Financing and Delivery of Health Services in Eastern and Southern Africa

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COST-SHARING AND LOCAL ACCOUNTABILITY: ALTERNATIVES TO THE FINANCING OF HEALTH SERVICES IN UGANDA.

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List of Abbreviations.

SAP Structural Adjustment Program.

WHO World Health Organisation.

NGO Non-Governmental Organisation.

PO People's Organisation.

HUMC Health Unit Management Committee.

NRC National Resistence Council.

LC Local Council.

TBA Traditional Birth Attendant.

HIV Human Immuno Defficiency Virus.

AIDS Acquired Immune Defficiency Syndrome.

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Executive Summary .

Although the public health service provision has suffered a great deal during the past-two decades and has continued to offer quite little, users of public health service facilities have always turned to them for the services due to partly limited alternatives and partly due to financial inabilities.

Individual private expenditures on health services takes a fair share of the individual house hold incomes, and recently, private expenditures have outweighed Government expenditures on health services. This indicates a natural reflection of the manner in which health services are produced and consumed, and is consistent with the pattern that resulted from the breakdown of the economy.

Since individuals have been meeting their health service costs by seeking private provisions or taking on other alternatives available, it is of little shock introducing cost-sharing in public health units and therefore this has not affected attendance. However, the introduction of the Cost-sharing scheme in Uganda has neither been protested in a more serious manner than merely expressing doubt in its effectiveness and benefit, nor has it improved on the services offered mainly because the amount charged is too low in most cases to make an impact on the already devastated system. Charges have also been confined to on First-Visit registration and consultation only.

The whole design and implementation of the cost-sharing scheme in the districts where it has been tried was very poorly done, and thus, it needs more improvement. A detailed and carefully designed plan should be done.

Staff numbers and levels of commitment at health service units have not changed much since the generated moneys are quite little to effect a significant change at this level.

The new mandate given to the decentralised districts gives a lot of room for community involvement in the management of health services. However, this needs more strengthening and mobilisation of opinion and other inputs at the community level.

There are still many areas of resource shortages particularly the basic infrastructure and personnel as well as drugs and other needs.

Due to the binding constraints on Government resources, priorities need to be selected carefully. Government therefore, needs to concentrate its resources on the provision of policy and infrastructural incentives to the private sector in health service provision, essential services (such as Immunisation, Family Planning and AIDS and Health Education) and areas where other agents would prove ineffective.

The public health sector strategies should explicitly exploit the current potentials of private expenditures. The central challenge therefore for Government in financing and delivery of health services in particular, is to develop a good policy environment as well as infrastructural incentives, while private expenditures are streamlined in such a manner that caters for all.

Alternatively, the precedence of the private and the informal health service provision can offer a small slot for government to implement a carefully designed Cost-sharing program, comprehensive enough with good infrastructure, well elaborate levels of community participation and inclusive of all groups.

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1.10. Introduction.

In many African countries, the structural adjustment programs (SAP) call for change in (among other areas) the financing and delivery of health services.

In Uganda, the pre-SAP national health care system emphasises free and centralised health service delivery. A common element of SAP is a reduction in government subsidies on health expenditures. In some cases of successful SAP implementation, the short-run victims are both the urban poor and the rural dwellers who can least afford the costs of health services.

In 1990, the government of Uganda proposed the introduction of user charges in all government health units. The aim was to supplement government budgetary allocations for the financing of health services.

After a long and unsuccessful debate in the National Resistance Council (NRC) or Parliament, cost-sharing in government hospitals was only allowed to operate in some districts as an experiment. Up to date, the experiment has not yielded enough data to enable the government translate the results into budgetary decisions. Neither there is enough data to derive the cost of health care in real terms for individual households.

Uganda is among the few African countries that are said to be managing the structural adjustment policies with a degree of success. The most direct link between adjustment policies and health services operates via government financing. A common element of adjustment is a cut in public spending on social services including health services. The government of Uganda has introduced cost-sharing as one way of achieving this objective. However, cost-sharing is frustrating to implement in a country where information regarding the costs, in real terms, of the health care services is lacking and where the response of the citizens to fiscal measures is not high on the priority list of policy makers. These two conditions make it impossible for the merits of alternatives to government health services to be easily mapped, and subsequently masks fiscal abilities and preferences of citizens.

Government support for social services, principally health and education has declined radically from the early 1970's. The deterioration of the health service system in Uganda is partly attributable to the complex ethnic legacy of colonial rule which helped to push the country into political, economic and social turmoil from which it may only now slowly be recovering. The effects of the turmoil on service provision were devastating. As a result of this, Uganda's aggregate health indicators, today, such as infant mortality and life expectancy at birth are among the world's worst.

Government's capacity to deliver social services is further hampered by a low revenue base and therefore low resources available to government for expenditure on social services. This is further exacerbated by an ineffectual prioritisation, lack of a "living wage" for government employees and extremely low rural incomes. This forms the backdrop to state capacity to provide services. Public sector support for improved services cannot be matched by adequate budgeting allocation while government is financing the strengthening of the economic base.

There are significant systemic and structural inequalities in both the emplacement of facilities and accessibility to health services in Uganda: between urban and rural areas and within them. Almost all public facilities are in a sorry state. There exists little effective management and the staff are inadequately paid. The management issue is partly a matter of training but mainly one of motivation. It is also a reflection of the poorly coordinated structure of responsibility for health services in Uganda

2.10 Statement of the Problem.

The corner stone of the liberal reform policy in Uganda today as far as service provision is concerned is cost sharing between the state and service users. The assumption is that user groups will operate these services more efficiently than the state especially if they directly contribute to their functioning. Cost-sharing is however, frustrating to implement since information on costs, in real terms, of the health care services is lacking and where the response of the citizens to fiscal measure is not considered by policy makers. Cost-sharing is being cautiously introduced at the same time as service provision and revenue collection is decentralised.

Government policy has largely been overtaken by a combination of the ascendancy of a private and voluntary health system as well as an informal one. These new developments call for extensive research into possible ways of revitalising the health system. In light of the shrinking of the state overall budget, it is essential to come up with possible ways of financing the health sector as well as delivery and sustaining the services. Decentralisation of both health financing and delivery of health services at the local levels may be one option. This also implies an examination of accountability and participation in decision-making at this level.

The main issue to be addressed in the provision of health services in Uganda today is therefore, how best to articulate different actors within this sector, and at different administrative levels, municipal, regional, community, in order to enhance access to health services.

a) Under structural adjustment, where the cost of services is partly shifted to the users, the question of equity and access become important research questions. How will poor and vulnerable groups especially in rural areas adopt to a payment regime for health services?

b) How viable is the informal and private access to health services in Uganda? Can these popular initiatives be institutionalised and regularised, and would this enhance access to services? Given the historical social expectations from the central state, will the institutionalisation of de facto payment for health services be workable?

c) What is the impact of cost sharing in terms of service delivery and financial abilities of the recipients in the communities where it is practiced now? What system of charges is administratively feasible for Uganda?

d) What are the attitudes and perceptions of the local communities towards the user-charges scheme?

2.11. Objectives of the Study

The main objective of this study is to access and evaluate the emerging health sector system in Uganda incorporating, as it does, various actors- public, private, voluntary and informal.

2.12. Specific Objectives

(a) to examine the relationship between revenue collection and service delivery, the budgeting process, management capacities and accountability at the local level in relation to implementation of the Decentralisation policy;

(b) to determine the cost of the health services to individual households and the degree to which the households afford the services;

(c) to establish attitudes and perceptions of the local communities toward the current health services, and the cost-sharing scheme;

3.10 Issues in Service Delivery in Uganda

Uganda had a population of approximately 16 million in 1990 (Uganda Population Census of 1990). It is expected to increase by over 130% by the year 2015 bringing this population to approximately 37 million people; with a per capita income of approximately $ 170. At this rate, Uganda is likely to continue having funding difficulties for the provision of social services including health services. Health statistics already indicate that, among the leading causes of death, AIDS, tuberculosis, malaria, pneumonia and diarrhoea top list, the last two being he leading causes of death among the under five. The population per physician ratio is quite high, with 25,000:1. This however, does not cater for the private practice.

The public sector commands over 60% of the clinical facilities, while the NGO sector nearly accounts for the rest. A three tier principle governs the system of health service delivery in Uganda. Each district has got a district hospital with a string of smaller facilities at the subcounty and parish levels, while Mulago hospital is the national referral hospital. However, several districts especially those in the northern part of the country still experience poor access to health facilities. Under decentralisation, the districts are charged with the administration of district hospitals as well as the lower levels.

Uganda government health service financing has been incredibly low, and donor disbursements have outweighed local spending by almost thrice.

The central government expenditures on health for instance between 1986-1993 were as follows:

Table 11. Central Government Expenditures On Health.

