- 7.1 Policy changes needed
 - 7.2 Future measurement of impact

