Cost Effectiveness and Resource Allocation

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Controversies in implementing the exemption policy for the elderly healthcare services in Tanzania: experiences from the priority setting process in two selected districts

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Abstract

Background Health financing system in Tanzania changed in the early 1990s as a result of the introduction of cost-sharing policies by the 1990s health sector reforms. The reforms brought about user fees which has led to inequity in access to health care services and catastrophic health expenditure among the elderly. In efforts to reduce the inequity gap among vulnerable groups, in 1994, the government introduced an exemption and waiver policy. More than three decades later, inequity in health care services access has persisted with the elderly population being more affected. The latter poses questions on the implementation efficiency of the exemption policy. We aimed to assess the implementation of the exemption policy on access to health services among the elderly in Tanzania by learning from the experiences of the priority setting process in two districts of western Tanzania.

Methods An exploratory qualitative case study adopting Key informant interviews (KIIs) was used to collect data in Nzega and Igunga districts. The key informants involved the representatives of the planning team and decision makers from the community, health facility and district level. Information saturation was attained after the 24th interview and thus data collection ended. The content analysis approach was used to analyse the data.

Findings Although there is a designated office that deals with exemptions for the elderly in health facilities, there are challenges in accessing health services. The challenges include insufficient drugs, some laboratory tests not covered by the exemption, a lengthy process to access service, poor financial mechanisms for exempted services, inadequate information and clarity of the exemption categories, and limited to no involvement of different stakeholders in the exemption process.

Conclusion The exemption policy was introduced to help disadvantaged groups, including the elderly. However, its implementation encountered challenges which burden both the elderly and the health facilities. Its implementation has thus become a controversy to its initial aim that was to relieve the elderly from high healthcare costs. Revisiting

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the policy through a thorough stakeholders' engagement and establishing alternative financing of the exemption policy are recommended.

Keywords Exemption policy, Elderly, Priority setting and health care financing

Introduction

After independence in 1961, the government of Tanzania abolished user fees and adopted the free provision of health care services to all people attending public health facilities [1]. The government aimed to enable poor people and vulnerable groups like the elderly to have free access to health care services. During this period, all private health facilities were banned while the health financing mechanism of the health sector was based on general tax development partners [1–3]. At the end of the 1980s, the cost of provision of health care services increased which became a burden to the government [3]. Health service financing reforms, in Tanzania, in the early 1990s marked the changes in the financing system from free access to health services to the mixed financing mechanisms that included cost-sharing policies whereby user fees were introduced [4]. The Ministry of Health at that time was responsible for monitoring the quality of service delivery. The introduction of user fees caused challenges, especially for vulnerable groups including the elderly in Tanzania and other countries [5]. These challenges include catastrophic health expenditure among households with poor elderly and reduced health care utilization, especially among the poor and vulnerable groups like the elderly [6]. These brought inequity in access to health care services [7–12].

In 1994, the government of Tanzania introduced the Exemption and Waiver policy that aimed to protect the poorest and most vulnerable population against healthcare charges in accessing healthcare services [4, 12, 13]. Exemption and waivers are offered to the public health facilities and some private health facilities which are under agreement with the government to offer free health care services to children aged five years, maternal and child health (MCH) services, to those with specific diseases, people with long term mental disorders, old people and poor people.

Exemptions, are not automatically granted to the poor people but can be granted to those who are in need of such services and are unable to pay for health care services [14]. The policy identifies different vulnerable groups including people living with disabilities who are unable to pay for health care services or people with specific diseases like HIV/AIDS, leprosy, Tuberculosis (TB), polio, and cancer, as eligible for exemptions. In 1999, the government of Tanzania established exemptions for elderly people aged 60 years and above at government health facilities. The exemptions and waivers are granted based on the experience and discretion of health care workers in consultation with local (community) leaders who may officially recommend people who are poor to afford charges at health facilities and confirms the age of the patients who are 60 years and above [15]. This method results in the occurrence of some complaints to the patients and health care workers since it lacks explicit criteria for those people who are eligible to be granted that exemption and waiver especially the poor people and vulnerable groups like the elderly [14–17].