Year	Expenditure (in millions. UShs.)
1986/87	210
1987/88	986
1988/89	2450
1989/90	4431
1990/91	6006
1991/92	.....
1992/93	24334

Source: The World Bank

Table 12. Central Government Expenditures On Health As % Of Total Expenditures (Locally Funded Expenditures)

Year.	% of total expenditure
1989/90	4.7
1990/91	4.9
1991/92	6.3
1992/93	8.5

Source: The World Bank

The management and provision of health services in Uganda has changed fundamentally over the last thirty years.
In the 1960's Uganda had one of the best health care delivery systems in Africa. Drugs were available without charge at Government health facilities, which were heavily attended. Between 1962-1975, the state perceived itself as the motor of development and the provider

of services. It therefore set out to centralise political and economic activity, secularise education and health institutions and restrict non state activity in general.
In the period 1976-1986, the advent of Idi Amin led to economic decline and anarchy. This in turn led to the collapse of the state services. Hospitals were critically affected by the expulsion and emigration of trained personnel; from 1968 to 1974 the number of doctors dropped from 978 to 574, and pharmacists from 116 to 15. For rural health centers and dispensaries, which never had resident doctors or pharmacists, lack of medicines seems to have been the most severe problem. A recent WHO report (1988), estimates that attendance at government health units dropped by half, from 1976/77 to 1988, and attributes this to 'gross shortages of drugs'. People's Organisations (POs) and informal enterprises emerged to meet unsatisfied social needs. The NGO's were subjected to the vagaries of changing state policy and its organisational capacity in this period remained limited. In recent years, (actually during the 1990s), a Structural Adjustment Programme (SAP) was implemented. The state institutions are being rehabilitated, and emphasis is shifted from state provision of services to privatisation. There is increased importance of donors and international NGO activity in Uganda's social sector. It is important to understand that with SAP new vulnerable groups may have been created due to massive loss of income of urban workers and the new tax structures put in place. The current political structure (resistance councils) introduced at five levels promotes participatory democracy and enhances socio-economic development and community participation from the grass roots.

All this has led to a more complex articulation between the state, NGO's, and the private sector in service provision. The voluntary sector has become more structured in this period. However, the state remains crucial to the equitable provision of services, even if its role and functions may be changing.

3.11. The Health Care System

The public sector accounts for 61 percent of secondary and tertiary hospitals, and 58 percent of the registered outpatient clinics. Although the Government has the largest formal health care infrastructure, the private, as well as the informal sector is also very important in the health care system. The Report of the Health Policy Review Commission of 1987, (pp. xv-xvi) underlines its significance:

> When Government Health Units were functioning well
> in the 1960s private practice was on small scale,
> but as services deteriorated and the economic
> conditions became severe... Private clinics,
> Medical laboratories, and Pharmacies mushroomed
> all over the country, involving even the
> health personnel employed in government.
> The general breakdown of law and order in the
> country made it impossible to enforce statutory
> controls laid down in various Acts governing health.
> Although good private practice is a very important
> service to the population, the existence of many
> illegal private clinics and the indiscriminate
> peddling of drugs by unqualified persons pose a threat
> to the lives of the people of Uganda.

According to the 10th issue (July 1992), on *Key Economic Indicators* in 1989 there were 200,000 persons per hospital with 23,000 persons per doctor. This is greater than in many other low-income countries, and twice the ratio of 1965. Uganda has reacted pragmatically to the loss of physicians by substituting trained medical assistants for them. That of nurses has improved, from one nurse per 3,000 people to one per 2,100. However, the bulk of health personnel remains in the urban areas and in hospitals; in 1988, 74 percent of all public sector health staff were located in urban areas and 76 percent worked in hospitals. Yet Uganda's population is 90 percent rural. The population is growing at an alarming rate (3.1 percent annually), much higher than the expansion in the delivery of services. An active presence by government is needed to confront these problems.

3.12. Government Policy.

Government health policy largely remains undefined. The absence of a practical health policy thus perpetuates the situation deplored by the Health Policy Review Commission in 1987:

> "there is uncertainty as to what specific policy the Ministry is pursuing across a wide range of its activities. Hence, even senior officers are not clear as to the Ministry's policy on specific issues. The absence of clear policies in turn leads to inadequate determination of priorities for the Ministry as a whole. Consequently the external donors take advantage of the apparent policy vacuum to lobby high political and top civil circles thus prejudicing the policy decisions in their favour but not necessarily in the national interest."

At present, in light of the limited scope for increasing Government resources for health, the Ministry of Health has identified various major objectives for the three years 1993/94-1995/96:

a) Consolidation[1] of existing health services, to improve the services they provide and hence improve coverage of the population.

b) Primary Health Care

(i) immunisation against major infectious diseases;
(ii) control of locally endemic diseases with particular emphasis on malaria;
(iii) adequate food;
(iv) clean water and sanitation;
(v) education concerning health problems and their prevention.

c) Strengthening the drug sector management through the "Uganda Essential Drugs and Equipment Program".

d) Pursue an inter-sectoral approach towards AIDS prevention through the Uganda AIDS Commission

the

(i) reducing the spread of HIV infection through increased public awareness of transmission mechanism;
(ii) reducing the adverse socio-economic impact of the HIV/AIDS epidemic; promoting action at the community level; and providing health care for people with HIV/AIDS;
(iii) strengthening the national, local and sectoral capacity for planning and policy development in relation to AIDS;
(iv) establishing a national information base on HIV/AIDS;
(v) strengthening research capacity relevant to prevention, care and control of HIV/AIDS.

e) Implement a food and nutrition policy (by Food and Nutrition Council) to address all aspects of food and nutrition in Uganda.

f) Implement a National Population Programme (a comprehensive multi-sectoral approach) which will evolve a national policyon population, attempting to make population growth compatible with development.

This policy framework must take into consideration the resources available to the state, the increased definition of priorities in the health sector by donors and the mushrooming of

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[1] consolidation includes both rehabilitation and re-equipping of dilapidated health units, improving their recurrent expenditure through more supervision re-deployment of staff, staff incentives and efficiency improvements.

informal and non state health providers. These form a rich area of study and could be useful in formulating recommendations for a more adaptable policy framework.

The 1980s have been considered a ***wasted*** decade for Africa and the poor economic performance of most African countries today has dictated that, African governments must adjust their structure of economic management. The adjustment programs call for change (among other areas) the financing and delivery of health services with the idea of user charges emerging as one most probable step in the adjustment program. Consequently, African Health Minister's attending the 37Th. regional meeting of the World Health Organisation (WHO) in Bamako, Mali in September 1987, embraced the strategy of improving on the health crisis. This strategy emphasized, government putting their resources squarely behind the proven elements of PHC, making more rational use of their slender health budgets, and examining creative approaches to community financing methods which had already enabled communities in a number of African nations to take charge of local health needs.

3.13. Health and the Health Sector in Developing Countries

Africa's struggle to over come illness and disease over the past quarter century has had mixed results.
On the positive side, infant mortality rate has been cut by more than one third, and average life expectancy has increased by more than 10 years. 40% of the African population was obtaining drinking water from a safe source. By the end of the 1980s, around half of all Africans were able to travel to a health care facility within one hour (Unicef 1992b quoted in World Bank 1994).

On the negative side, however, life expectancy in Africa in 1991 was only 51 years, compared with 62 years for all low income developing countries and 77 years for industrial countries. Africa's infant mortality rate is almost 50% higher than the average for all low income countries and at least 10 times higher than the rate in the industrial countries. In other African countries the range is more than 200 deaths per 1000 live births in Mali, Angola and Mozambique to fewer than 100 in Botswana and Zimbabwe (Unicef 1993 quoted in World Bank 1994). In Uganda, 164 out of every 1000 children under 5 years die from one of the six preventable diseases each year (Unicef 1992). Maternal mortality in Africa is twice as high as in all low income developing countries and six times higher than in the middle income countries. Maternal deaths per 100,000 live births have been estimated to range from 83 in Zimbabwe to more than 2,000 in Mali. Adult mortality (the risk of dying between ages 15 and 60) has been estimated to range from 18% in Northern Sudan to as high as 58% in Sierra Leone (Feachem et al 1992 quoted in World Bank 1994). Mortality also varies widely within countries, revealing inequalities in health status between urban and rural residents as well as between different socio-economic and ethnic groups. In Zimbabwe, for example, childhood mortality in urban areas is 45% less than the rate in rural areas and is up to 20% less among urban dwellers in Sudan, Togo and Uganda (World Bank 1994).

The children of married women with a secondary education are 25 to 50% less likely to die before age 5 than are the children of w222omen with no education, also life expectancy of the richest 10 to 20% of the population is somewhere on the order of 10 to 20 years higher than that of the poorest 10 to 20% (Gutkin 1991 quoted in World Bank 1994). Malaria is Africa's largest and most persistent disease problem followed by tuberculosis and Aids which is the most dramatic new threat in Africa.

The health sector in developing countries consists of a heterogeneous mixture of public or government activities and non government activities, including services provided by both modern and traditional practitioners. Use of the government service system varies enormously among and within countries, depending on its effectiveness and its competitive environment.
For example, in the Cote d'Ivoire the government system serves 90% of the outpatients, in the Philippines, which has a large modern private sector, the government system serves at least 25% of the outpatients. In the non government sector, modern private care is dominated by independent physicians. In Bangladesh, Cote d'Ivoire, Indonesia, Malaysia, Peru and Thailand, surveys show that private physicians account for at least 25% of outpatient visits, while densely settled middle income countries such as the Republic of Korea and the Philippines, is up to 40%, even in rural areas. In Africa and parts of Latin America, modern non public care is provided by religious missions and other non-profit groups, pharmacists, traditional healers and midwives (World Bank 1987).

It is important to understand that the countries are quite different in ways that affect the delivery, accessibility and financing of health care.

3.14. Problems in the Health Sector.

Three basic problems may hinder the performance of the health sector in developing countries, including Uganda (World Bank 1987).

Allocation - insufficient spending on cost-effective health programs.
Internal inefficiency - wasteful public programs of poor quality.
Inequity inequitable distribution of the benefits of health services.

Piece meal efforts to address these problems, such as foreign funding of high-priority programs or the addition of more supervisory staff to control quality, fail to address a fundamental cause - poor approaches to financing. Burdened by massive debt and interest repayments to the richer nations of the world, most sub-Saharan African governments have undertaken to restore their economies by shedding costly public enterprises, devaluing currencies, and slashing public expenditure on basics such as education and health. This restructuring has adversely affected different groups of the populace to varying degrees. Most countries have embraced an explicit social goal- to bring basic health services to their entire population by the year 2000. This was the case in Bamako and Mali in September 1987 when African Health Ministers attended the 37th regional meeting of the WHO and embraced a new strategy designed to revive primary health care, particularly for children and women in their region.

With reference to the 3 problems cited above, World Bank statistics indicate that between 1981-82, public and private spending on health care in developing countries averaged about US $ 9 per capita in low income countries and US $ 31 in middle income countries, compared to US $ 670 in industrial countries. The difference reflects differences in overall per capita income the proportion of total national income devoted to health ranges from 2 to 12% in almost all countries, developing and developed. Health spending is highly income elastic. This current spending does not address fundamental health problems, and goes almost completely to curative services provided almost exclusively by hospitals. The allocation problem in the health sector is due to a combination of limited overall resources for health (due to low per capita income and allocation to high-cost relatively ineffective care. The mismatch between resources and problems can be attributed to a centralized system, without any pricing mechanism to assist in resource allocation; thus investment over the long run can diverge considerably from needs.

For example, in Niger about half the government health budget goes to hospital services in urban areas, 40% on provincial facilities in main towns and only 10% in rural areas where over 80% of the population lives. 50% of budget devoted to hospitals in 1984 benefited 350,000 hospital patients, while the other half of the budget provided services for more than 10 million clients. Low salaries and poor amenities in the public sector contribute to loss of personnel. India, which is widely regarded as having a surplus of physicians and is a major contribution to the
international migration of physicians and nurses, had vacancy rates of 30 to 90% for professional health service positions in rural states during the early 1980s.

Concerning the problem of internal inefficiency of government programs comprises both demand and supply problems. The demand side; is characterised by inappropriate use of services and rationing by queue. In Colombia and Somalia for example, hospitals at the highest level (tertiary care) in major cities had occupancy rates of over 80% in recent years, while local (secondary) hospitals had rates of 40% or less. In India, health clinics that have 8 to 10 beds serve about 100,000 people. Consumers crowd themselves into modern urban institutions because personnel are better trained, equipment and laboratories are more complete, but this leads to inefficiency. Inappropriate pricing policies result in inappropriate investment patterns. The problem of queuing is evident in a number of countries. A study in Calabar, Nigeria, found the average visit to a government hospital to take one and a quarter hours but at times as long as 8 hours. In Uganda, about half the patients were seen within 2 hours and about 10% waited more than 5 hours. This tends to elevate the opportunity cost of waiting time especially for the working for the working poor- including mothers which could be spent on child care, other home activities and agricultural work.

On the supply side; under-funded recurrent costs, over-centralisation and costs, logistics and poor quality in the public sector are some of the problems. Pressure to expand the system combined with sufficient funds to do so leads to cutbacks on critical complementary inputs short run cuts usually include expenditure on fuel, drugs, vehicle and building maintenance. The price of a small financial saving is a large drop in the effectiveness of workers. In Zambia "free" government provided health services were inoperative because fuel and drugs were unavailable; yet non government services flourished. Secondly, tax supported health systems are highly centralised in financing and management and thus tend to use resources inefficiently. For example, rural health demonstration project in Mali consumed 63% of operating cost on supervision and administration work that replicated an existing decentralised private distribution system. In Uganda, political upheaval prevented the central authority from effectively managing and funding the health system thus Ugandans relied on existing mission health systems. Thirdly, logistical problems in the supply of drugs, equipment and fuel, for example, brand name drugs bought in small, expensive lots, drugs often spoil in storage, lax inventory control results in thefts, etc.

In Nigeria, in the late 1960s, measles cases were increasing among children with clear records of having been immunised, tests of the vaccine found that only one of twenty samples was capable of immunising a child. Fourthly, poor quality of government services is difficult to quantify yet un ignorable, for example, a 1984 survey in Tanzania showed that rural health clinic personnel referred only 3% of their patients to a higher level, yet they were not capable of treating 36% of their clients.

Concerning inequality, the urban-rural distribution of benefits gives a clear indication. In most developing countries 70% or more of government funding on health goes to urban hospital-based care. This is further compounded by income inequalities, the urban bias of most health systems creates a distribution of facilities and personnel that favours the better off.

3.15. User Charges for Health Care.

At the meeting in Bamako in 1987, WHO adopted a resolution to introduce community cost-sharing to support primary care. The Bamako Initiative was launched and involved from one to 50 districts in 13 countries, some 1,800 health facilities, and about 20 million people. The major feature of the Bamako initiative is the concept of self-sustained health care. Under this concept, two features form the central focus: (a) Decentralization to the community health centers and posts; (b) charging the users of the services a fee to cover the costs.

Government health facilities in developing countries tend to charge no fees or very low ones for services, drugs and other supplies. An outpatient visit for an adult in Botswana, Burundi, Lesotho, Pakistan, the Philippines, or Rwanda costs less than one-third of the average daily agricultural wage. In Indonesia, the cost is about half the daily wage, while in Burkina Faso, Malawi, Mali and Zimbabwe it is free. Increases in charges to users can help solve typical health sector problems. First, higher charges at government health facilities would generate more revenue. In Colombia and Indonesia fees cover more than 15% of the operating costs of the system as a whole. Health projects in India, Indonesia, Mexico, Sierra Leone and Zaire cover 20% or more of recurrent costs with fees, a project in Cameroon covers 95% of its costs with fees while mission facilities in Africa cover as much as 70% of their costs with fees. Secondly, the imposition of fees makes it possible for governments to generate revenue to extend appropriate services to the under served. Thirdly, even modest charges to users are likely to make delivery of government health services more efficient. Different charges for different type of service can also signal to consumers the importance of certain kinds of care (World Bank 1987).

Drugs have been priced to serve as a mechanism of cost recovery and financing of local services. In Benin, Nigeria and Guinea approximately 40 to 46% of local operating costs, including salaries, are being covered by fees. Countries can raise funds by increasing user charges and developing community financing schemes. Ghana raised user fees in 1985, increasing cost recovery receipts from 5.2% to 12.1% in only two years; part of the proceeds are reinvested in the health center to improve the quality of service. The plan reinforces the referral system by making curative care more expensive at the hospital than at the health center (World Bank 1994).

Charging users of health services, although a good idea, has not been without shortcomings. A report by Dr. Wamayi, revealed that at a nominal fee of UShs 100 (US $ 0.10) at Kasangati Health Centre (Uganda), patients numbers fluctuated depending on the prevailing economic circumstances (Wamayi 1992). However, there is no elaboration on the particular economic circumstances that were at play and the margins of the fluctuations. The report further revealed that staff absenteeism remained unaffected by the cash incentives. The report indicates that other factors were at play, and attributes it to supervision, administration, training, lack of obligation to work, and that the value of the cash incentive was too low to influence behaviour.

Wamayi's report brings us to another crucial factor in the delivery of health services- staff remuneration. While the Bamako initiative emphasizes fees for the recovery of the drug costs, it does not emphasize staff remuneration, an important factor in the delivery of health care services. Most important is the remuneration rate that is big enough to effect behavioural change, but affordable enough to keep the patient load unaffected.

Similarly, Brunet-Jailly (World Bank 1991), argues that the size of the expected benefit and how long it would take to implement the desired changes poses a big question. The question posed here still demands for clear answers. Jailly raises another equally important issue, staff are not in place where the demand for services exists. This aspect erects an enormous barricade towards the decentralization process in the delivery and financing the health services.