Studies [18, 19] indicate that health providers do not provide free care to elderly people. The elderly are still facing a challenge of being neglected in accessing quality health services from public health facilities due to reasons, which are not explicit [20, 21]. In 1999, the government instituted an exemption policy for access to health services for vulnerable groups including elderly people (60 years old and above), pregnant women, children under 5 years old, people who are suffering from chronic diseases like HIV/AIDS, leprosy, TB, polio and cancer from paying for healthcare services [15, 22, 23]. However, this policy of exempting the elderly is still questionable in its effectiveness and efficiency in terms of its implementation [4, 13, 19, 24]. This is due to the fact that, among others, the government has no clear arrangement for providing funds to the health facilities to compensate for the free services to the elderly [15, 24]. This leaves most of the health facilities overwhelmed with the exemptions and waivers expense making it difficult for them to provide health care services [13, 25]. The aim of this study is to assess the implementation of the exemption policy during priority setting on access to health services among the elderly.

Methods

Study design

This study adopted an exploratory qualitative study design using Key Informants Interviews (KIIs) to collect information about their experience in implementing exemption policy for the elderly in Nzega and Igunga districts. The design explores and investigates the phenomenon in real life context through a comprehensive analysis of a limited number of events and their relationships [26]. Priority setting is a social process and thus the design fitted because exploration of the information on the exemption policy for the elderly in the priority setting process was extracted from the KIIs who participate in priority setting and decision-making at the district level.

Study context

The health systems in Tanzania operate under a decentralization process in a pyramidal form with three levels of healthcare services delivery: primary, secondary and tertiary levels. The primary level comprises the district hospitals and all other health facilities within that district. The secondary level contains the regional hospitals and regional referral hospitals while the tertiary level composes the national hospital, zonal referral hospitals and consultant hospitals. The priority setting during the planning process of health care services delivery is done under the decentralization process. The decentralized health system has different levels in making decisions and setting priorities at LGAs. The process of granting exemptions and waivers to the elderly starts from the community level where the local leaders provide a confirmation letter about their ages for the identification of the elderly at the health facility. In addition, the priority setting process starts from the community, facility, district, regional to the national levels. This study was conducted in Nzega and Igunga districts in Tabora Region in Tanzania from July to August 2020. The study involved the representatives of the planning team and decision makers from the community, health facility and district level. These include representatives from Council Health Management Team (CHMT), Health Facility Governing Committee (HFGC) and Council Health Service Board (CHSB). The provision of health services with exemptions and waivers for the elderly at the district level is composed of dispensaries, health centres and district hospitals. Approximately the two districts have 50,547 (5%) elderly people of the total population [8]. The two districts were appropriate districts for this study since most elderly (around 92%) live in rural areas. These districts were among the first districts to implement a Community Health Fund (CHF), whereby Igunga district was the first district in Tanzania to implement CHF as a pilot in 1996. All health facilities (primary and secondary health facilities) are available in these districts which offer health care services to the elderly and thus we found them appropriate for setting priorities at the health facility from primary to secondary and beyond. Administratively, Nzega district is divided into two councils (i.e. town and rural council) that are divided into 37 wards with a total of 151 villages/streets, and Igunga has one council that is divided into 26 wards with a total of 93 villages/streets.

Data collection

A total of 24 KIs were involved in this study, 12 from each district. These include 1 District Planning Officer (DPLO), 1 District/Town council Medical Officer (DMO/TMO), 1 Medical Officer In-charge (MOI), 1 Health Management Information System (HMIS) focal person, 1 District Social Welfare Officer (DSWO), 2 HFGC members, 1 District Health Secretary (DHS), 1 Hospital Secretary (HS), 1 CHSB members and 2 CHMT.

Interviews stopped at 24th interview after attaining information saturation whereby there were no more emerging new ideas for conducting more interviews. This study used the interview guide applying an in-depth approach to explore information on the implementation of exemption policy during priority setting for the elderly. The respondents were asked about their experience on the implementation of the exemption policy, criteria for granting exemptions, sustainability and challenges of the exemption policy. All interviews lasted between 50 and 74 min and were recorded.

Data analysis

All interviews were conducted and recorded in Kiswahili as it is the most used language in the study area. The audio-recorded interviews were reviewed and transcribed verbatim from audio to written documents then translated into English by experts for analysis and extraction of quotes. The content analysis approach was used to analyze the data. This approach is used to determine the existence of concepts and categories within texts or a set of texts which limit bias. Furthermore, the approach entails the interpretation of the content of text data through a systematic classification process of identifying codes and patterns. A content analysis as described by Graneheim and Lundman (2004) was performed [27]. This means that condensed meaning units were created from the transcribed text. The meaning units were assigned corresponding codes from which categories were derived focusing on the manifest meaning. The transcribed data and other field notes and documents were carefully studied and read to identify broad areas which helped to form initial codes and codes. The authors extracted primary codes which were revisited and the final codes agreed upon by all authors. All similar identified codes were grouped by comparing codes to have subcategories which were further analyzed to differentiate their similarities and differences. Similar subcategories with related concepts were grouped to form categories.

Findings

The categories generated from the analysis of the gathered information (Table 1) included a supportive environment for the implementation of the exemption policy, pragmatic challenges facing the implementation of the exemption policy and financial hurdles facing the implementation of the exemption policy. It involved 24 (7 female and 17 male) respondents with experience in the implementation of the exemption policy on access to health services for the elderly.

Table 1 Content analysis process for the categories

Sub-Categories	Categories
• Existence of a guideline to operationalize the exemption policy • Existence of a rigorous process for identifying the elderly who deserve exemption • Presence of specific windows dealing with the elderly in the health facilities • Existence of a clear administrative structure from the district to the community level dealing with elderly social welfare	A supportive environment for the implementation of the exemption policy
• Lengthy and bureaucratic procedure in accessing exemptions • Lack of clarity on groups deserving exemption • Exemption limited to public health facilities	Pragmatic challenges facing the implementation of the exemption policy
• The financial burden of the exemptions to the Health Facility • Lack of defined mechanisms to finance the exemptions • Limited interest of stakeholders to finance the healthcare of the elderly	Financial hurdles facing implementation of the exemption policy

A supportive environment for the implementation of the exemption policy

The existence of a guideline to operationalize the exemption policy, the existence of a rigorous process for identifying the elderly who deserve exemption and the presence of specific windows dealing with the elderly in the health facilities were stated as essential ingredients for providing a supportive environment for implementing the exemption policy. Participants stated that the existence of an exemption guideline for implementing the exemption policy for the elderly to access healthcare services sets a supportive environment for implementing the exemptions. The guideline states that all elderly aged 60 years and above should be considered for exemptions.

> *"... We have a guideline which states that it is every elder person from the age of 60 years old and above deserve exemption...., ..." (KI #1).*

The participants alluded that implementing the exemption policy for the elderly is supported by a well-formulated, rigorous process for identifying the elderly who deserve an exemption. They added that not all elderly aged 60 years and above are exempted automatically; instead, there is a rigorous process with the help of the community leaders at the lower level to identify the elderly who are financially disadvantaged and thus deserve the exemption.

> *"...we are living as one community, ... you may have fifty elderly in the area, and among those, we need to identify some who qualify for exemptions. ...it is not easy,..... some of the elderly were government employees, and lucky some of them have now retired and get pensions that can support their living; some are businessmen/women, and they have good earnings...some elderly have children who have good positions (well off) and support them ...." (KI #5).*

Informants stated that in the health facilities, there were designated windows dealing with elderly care. They stated that this initiative was a commitment of the health facilities to properly handle elderly people. Furthermore, they stated that the initiative made it easy and conducive for elderly people to get support.

> *"...Strategies for prioritizing the elderly at LGAs include the issue of dealing with their complaints, prioritizing poorer elderly than those who can pay for health services, an introduction of the slogan of "elderly first" at the health facility that the elderly should be treated first and have special windows for the elderly" (KI#8).*

A clear administrative structure from the district to the community level dealing with elderly social welfare was another support environment for implementing the exemption policy that the participants of this study stated. They stated that at the Local Government Authority (LGA) there is a special department called social welfare which is led by the District Social Welfare Officer (DSWO) who deals with elderly matters including their exemptions. The department has officers at the council level who coordinate its activities with support from the officers at the ward and village levels.