Regulating for user charges means setting minimum standards and price ceilings. In a poorly functioning health system, these aspects aggravate the hitherto unanswered questions and may depress demand further. While the Bamako initiative advocates for reforms in the area of financing it leaves out these important aspects. In the philosophy of the Bamako initiative it is not clear how these challenges can be overcome.

While we debate the issue of financing, which is fully addressed in the Bamako initiative, this eludes us to only think that it is only financing that matters. And as such, other issues majorly accountability both at the local and national level is not tackled. In Cuba, the elimination of private practice, socialization of medicine, and a commitment to equal access to health care, have enabled the country to realise great improvements in the health sector. Life expectancy at birth for women was 69 years in 1965 and 77 years in 1985, Jamaica has made similar improvements 67 years in 1965 and 76 years in 1985 (Carrin 1988).

These figures warn us that private or public sector should not entirely dominate our debates. In the concept of the Bamako initiative, key issues under review do go beyond the debate on private versus public. These issues are clearly understandable. In countries like Uganda, little data is available for any meaningful conclusions to be drawn. The implementation experiences are too narrow to address the issues under review quite exhaustively.

The Bamako initiative cites a number of countries where user fees have been introduced. In addition to the limited evidence of the successes of the initiative, there is no criteria for paying the user charges and how to determine those who are too poor to pay. Whenever, the question of affordability is raised, it often generates many related questions. First, what is the level of affordability and secondly, how would this level be determined. The effect of this phenomenon, is most likely that patients will turn away from the services. Wamayi (1992), on this score says, that increases in the user fees were followed by decreases in patient load but there was no increase in the number of people unable to pay. This fact brings us to yet another question as to where and what did the patients do?. This effect is immensely greater than what it sounds like. Wamayi suggests that patients simply stay at home. But the actual practice may be far from that one important aspect we must bear in mind is the practice of self medication.

Similarly Carrin (1988), says most patients in developing countries often have direct access to drugs in pharmacies and general shops.
The effects of self medication are another issue of a mammoth scale. While considering alternative ways of financing and delivering of health services we should not forget the mode of payment and most important payment for what?.

Wamayi (1992), found that when the fee for service charge was introduced, there was concern that patients would demand treatment for all consultations and that prescribers would

give more drugs in an effort to give "value for money" to the patients. Carrin (1988), has similarly argued that there is a danger that patients will press for excessive prescribing. These aspects of alternative financing and delivery of health services leave gaping questions whose answers must be carefully sought.

Zaire is one of the countries cited as an example where communities have recovered a substantial amount of the costs for health care. One of the salient issues that bothered Zaire was the criteria for determining those who can afford the charges and those who can not. This aspect has its own social-cultural causes which may prove even difficult to dismantle. Wamayi (1992), reports that at Kasangati Health Centre the number of the indigent remained constant while the patient load dropped in relation to an increase in charges because patients always preferred not to be categorised as indigent due to social stigma. Similarly, Pangu & Van Lerberghe (1990), found a similar situation in Zaire.

Looking at the questions raised through the review of literature and given the fact that new strategies and alternatives have to be sought in the financing and delivery of health care services, research in this area is an undebatable subject.

4.10. **Methodology**

A study on local forms of participation in the service delivery system, financing and efficacy of service provision clearly calls for a multi-disciplinary approach. The state in most of the African countries had claimed the role of redistribution and service provision. Its disengagement from these activities has therefore got political implications: analysis of social expectations, the exchange of resources for political support, local accountability and participation in decision making on priorities, decisions on emplacement of service infrastructure and recruitment of personnel in the community health care system. All these variables call for a sociological and political approach. This aspect of the study was carried out using in-depth open-ended interviews with service users. Services and service provision were clearly measurable, and trends in them could be determined by a historical transect of service provision. Equipment, infrastructure, personnel, number of patients, presence of drugs, distances from health units, health costs, required a quantitative approach in which several variables will be correlated to determine:

a) level of access to services and their trends.

b) capacity to pay for services by different communities including vulnerable groups.

c) willingness to pay, measured against the understanding of the community of the relationship between decentralisation of revenue collection and service provision.

The project, therefore interface economic, political, sociological and anthropological approaches.

The multi-disciplinary approach was complimented by stratified samples according to income groups and according to region to reflect revenue bases for communities, and income bases for individuals. Three clusters were identified, one with high levels of access to services, an intermediate one, and an area in which health services are scanty and inaccessible. The aim was to establish association or non-association between income levels at household level, health policy at local level, local capacities to provide these services and the policy environment at a wider level.

The country was therefore, divided into 3 regions; eastern, central and western regions. From each region, 3 districts were selected to represent the various levels of access to services; high, intermediate and scanty. In each district, actors in the health sector; public, private, voluntary and informal were selected as well as 30 households with varying incomes; high, medium and low income (10 of each category). Owing to the fact that the current political structure of Local councils (LCs) were present in all areas it was of importance to select 5 LC members one at each level (LC1 to LC5) within each selected district as well as policy makers at the ministry level. This generated information on existing health policies at local and country level.

5.10. Study Findings and Discussion.

A. Households. (Demographic Characteristics)

Age: The youngest household head (HH) interviewed was 18 years and the oldest 80 years with majority aged 30 years (14.9%).

Education: The level of education among household heads also varied significantly. Those with no education (7.5%), primary (30.4%), secondary (27.3%), college/institution (23.0%), and University (10.6%).

Marital Status:

Majority of the respondents were married (57.8%) other categories included single (29.8%),separated/divorced (3.7%) widowers (3.7%) and widows (3.7%).

Occupation: The respondents are involved in several activities. Many are salaried employees (39.8%), business men/women (10.6%), self employed (17.4%), casual workers (3.7%), peasants (14.9%), students (1.9%). Some small percentage of respondents had multiple occupations for example, salaried employees/ business men or women (0.6%). 8.7% were unemployed.

Status of Family Members:

These were categorized into 5: employed, unemployed, school going, pre-school and self-employed. Those families with employed family members ranged from a minimum of 1 person (28.0%) to a maximum of 5 persons (0.6%); unemployed minimum 1 person (18.6%) to a maximum of 6 persons (0.6%). For those in school minimum of 1 person (18.0%) maximum of 9 persons (0.6%) while with pre-school family members majority had only 1 or 2 children in this age group and maximum of 4.

For family members in self employment majority had only 1 member.

B. Health Facilities

Majority of the health facilities were situated approximately 5 km from home.(see. Table 1) It was also established that some patients had to travel distances of 10 km to over 20 km to get to any health unit. This tends to have implications on the choice of where one took patients. Many of them took their patients to government facilities (60.9%) while a few others (37.9%) preferred non-government facilities. Health facilities varied from hospitals (22.4%), health centers (35.4%), dispensaries (22.4%), sub-dispensaries (9.3%) and aide posts (3.7%). (see. Table 2) Several others went to private clinics, private hospitals, church-owned health units, NGO owned, dispensaries, traditional healers/herbalists, or to church. It was common to find that at times patients visited more than one of these, mostly combining modern and traditional methods of healing.(see. Table 3)

Table 1. Distances to Nearest Health unit.

Distance (Km)	Percentage of Respondents
1	18.0
<5*	15.5
5	52.2
10	5.0
15	1.2
20	1.9
20+	2.5

* excludes 1 Km

Table 2. Type of Health Facility Nearest to Household

Type of Facility	Percentage of House holds
Hospital	22.4
Health Center	35.4
Dispensary	22.4
Sub-dispensary	9.3
Aide Post	3.7
No response	6.8
Total	100.0

Table 3. Health Facility to which Patients were Usually Taken

Type of Facility	Percentage of Household Heads Taking Patients to this Facility
Government-run	50.9
NGO-owned	1.9
Private hospital	13.7
Church-run	8.7
Traditional healer/herbalist	0.6
Private clinic	18.6
Dispensary	1.2
Church	0.6
Non specific	3.8
Total	100.0

5.11. Choice And Decision Making at the Household level.

The choice where to go for health services is dependent on a number of factors. These range from diseases that are believed to be incurable by the conventional health service system, lack of money, severe diseases, quality of service, availability of drugs and distance. Nevertheless, government run health facilities attract the biggest percentage (table 3) for the major reason that, government runs the best established infrastructure as well as personnel as compared to the mission based facilities and the private facilities respectively. Financial inability of clients also explains, to a large extent, the big number of patients that visit government run health facilities. Financial constraints further drives patients to search for more alternatives in case government health service units have run out of services to offer or if simply are out of reach. In such cases patients would practice self-medication; seek where they can obtain services on credit or borrow some money from relatives and friends; go to herbalists; some buy what their money can afford from clinics and ordinary shops; and others simply stay home during the illness, especially in case of terminal illnesses like AIDS.

5.12. Self-medication

There was notably a high percentage of respondents who practice self-medication (89.4%) for various reasons. Those who practiced this did so under the following circumstances:

- Short or simple illness e.g. stomach ache, headache, light fevers, and minor cuts and injuries.
- Lack of enough money to afford the charges as well as transport costs.
- When one had knowledge about the disease/prescription especially in the case of young children who tend to have the same illnesses repeatedly
- For emergency cases and First Aid.
- When the distance to the nearest health centre is very long.

Self medication can further be explained by the general decay of the health service machinery that gave way to the private and informal health service. The disperities in the costs between the informal health service provisions and the private provisions may also explain the high percentage of self medication. The costs of health services for the common

sicknesses indicated in table 4 shows that the minimum charges for each kind of disease was a reflection of what patients paid for drugs usually bought from ordinary shops and market places. These expenditures also indicate that, at times patients pay more than what the actual costs would be. This could be attributed to the ascendancy of the private provision as well as the informal provision over the devastated public provision in the absence of policy guide lines:

Table 4. Private expenditures on Various Common Ailments. (US $)

Disease	Minimum charge	Maximum charge	Average charge
Malaria	0.30	70.00	5.06
Respiratory infection	0.50	20.00	3.06
Measles	0.20	70.00	10.83
Tuberculosis	0.50	300.00	47.72
Malnutrition	0.30	60.00	14.19
Worms	0.20	60.00	3.19
Anaemia	0.50	35.00	7.95
Diarrhoea	0.10	50.00	4.57
Dental Problems	0.50	40.00	4.93
Skin infections	0.30	12.00	3.26

(at the exchange rate of Ushs. 1000 to US $ 1)

5.13. Cost sharing.

In Uganda, until recently, government health facilities tended to charge no fees.[2] In 1990, the government of Uganda, partly as a response to the Bamako initiative, and partly in a desperate search for alternative financing of health services in the country, proposed the introduction of user-charges in all government health units. The legislation never succeeded mainly due to the financial inabilities of the population where the majority fall below the poverty line with approximately US $ 170 income per capita, the past legacy of free medical, and the failure of the public health system to deliver, which cast uncertainty on whether user-fees would make the necessary improvement. Also the lack of an alternative in the proposed paying regime that offered neither credit nor hope for a service to those who would fail to raise the money for the fees, further weakened the government's position. As a compromise, government, gave a lee-way to the decentralised districts which now enjoyed administrative powers independent of the central government, to institute a paying regime as their own initiative. The decentralised districts instituted the user-fees programs with little preparations for it and almost with no much mass mobilisation of opinion and support from the users. This has resulted into the various attitudes and interpretations of the paying of fees as will be shown. However, we must note that the ill-introduction and implementation of these initiatives did not raise the much feared violent protests as a form of resentment. In total, Cost-sharing has been accepted only with mixed feelings as a result from the ill-implementation with which it was done and the uncertainties resulting from this.

Majority of the respondents (85.7%), were aware of the existence of cost-sharing schemes in the districts, The scheme as noted by the majority, started about a year back (26.7%), but several time-frames were suggested by the respondents, some as far back as 20 years (0.6%), an indication of the poor organisation and poor coordination with which the program was instituted. The amount paid, generally varied between the various health units and within them, from a minimum of U.Shs 200 (US $ 0.2) to a maximum of Ushs. 10,000 (US $ 10) For instance patients needing to consult a medical officer in some health units would be required to pay higher fees than those consulting medical assistants.

Even the money paid, patients had no clear view of what they paid for. The money paid, according to the respondents, was for registration (26.7%), consultation (21.1%), consultation and drugs (19.3%), drugs only (3.1%),for medical staff "top-up", stationery,

[2] Although government policy does not recommend any charges, District Health Committees have been granted permission to institute user-fees at government health units.

accommodation. Surprisingly, majority of our respondents were not sure of what exactly they were charged for.(Table 5)
Given the ill-preparedness of government in introducing the Cost-sharing programs, one would expect very negative reactions from the users. This was not so because paying at the public run health units could not bring shock to the users who were already familiar with the private provision as well as the informal one. It must also be noted that users were already paying informal charges at the public run health units. A combination of these, and other factors explain the absence of protest (or limited protest if any at all) to the introduction of Cost-sharing.

Table 5. Use of Payments (According to patients)

Use of Payment	Percentage of Patients' responses for the specific use
Consultations and drugs	19.3
Consultation only	21.1
Drugs only	3.1
Registration	26.7
Medical staff "top-up"	0.6
Stationary & accommodation	0.6
Don't know	28.6
Total	100.0

When asked to compare services before and after, many suggested that there had only been slight improvement. Other suggestions are as tabulated. (see. Table 6)

Table 6. Comparisons of Services Before and After Implementation of Cost Sharing Scheme

Respondents' Views of Services Provided	Percentage of Respondents who felt that way
Same (No Change)	30.4
Slight Improvement	50.3
Well Improved	4.3
Much Improvement	1.2
Worsened	2.5

The above responses in table 6 were based on the un explained changes and improvements at the various health service units. For the health service units that were receiving rehabilitation grants at the time, and significant inputs in terms of drugs and services from external donations, these improvements were mistaken to be resulting from the introduced charges. Respondents could not easily figure out how much could be raised from the charges and what percentage does this contribute to over all budget of a given health service unit. This reality completely masks the attitudes associated with fiscal measures. We must point out here that from all the districts visited, charges were in respect of registration and consultation only. In case of lack of the prescribed drugs, patients were advised to look for the prescribed drugs.

Several suggestions were given by the respondents on how to improve on the services. Majority of the respondents suggested that if health worker's salaries could be increased, they would be motivated to provide services in an effective and efficient manner. Other suggestions included:

- Timely payment of the health workers' wages and salaries.
- Re-equipment
  More health units.
- Introduction of 'mobile clinics' so that every one gets treatment
- Mass sensitisation on the user-fees.
- Supporting and strengthening of the private health service sector
- Up grading of Health centers to hospitals for better treatment and examination.
- Improvement of supervision and methods of accountability
- Improve on hygiene in hospitals especially lavatories
- A small percentage of tax should go to health e.g. graduated tax

Problems associated with cost sharing were also discussed. On the question of failure to pay for services required, although majority (57.1%) had never failed to raise enough money some significant (28.6%) had faced this problem.
With failure to pay for services, 67.7% of respondents said one would not receive treatment, another 18.0% said one could receive treatment on credit.
On the issue of credit facilities, 70.8% failure to obtain services on credit. For those respondents who received credit facilities, 6.2% reported that credit was limited to a specific amount.

Table 7. Level of Credit (US $) Provided to Patients (at exchange rate of Ushs. 100 per US $ 1.

Amount of Money (US $)	Percentage of Respondents Offered this Amount
0.20	0.6
0.50	1.2
1.00	0.6
7.00	0.6
10.00	1.9
15.00	0.6
Non specific	94.5
Total	100.0

Credit facilities were reportedly only offered in certain circumstances; when one failed to pay (5.0%), or if one was vetted for by a Local Council member(s) (2.5%) and thirdly, to seriously sick patients (0.6%). The time frame to settle the payments varied from one respondent to another. However, the majority (94.0%) reported they would pay back any time.
(see. Table 8.)

From the data we received, it is evident that introduced charges, in addition to being a domestic issue to the respective districts, it was rather more informal and personal between the users and the providers. No specific amount was set as a maximum beyond which one would not be given credit, neither a specific time, nor procedures of payment of the credit were laid any where. Precisely, no district had a policy document on the practice of user charges.

Table 8. Time Frame within which Credit is Due For Payment.

Time Allowed	Percentage of Respondents
6 Months	1.9
< 4 weeks	0.6
1 Week	1.9
Next Visit	1.2
Negotiable	94.0
Any time	0.6
Total	100.0

Several measures were reportedly taken against absconders: the case would be reported by the health administration to the local authorities (LCs), alternatively no additional attention would be given to the patient until one paid.

5.14. Institutionalization of Payments.

On whether or not payments should be institutionalized opinions were sought on the feasibility of this procedure. Majority of respondents were in favour (55.3%) while (39.1%) were of the opinion that it should not, majorly because some people could not afford the costs;(it would be disastrous since many who visited hospitals were the poor. It undermined their human rights and would increase the death rates among the poor) Secondly it was felt that people already paid very heavy taxes and the argument was that, this money should have gone towards the health service provision. Several other reasons were given: it was a burden to those who did not have permanent sources of income; some people were simply not

willing to pay for these services; besides, health services should be free and health workers more caring, and lack of accountability for the money paid.

A similar scenario was observed concerning people's attitudes and opinions on joint expenditure on health services between government and users. 59.6% felt they would go along with the idea while 36.0% rejected it. Those who rejected joint expenditure gave the following reasons. Some people were not willing to pay; general poverty; and the rationale (since taxes were already being paid) lack of a reflection of the collected money (fees) into better services, availability of drugs/other services. Lack of a comprehensive explanation about this policy therefore, it was not understood clearly thus one could not decide on the success or failure.