> *"...Social welfare officer is dealing with exemptions at the LGAs who is responsible for elderly matters, but he/she cooperates with other people at different levels, including village and ward level...:" (KI#2).*

Pragmatic challenges facing the implementation of the exemption policy

Lengthy and bureaucratic procedures in accessing exemptions, lack of clarity on groups deserving exemption, and exemption limited to public health facilities were stated as pragmatic issues for implementing the exemption policy.

Accessing exemptions by the elderly was reported to be a long process. Participants stated that it involved the identification of the elderly in the community using the community leaders, Village Executive Officer (VEO), Ward Executive Officer (WEO) and then the District Social Welfare Officer (DSWO) at the council level. The hamlets wrote a letter to introduce the elderly to the VEO, WEO and DSWO. Each office in that series should provide approval for the elderly to be granted an identity card for exemption purposes.

"....So, the identification of the elderly for exemption is done by the office of the district development officer in collaboration with leaders of hamlet, village, and the ward levels. The names are submitted to the lowest respective office level, especially Hamlet, and then passed to all higher levels up to the district level. Then the district development officer go to the respective areas for verification ..." (KI #3).

Lack of clarity on groups deserving exemption was another stated issue that challenges the implementation of the exemption policy. The participants stated that the exemption policy is not clear regarding the elderly groups that should be included in the exemption schemes. The policy lacks clarification on the elderly who can pay and the ones who cannot. Sometimes, it was found to be difficult to include the elderly who are doing small businesses, assuming that they are capable of paying for their insurance.

"Basically, in the guidelines, it is any elderly person from the age of 60 years old and above, but there are times when you may find someone who is older than 60 years and above and has the ability to pay, children support, retired and receive pension, or has a health insurance...this one not need to be exempted but the guideline is silent on these groups...." (KI #1).

Informants also alluded that limiting the exemptions to public health facilities was another challenge that faced the elderly in accessing healthcare. They added that exemption been a policy for the elderly would have a significant impact if could carter also to the private facilities in the areas where public facilities are not available.

"...not all areas have public health facilities which is a problem to the elderly in accessing healthcare services since exemptions apply to public health facilities and not to the private health facilities...this is because there is no direct compensation of funds for the exemption/waiver to the health facility from the government for the elderly...." (KI#8).

Financial hurdles facing implementation of the exemption

The financial burden of the exemptions to the health facilities, lack of defined mechanisms to finance the exemptions and limited interest of stakeholders finance the healthcare of the elderly were stated as financial hurdles facing the implementation of the exemption policy.

Informants stated that most of the health facilities are overwhelmed by the financial burden of the exemptions including those of the elderly hence affecting their ability to provide services. They alluded that the exemptions were consuming a large amount of financial resources of the health facility not corresponding to the share generated by the health facilities as out-of-pocket payments, health insurance funds and funds from the central government. They further added that on top of the elderly other categories excepted were; pregnant women, children under five years, disabled and people living in difficult conditions.

".... we are having too many exemptions, including of the elderly themselves, children who are under five years, pregnant women, etc. The group is so large and it consumes a lot of money contrary to our collections..." (KI #6).

The lack of defined mechanisms to finance the exemptions was stated to be another challenge facing the implementation of the exemption policy. Participants stated that the budget for elderly care is lumped into the social protection budget which covers the needs of special groups such as the people or children who are living in poor conditions and the disabled. This budget does not cover exemptions on accessing healthcare services, instead, it covers the expenses of the elderly who are living in camps. Therefore, there is no specific percentage of the budget allocated to cover exemptions for the elderly from either LGAs or the central government.

"...I think that the main challenge is a lack of clear budget line to finance the healthcare of the elderly population despite the limited budget for the elderly compared to other priorities which get first priority ...." (KI #4).

Informants of our study stated that the limited interest of stakeholders in financing the healthcare of the elderly is another contributor to financial hurdles in implementing the exemption policy. They added that most of the stakeholders including NGOs, members of parliament (MPs), development partners, etc. do not prioritize the elderly. For instance, participants reported that CHWs at the community level are not well utilized to help the elderly due to financial problems at the LGAs. On the other hand, it was reported that political leaders

and LGA officials insist on implementing the exemption policy at the health facility by ordering all health facilities to implement the exemption policy to all elderly without providing strategies for sustainability of the provision of health services. Elderly matters are not much prioritized at all levels including family, village, ward and district council.