The most common view was that not everyone would afford the costs because some were too poor to pay (majority of Ugandans live in absolute poverty conditions) secondly, people's incomes varied with time.

5.15. Willingness to Pay for Health Services

Attitudes varied on willingness to pay, many though prefer to pay and gave several reasons:

- To support health staff so that they provide good health services
- To improve on the services offered even to those who could not afford to pay (maximum efficiency of services)
- With payment treatment was prompt and usually guaranteed; to alleviate pain and suffering.
- Increase accessibility to most services
- If it was affordable
- Simply to save life
- Improved services.
- Would alleviate hygiene related problems found in government run hospitals

On the contrary other respondents were not willing to pay and gave the following reasons.

- Health services were not good or even efficient.
- The system of payment was not well established
- Lack of money to spare to pay for health services
- Services should be free or were currently free (it is government's service to citizen's)
- Very heavy taxes were being paid(government should therefore provide free health services)
- Some people could not afford especially since the salary structure was very low
- User charges were less advantageous since their introduction
- If it was not a government policy there was little for paying.
- It was of little benefit since one paid for consultation and prescription and had to buy drugs from else where.

Varied opinions were given by the respondents on cost sharing and it's role in leading to a better health system.
It is clear that there were some in favour and others not in favour, as was reflected in their opinions. Many felt that with affordable subsidised costs, cost-sharing had a role to play. On the contrary, it is worthy to note that several others expressed their unwillingness to support the role of cost-sharing for example, 14.3% of the respondents just gave a plain no!.
Nevertheless, those who supported cost-sharing based their support on the following conditions:

- If charges are affordable (costs subsidised)
- If health services improve and salaries can be increased i.e. better motivation
- It is a good idea
- As long as there is more equipment, drugs, and staff (well planned for) and financially well managed i.e. streamlined
- If health service provision will be timely
- If it is effected everywhere and people are willing to pay
- If patients receive better attention and treatment
- If patients knew what exactly they were paying for
- If there were laws to govern cost-sharing

- If it would not be profit-oriented
- If it was included in the tax and made affordable (health tax)

Pessimism and apathy characterised the responses that were against cost-sharing. Many respondents expressed doubt of the applicability of the paying regime and feared for the uncertainties it may involve, and such expressions as below were quite common:

- There would be no change in the services
- Some people are too old or poor to pay for the charges and would therefore die; majority of Ugandans live below the poverty line; undermines their human rights
- Failure to pay would probably mean denial of adequate care.
- It is government responsibility to cater for the health of its citizens
- Lack of a clear system of managing the funds from the cost-sharing scheme.
- It is not a good idea
- We do not know why it was instituted

5.16. The Role of the Herbalists.

A very significant number (45.3%) of our respondents had, at one time or another visited herbalists to seek treatment. Various reasons were given for their role. For only (11.8%) was it because of financial constraints. Other reasons given included:

a) The disease could only or best be cured by a herbalist e.g. convulsions, epilepsy, worms, measles, some diseases according to popular belief could not be cured by medical practitioners.
b) When the patient could not be diagnosed by the medical practitioners.
c) The disease was known to be a traditional one e.g. false teeth.
d) When herbs were judged to be more effective and better than other medication.
e) Bone-setting was best done by herbalists.
f) Herbalists offered special care to patients compared to medical practitioners
g) Children needed natural herb medication

5.17. Services for Expecting Mothers.

In most of the areas covered by the study, there was a near-by maternity home accessible by respondents. These homes varied in distance from homesteads, more commonly 2 to 5 Km, and as far as 10+ km in rare cases. (see. Table 9)

Table 9. Distance to Near-by Maternity Home.

Distance (Km)	Percentage of Mothers at this Distance
<1	8.7
1	14.3
2 to 5	51.6
6 to 10	3.1
10+	0.6
Can't estimate	21.7
Total	100.0

Concerning the number of Traditional Birth Attendants (TBAs) many were not aware of their existence in their respective villages. A few villages had at least 1 who was known while others have between 2 and 10 TBAs, as is shown in table 10.

Table 10. Number of TBAs in the Village.

Number of TBAs	Percentage
6 to 10	13.7
2 to 5	29.8
1	7.5
None	37.9
Don't know	11.0
Total	100.0

The TBAs provide anti-natal services to the expecting mothers. The most common herbs were given to pregnant women to speed up the birth process during labour; checking the condition of the mother and the baby e.g. in case of anaemia and give advise; giving medicine to pregnant women for example, they were given herbs for diseases like measles, syphilis, and other common diseases in children. Some of the respondents were not sure of the services provided, by the TBAs.

They also provide some post-natal services to a limited extent. They usually treat problems of severe abdominal pains that may occur after birth as well as immunization of the child. It was not established the particular diseases for which children were immunised against. Other services included, regular weighing, advising mothers; providing medicines for the child (children), as well as medicines for the mothers which help clean the womb and stop the bleeding after giving birth. They also teach mothers child care especially the first mothers. A few respondents were not aware of all these kinds of service.

5.18. Private Health Facilities.

Several opinions about private health facilities were established among the respondents. In Uganda, as elsewhere, the private health service sector lacks a strong infrastructural base. However, the role of the private health service provision was very significant, and respondents expressed such opinions as below:

- Expensive but effective and efficient
- Better equipped compared to publicly owned facilities
- Ensure all drugs are available
- Better maintenance compared to publicly owned facilities
- Offer credit for consistent clients
- Proximity
- Should be encouraged since they provide a service that government would not have given.

Nonetheless, respondents expressed strong reservations for their support of the private health service provision, and gave the following reasons:

- Expensive
- Some lack certain equipment
- Can not handle some serious cases which are referred to government hospital.
- In order to improve cost sharing need to ban all private clinics
- Government should supervise and/or control private clinics.
- Most of these had mushroomed everywhere and have unqualified personnel
- Problem of being given under dose when one had less money
- Laws to govern them should be put in place/enforced
- Usually prescribe over-doses in order to sell off stock and then patients suffer side effects
- They had failed the main hospital services since it was the same doctors operating the clinics

5.19. Decentralisation and the provision of health services.

At present the Uganda government finances all the health services, albeit, with very meager budget allocations.
The ministry of health had been, prior to decentralisation, in direct charge of all hospitals. Hospital Medical Superintendents and the in-charge of health units had been working out side of the formal coordination of the local councils, the district executive Secretary and the District Medical Officer, who now assume the overall supervisory functions over hospitals and all other health units, except the referral hospitals. This means that Medical Superintendents and in-charge of health units report to the District Medical Officer who, in turn reports to the District Executive Secretary.

5.20. The New Mandate to the Districts.(Level of Community Involvement)

Under this arrangement, districts and sub-counties have been given the mandate to do the following:

5.21. Districts:

- Instituting the District Health Committee.
- Running Public Health And Primary Health Care Programs.
- Supervising of Hospitals and all other Health Units.
- Provision of funds and training materials for the Community Workers training programs.
- Preparation of an integrated District Budget for the health sector.
- Identifying development projects for inclusion in the district and National Plan.

5.22. Sub-counties:

- Institution of Sub-county Health Management Committees.
- Promotion and Implementation of Primary Health Care.
- Supervision of all Health Units located in the Sub-county.
- Supervision of the delivery of health services including the use of drugs.
- Maintenance of health units.

5.23. Village:

Villages,(LC1) are to institute Health Committees composed of two or three villages depending on the size of population and economic activities, keep registers of births, deaths, TBAs and Community Health workers;
Maintain health unit related infrastructures including safe water sources and promotion of sanitation and control of vectors.

5.24. District Budgeting.

Following the decentralization programme, District Councilors have been given specific guidelines by the Decentralization Secretariat which enable the Councilors to participate fully in the process of budgeting for their Districts. For example, in April, Councilors, District Chief Executives, Heads of Department, Central Agencies and NGOs produce a list of political and economic priorities for the District to facilitate sectoral planning. This is Stage I and it is known as Budget Conference. In May, the Sectoral Committee Members, Chief Executives and Heads of Department, produce Sectoral policy guidelines and costed Sectoral Policies.(This is known as Stage II.) In June, The Finance Committee, The Chief Executive, The Chief Finance Officer and Heads of Department, examine the Committee proposals to establish whether they are consistent with policy and the available resources. (This is stage III.)

In July, the Finance Committee, the District Development Committee and the Committee Chairman produce a draft budget. (Stage IV.) In August, the Chief Executive, the Chief Finance Officer and the Planner/Economist produce a final draft of the budget.(Stage V) This is approved in September by members of the District Resistance Council. (Stage VI). Stage VII, which is the last stage of the budgeting process concerns implementation and monitoring of the approved budget. Councilors, Sectoral Committees, Chief Executives, Chief Finance Officer and Heads of Departments work together to ensure that the Budget is implemented. This stage entails coming up with implementation plans and performance reports.