> *".....I have never seen any NGO dealing with elderly matters. Most of the NGOs are for HIV but not the elderly...also politicians like MPs, I have never seen them engaging themselves in helping the elderly...." (KI #7).*

Discussion

This study found that there are supportive environments for the implementation of the exemption policy due to the existence of a guideline to operationalize the exemption policy, the existence of a rigorous process for identifying the elderly who deserve exemption from the community level to the district level and the presence of specific windows dealing with the elderly in the health facilities. The existence of this guideline may help to operationalize the exemption policy that requires all elderly aged 60 years and above to be eligible for exemptions. However, it was revealed that in some of the health facilities the elderly who have financial ability and health insurance were not considered for exemptions while other health facilities consider all elderly aged 60 years old and above. This suggests that some elderly may be excluded even if they meet the main criteria of 60 and above. Our findings concur with other studies that were done in Tanzania that found that there was an influx of elderly people who were 60 and above who were in need of health care exemption, however, only those who were unable to pay were exempted [13]. It was also reported that there is confusion in the interpretation of the elderly exemption policy where some respondents thought it was for all elderly aged 60 years old and above while others thought it was only for the elders who were financially disadvantaged [13, 28]. This might indicate an absence of written documents that guide the exception and a lack of common understanding of the exemption policy for the elderly [29]. Other studies suggested that for successful implementation of policy, it should be well understood by implementers. This could be done by disseminating the policy to the implementers and beneficiaries [30, 31]. This calls to the Ministry of Health to communicate the policy to the Tanzania community, especially the elders and those responsible for implementing the policy to avoid the already existing confusion on this policy initiative.

This study revealed that there are pragmatic challenges facing the implementation of the exemption policy including lengthy and bureaucratic procedures in accessing exemptions, lack of clarity on groups deserving exemption, and exemption limited to public health facilities. The lengthy and bureaucratic process for the elderly to seek approvals for exemptions was one of the pragmatic issues. Some elderly fail to go through this bureaucratic process to get exemptions for their health services. These findings corroborate with other studies [32, 33] which reported that there is a long process and time consuming on identifying the elderly to be granted exemptions in accessing health services. Lack of clarity on groups deserving exemption whereby the exemption policy is not clear regarding the elderly groups that should be included in the exemption schemes. The findings are supported with other another which revealed that sometimes, there is confusion about the eligibility criteria for granting exemption to the elderly which prolongs the process [34]. This leads to variations in its implementation due to unclear ways of granting exemptions to the elderly. In addition, this controversy about the policy is still prevailing among health workers about the age criteria for granting exemptions to the elderly [5, 33–36]. This is due to it's difficult to identify the elderly's age as the criteria since most of the elderly in rural areas have no birth certificates to confirm their ages [37, 38]. This may lead to a prolonged process of granting exemptions and low coverage of the elderly who are eligible in accessing exemptions [32]. In addition, the exemption is limited to public health facilities which restrict the elderly from accessing health services using exemptions in the areas where there are only private health facilities. The findings concur with the previous studies which revealed that the exemption does not extend to private health facilities to provide a wider choice of health seeking among the elderly due to the fact that some of the public health facilities are not allocated to some places and some have no medicines [15, 19, 20, 39]. The government through the responsible Ministry should integrate the exemptions for the elderly in private health facilities to widen access to health services.

Financial hurdles were another challenge facing the implementation of the exemption policy. This study revealed a lack of defined financial mechanisms to cover the exemption expenses. This means that there was no specific percentage of the budget al.located to cover exemptions for the elderly after accessing health services at the health facility. It is argued that the resource envelope for revenue to fund the exemptions at the health facilities level is mainly from health insurance and out-of-pocket. However, the amount collected through health insurance is insufficient due to low enrollment [40]. Other studies indicated that in order to have sufficient

funds to finance the exemption, the government should invest in mobilizing the pooling of funds from people in the community [41, 42]. This should go hand in hand with improvements in the delivery of health services at this level including the availability of enough and qualified human resources for health, medicines and medical supplies. The lack of these has been documented by other studies to discourage communities in pooling funds [43–46]. Despite the low amount collected through health insurance, the health financing in Tanzania is also coupled with other challenges such as delayed reimbursement from health insurance, inadequate budgetary allocation for health and hence limiting the amount of funds available for financing elderly exceptions [47]. This suggests that the lack of sustainability in financing may jeopardize the financing of the elderly exemptions and hence calls for putting strategies on adequately financing the healthcare.