5.25. The Cost-Sharing Initiative

To this initiative districts have, independent, of each other, and of government, instituted user-fees basically on First Visit consultation and registration, while drugs and other services remain free of charge.

Each Health Unit Management Committee manages the user-fees funds quite independent of the District Health Management Committee. This implies that health units with long clientele have an advantage over those with a short clientele. This in itself creates a myriad of problems. Mainly the inefficiency problem comes up here. Overcrowding in health units that

receive drug donations is very evident and benefits of user-fees are wrongly mapped. The different consultation charges between a patient who consults a medical officer and one who consults a medical assistant lead to patients seeking to consult medical officers where other lower medical personnel can do. Since the fees that are charged in the health units we visited, only cater for the staff welfare, it means drugs still remain scarce in most health units. In some health units, patients simply make consultation visits while they have to look for the prescribed drugs else where, mainly from pharmacies.

The practiced user-fee schemes do not lay down the mechanisms through which the poor can be protected. Apart from the prisoners, other patients that are un able to pay are judged by individual medical personnel at the health units. health units also do run credit schemes. Neither do they have a mechanism through which debts if extended can be recovered. Since we have no reports to the effect that patients are denied services due to inability to pay, it means that health units lose moneys from patients who are willing to pay and are able to pay but at a latter date.

Since health units have got no worked out formula for identifying those that are unable to pay, it can be correctly argued that equity is greatly compromised.
Though the health unit management committees comprise of some members from the community, communities still have very little input in decision making and accountability. We rightly argue here that accountability is very weak.

Government health facilities remain with surmountable problems. The user fees charged first of all are decided by the individual districts with out the concern and involvement of government since government policy remains that health services are free at all government health units. Secondly, the fees charged are too small to meet the running costs of an individual health unit. Drugs remain very scarce at government health units. It appears that a uniform charge of between U.Shs. 500-1,500 for the out patients set by some District Health Management Committees is fare. But appearances are some times deceptive. In such circumstances, rather the rich benefit more because big wealth means big chance in getting access to the prescribed drugs else where in case where drugs are not available at government health units.

From our data, it is clearly noticed that externally aided health units in terms of drugs and other requirements maps the benefits of aid on to the introduced user fees. Because of lack of enough knowledge about the various inputs in the health care system, accountability becomes difficult. Such inputs include drugs, medical personnel and equipment. These, are not and cannot be borne from the fees charged. And yet, their cost is not known to those whom accountability is owed. (The communities)

5.26. Situation Analysis of District Health Service Provision

With decentralization, districts are responsible for appropriation of funds as received from government and revenues collected within. In the health sector, district hospital medical committees were set up, in order to execute the district health programs.

The study established that the respondents were not aware in most cases of the existence of these DHMCs. 77.6% noted that they had no knowledge of them or even having a village member represent them on this committee. The question then arises, how do they have their ideas or complaints attended to? Similarly, 82.0% were not aware of any program on revenue collection. One respondent said he was aware of the existence of this program and that it is managed by government in collaboration with NGOs similarly on accountability procedures one respondent noted that the district health officer was responsible and sometimes visited the mother's union clinic to explain these measures. But there was obviously no notable acknowledgment of accountability. The implications of such a situation will not be-expounded on, but are reflected in other scenarios.

5.27. Resources Available for the Health Sector/Level of Resource shortage.

A number of constraints such as the low revenue effort, the lack of an adequate system for prioritising government expenditure, and the lack of a "living wage" for Government employees restrain Government's capacity in the delivery of social services. Therefore, in

considering how rapidly Government provided social services can be expanded, and what roles can and should be left to the private sector, it is helpful to have an appreciation of these problems.

Low income and lack of domestic savings are two important constraints. In the 1960's, Uganda had one of the best health care delivery systems in Africa, and it was one of the most prosperous African countries at the time (20 years ago), today it lies towards the poorer end of low-income group. Related to the low incomes, high fertility and mortality rates which make it difficult for families to save, Uganda is one of the few countries with a negative savings rate (-2.7 percent of GDP). This implies that social sector spending should be centered on the most cost-effective interventions, and that there should be significant cost recovery in selected areas.

According to the World Banks 1991 Public Expenditure Review, Uganda's revenue/GDP effort was unusually low, this constrained the Government expenditure/GDP ratio to a low level, causing the Government's budget to be highly dependent on external aid. Coupled with these are weaknesses in the existing arrangements for planning and budgeting of Government expenditure. Among these are distribution, and objectives of expenditure and medium-term frameworks for resource allocation. These general weaknesses are fully apparent in both the health and education sectors.

There does exist, inadequate official compensation in health and education sectors and this has led to absenteeism and other abuses. In 1991/92 the Government wage and salary bill was only 1.6 percent of GDP, far below other low-income African countries. Since health and education are both "labour-intensive" sectors, compensation which enables health workers and teachers to devote an appropriate amount of time on job is a critical factor in the delivery of service. As part of SAP, Government has began to implement a program of Civil Service Reform (identify a minimum wage, formulate a projection of the funds available for salary enhancement over the next three years, and develop a proposal for monetisation of benefits).

6.10. Recommendations.

From our findings, it can easily be discerned that individual private expenditures on health services takes a fair share of individual house hold incomes. And thus Government budget is not the only source of expenditure on social services. In Uganda recently, private expenditures have outweighed Government expenditures in both health and education. In health services, the predominant share of private expenditure, is a natural reflection of the manner in which most health services are produced and consumed, and is consistent with the pattern that resulted from the breakdown of the economy.
Due to the binding constraints on Government resources, priorities need to be selected carefully. Government therefore, needs to concentrate its resources on the provision of policy and infrastructural incentives to the private sector in health service provision, essential public goods (such as Immunisation, Family Planning and AIDS and Health Education) and areas where other agents would prove ineffective.

The existence of a social need does not necessarily mean that the Government should provide for that need, because there are some social services that the private sector can provide at least as efficiently as the Government. Thus Government's social sector strategies should explicitly exploit the current potentials of private expenditures. The central challenge therefore for Government in financing and delivery of health services in particular, is to develop a good policy environment as well as infrastructural incentives.

Alternatively, the precedence of the private and the informal health service provision can offer a small slot for government to implement a carefully designed Cost-sharing program, comprehensive enough with good infrastructure, well elaborate levels of community participation and inclusive of all groups.

Further studies on the design and implementation of a cost-sharing scheme for Uganda should be urgently carried out, since cost-sharing is already in practice with hardly any policy document and guidelines.

REFERENCES

Brunet-Jailly, J. (1989). Health Financing in the Poor Countries. The World Bank.

Carrin, G. (1988). "Community Financing of Health Care". World Health Forum Vol. 9.

Ministry of Finance and Economic Planning (1993). Rehabilitation and Development Plan 1993/94 - 1995/96: Macroeconomics and Sectoral Policy. Vol. I Dec.

----------. (1993). Background to the Budget 1993-1994: Economic Performance 1992-93 and Prospects for 1993-94.

Nabuguzi, E. (Forthcoming). "Popular Initiatives in Service Provision in Uganda", in Ole Therkildsen and J. Semboja (Ed.), Peoples' and State Provision of Services in Uganda, James Currey.

Pangu, k.A., and Lerberghe, W.V. (1990). "Self-Financing and Self Management of Basic Health Services". World Health Forum Vol. 11.

Unicef (1992). The State of the World Children. New York: Oxford University Press.

Wamai, G. (1992). Community Health Financing in Uganda: Kasangati Health Center Cost Recovery programme. A Two Year Report, 1988-1990. (Unicef, Unpublished Report).

World Bank (1987). Financing Health Services in Developing Countries: An Agenda for Reform.

---------. (1991). Public Choices for Private Initiatives: Prioritising Public Expenditures for Sustainable and Equitable Growth in Uganda. Vol. II Feb. 12.

---------. (1992). Uganda Social Sector Strategy: The Main Report. Vol. I July 24.

---------. (1994). Better Health in Africa: Experience and Lessons Learned.

Appendix 1

Comparable Areas Across The Health services Studies In Uganda Tanzania And Zambia.

Where people decide to go for services and why; have these patterns changed before and after the introduction of Cost-sharing?

Standards of services before and after the introduction of Cost-sharing.

Levels of Charges.
Levels of spending on health services as a percentage of income.

Reaction of users to the introduction of Cost-sharing.

Management of the Cost-sharing program. i.e. credit facilities and exemptions.

Alternative sources for health care. e.g. Herbalists, local healers, preventive measures rather than curative measures

Effects of Cost-sharing on attendance.

Levels of Community involvement.

Staff numbers and trends before and after the introduction of Cost-sharing.

Areas of Resource shortages.

Appendix 2.

QUESTIONNAIRE ON LOCAL ACCOUNTABILITY, COST SHARING AND DELIVERY OF HEALTH SERVICES IN UGANDA.