This study found also that there was an increase in the burden of exemption to health facilities. This is attributed by the existence of several other groups that are exempted including under-five, pregnant women and people who are living in poor conditions and are vulnerable to diseases. This leads to high exemption expenses compared to the collected revenue at the health facilities. These findings concur with other studies in Tanzania and elsewhere which found that lack of funds was among the barriers to the implementation of an exemption policy [5, 13, 35].

Lastly, this study found that there was a limited interest of the stakeholders in financing healthcare for the elderly and put little emphasis on exempting the elderly from paying for health services by subsidizing their services compared to other health services. Politicians, NGOs and other development partners are less willing to inject funds specifically for elderly health care services than other groups. Development partners focus on diseases specific programs and some of them do not affect the elderly. On the other hand, politicians normally think about short-term activities or interventions which will give them legitimacy for the next election. These findings concur with other studies done in Tanzania and elsewhere [33, 48, 49] which indicates that there is less involvement of development partners and CHWs in prioritizing elderly healthcare activities.

Strengths and limitations of the study

This study has contributed to knowledge and provided valuable information that will contribute toward improved implementation process of the exemption policy on access to health services among elderly people. The limitation is based on the fact that the respondents were involved in the implementation of the exemption policy and are likely to defend their positions. They may have described the implementation of the policy during priority setting to defend themselves. However, the findings of the study provided an understanding of the implementation of the exemption policy on access to healthcare services among the elderly. To address the limitation, the study included many participants including members of the different committees and the community.

Conclusion and recommendations

The introduction of the exemption policy had a good intention to help different disadvantaged groups including the elderly. However, its implementation encountered many challenges including lack of specific funds allocated for reimbursing the exemptions, exemption policy becoming a burden on the health facilities and the implementation of exemption policy is controversial since it has no clear criteria for the elderly who are eligible to benefit from the exemptions, bureaucracy on accessing healthcare services using exemptions and most of the stakeholders are not prioritizing the elderly matters. Therefore, the government through its agencies including the Ministry of Health, PORALG and Ministry of Community Development, Gender, Women and Special Groups to review the policy by removing the barriers facing the disadvantaged groups including the elderly on access to healthcare services. This calls for the Ministry of Health to provide clarity and training to the implementers of this policy to avoid confusion and ensure uniformity in the implementation of the policy.

Abbreviations

AIDS	Acquired immunodeficiency syndrome
CHMT	Council health management team
CHSB	Council health services board
CHWs	Community health workers
DHFF	Direct health facility financing
DHS	District health secretary
DMO/TMO	District/Town council medical officer
DPLO	District planning officer
DSWO	District social welfare officer
HFGC	Health facility governing committee
HIV/AIDS	Human immunodeficiency virus
HMIS	Health management information system
HS	Health secretary
IDs	Identities
KIIs	Key informant interviews
LGAs	Local government authorities
MCH	Maternal and child health
MOI	Medical officer In-charge
MPs	Member of parliament
MUHAS	Muhimbili university of health and allied sciences
NGOs	Non-government organizations
PO-RALG	President's office, regional administration and local government tanzania
TB	Tuberculosis
VEO	Village executive officer
WEO	Ward executive officer

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Author contributions
MT conceived the study. MT and NS participated in its design, collected data, analyzed data and drafted the manuscript. GF participated in the design, was the overall coordinator of the project and helped to draft the manuscript. NT, TR, PL and AK participated in the design, analysis and helped to draft the manuscript. All authors read and approved the manuscript.

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Data availability
Not applicable.

Declarations

Ethics approval and consent to participate
Ethical clearance was obtained from the Muhimbili University of Health and Allied Sciences (MUHAS research review board) in June 2020 (MUHAS-REC-6-2020-288). Permission for data collection in Tabora region was granted by the Regional Administrative Secretary. Permission for data collection was granted by the District Executive Directors of the Igunga and Nzega districts. Participants were duly informed of the purpose of the study and their rights. Written informed consent for this study that includes data collection and consents to publish the information collected was requested and obtained from the participants and they were assured of their anonymity in publications.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

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