Dear respondent,

The main purpose of this research study is to examine the cost sharing policy in the health sector, management of the
health services obtained and to find out whether the charges are affordable by the users of the health services and also to find out how the delivery of services to the various health units, can be improved upon.

We believe that the implementation of this policy will improve the quality of services offered and delivery of
services. This study also will seek ways of involving the community in making decision on delivery and management of health services .

Please you are kindly asked to respond to the questions contained in this questionnaire and we commit ourselves to treat all information obtained with the confidentiality it deserves.

All errors, omissions or distortions of facts will be the responsibility of the researchers.

Yours sincerely,

Frederick Mwesigye (investigator)
Susan Balaba (member, research team)
Diana Atungire (investigator)
Dr. Christine Lwanga.
(member,research team).

Part I [For the Users]

Form #_____.

Village R.C.I_____.

Parish_____.

Sub county_____.

District_____.

Name of the respondent_____.

Age_____.

Level of education_____.

01. None

02. Primary

03. Secondary

04. College

05. University

06. Other (specify)

Marital status

01. Single

02. Married

03. Separated/ divorced

04. Widower

05. Widow

Occupation

01. Salaried employee

02. Business man

03. Self employed

04. Casual worker

05. Peasant

06. Unemployed.

List the number of the people you stay with.

Surname	relation	Age	Sex	Occupation

01. Employed
02. Unemployed
03. School
04. Pre-school
05. Self-employed

1. What is the distance to the nearest health facility you usually attend?
   01. 5 Km
   02. 10 km
   03. 15 km
   04. 20 Km
   05. 20 Km+

2. Is it a government health facility or not ?

   01. Yes 02. No

3. Is it a: 01. Hospital

   02. Health centre

   03. Dispensary

   04. Sub-dispensary

   05. Aide post.

4. Where do you usually take your patients?

   01. Government run health unit.

   02. NGO owned (which has no ties with any creed or religion).

   03. Privately owned Hospital

   04. Church owned health unit.

   05. Traditional healer/herbalist

   06. Private clinic

   07. Other [specify]

5. What criteria do you use in deciding where to take your patients? [Give responses to each of the following]

(a). When the disease is not considered to be curable by formal medical practitioners.

(b). When there is no enough money.

(c). When the disease is severe or complicated.

6. In case of a government health unit of any level, is it a cost- sharing or non cost-sharing facility?

01. YES 02. NO.

If yes, how much is paid? shs.---------/=

For what is this money paid? 01. Consultation and Drugs. 02. Consultation only. 03. Drugs only.

7. If it is a non cost-sharing facility, would you be willing to pay for health care services? 01. YES. 02. NO.

If Yes, give reasons

If No, why? ----------

8. Have you or your sick relative ever visited a government run health unit [be hospital or not] and there were no drugs?

01. YES. 02. NO.

What alternative did you take?

01. Bought the required drugs from the pharmacies

02*. Took the patient to another health unit.

03. Bought the drugs from the medical practitioner who was treating the patient.

04. The patient was discharged without treatment.

9. In case of [02*] in 8 above, to which health unit did you take the patient?

01. Government health unit

02. NGO health unit (which has no ties with any creed or religion).

03. Church health unit.

04. Private clinic.

10. Have you had of the District Health Management Committee? 01. YES. 02. NO.

11.[Skip this question if your answer in question 10 above, is No] Do you know of anybody in your village on that committee? 01. YES. 02. NO.

13. At the local level, do you have any program for health service revenue collection? 01. YES. 02. NO.

14. [If YES in 13 above] How is this program managed?

_____

_____

_____

15. What are the accountability procedures?

_____

_____

_____

16. Can you estimate the cost of one dose for the following 10 mostly common diseases? [This may be what the respondent usually pays].

Malaria	**Shs.**
Upper respiratory Tract Infections	**Shs.**
Diarrhoea	**Shs.**

17. Is this what usually it costs you or should be the actual cost. 01. Actual cost.

02. What usually it costs.

18. If that is what it usually costs, do you think it deviates from the actual cost? 01. YES. 02. NO.

If YES in 18 above, can you estimate by how much it deviates? Shs._____/=

19. Since you have already been paying for some of the service and drugs [in case one report that he/she has been paying] don't

you think, this should be now institutimilised in gov't run hospitals? 01. YES. 02. NO.

If NO, give reasons----------

---

20. Do you believe a cost sharing system between gov't and users can work? 01. YES. 02. NO.

If NO, why? _____

_____

_____

21. Have you or any member of your family ever visited a herbalist whom you believe can cure diseases that would otherwise be treated by medical practitioners? [Obulwadde obuzungu[3]] 01. YES. 02. NO.

22. If your answer to Q.22 is YES, did you do so necessarily because you had no enough money to cover the treatment costs at the health units to which you usually go? 01. YES. 02. NO.

[3] Translate into the appropriate local language.

If NO, give other

reasons_____

_____

23. For short and simple illness, where do you mostly go for treatment?

01. Government health unit.

02. NGO health unit (which has no ties with any creed or religion).

03. Church health unit.

04. Private clinic.

05. Duuka [ordinary retail shop]

24. For your answer to Q.23 above, what particular advantage is associated with the place you visit.

01. You see the doctor.

02. Drugs are available.

03. Drugs are free.

04. Treatment costs are broken down into small and affordable proportions which one pays over time, even after treatment.

05. When you can't afford the cost for the full dose, you are allowed to take the drugs that are covered by the amount of money you have.

25. Do you have a nearby maternity home?

01. YES. 02. NO.

If yes, how far is it from here?

01. 2 - 5 Km

02. 6 - 10 Km

03. 10 Km+

26. How many Traditional Birth Attendants [TBAs] do you know to be living in your village?

01. 6 - 10

02. 2 - 5

03. 1 Only

04. None

27. Do any of them provide some Anti-natal services?

01. YES. 02. NO.

If YES, what kind of services? [Just mention them]

_____

_____

_____

_____

28 How abount Post-natal services?

01 YES 02 NO

If yes, what kind of services? [just mention them].

_____

_____

_____

What is your itemized e penditure like?

Item	Who Pays?

01. My self
02. Other member
03. Other members + Self

SPECIFIC QUESTIONS ON COST - SHARING.

29. Do you have a cost-sharing system in your district?

01. YES. 02. NO.

30. If YES to 28, does it apply to all govt health units?

01. YES. 02. NO.

31. If NO to 29, at which level does it start?

01. District hospital

02. Health centre

03. Dispensary

04. Sub dispensary

05. Aide post

06. Other [specify]

32 Since when did this system start? ---------- years ago.

33. For what are you specifically charged?

01. Consultation

02. Drugs

03. Consultation and Drugs.

34. How do you compare the services now and before this system was introduced.

01. The same as it were

02. A little bit improved.

03. Well improved.

04. Much improved

35. What would you suggest for the improvement of the service?----------

---

Now that you have a cost-sharing system, what would happen if one failed to raise the money required?

01. No treatment

02. Treatment on credit

Have you ever failed to raise the money required for your treatment or for the treatment of any of your ative?

01. YES. 02. NO.

Do the health units which have implimented a COST-SHARING scheme,extend credit facilities?

01. Yes 02. No

If yes to Q.38, is credit limited to any specific amount of money? 01 Yes. 02 NO. If yes, how much? s._____/=

If Yes to Q.38, to whom is credit extended?

)1. Who ever fails to pay at the time of treatment.

)2. To those vetted by their respective RCs as unable to pay..

If credit was extended to someone, when is payment expected? Within:

01. Six months

02. One Year

03. Over a Year but not more than two Years.

04. Any time.

If an individual absconds, what measures are taken?----------

---

Are there any instance when you administer drugs to your self or any member of your family or friend hout consulting the doctor?

Yes 02. No

44. If yes in Q.43 above, under what circumstances are you most likely to practice self-medication?

45. What is your opinion about privately owned health facilities?

46. Do you think cost-sharing would lead to a better health system?

Part II [For the Providers]

1. Type of ownership

01. Government 02. Private

03. Non-government organization

04. Church

2. How many medical staff members do you have?

Category	#
01. Consultants	
02. Medical officers	
03. Medical assistants	
04. Nurses/Midwives	
05. Nursing aides	
06. Others(specify)	

3. Has the number of medical staff increased, decreased or remained constant over the last five to ten years?

[Check in the records if available]

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
Codes											
01											
02											
03											
04											
05											
06											
07											
08											

4. What type of patients do you receive?

01. In-patients

02. Out-patients

03. Both in-patient and out-patients.

5. How many patients on average use this facility (daily)

[Check the records].

6. Do you have a cost sharing scheme? (in case of government health units). 01 Yes 02. No

7. What are the patients required to pay for?

[Check the records for the amount]

01. Consultation

02. Drugs

03. Accommodation and food as in-patients

04. Others (specify).

8. Do the patients purchase the required drugs from within, or do they have to go out?

01. From within 02. From out.

9. What is the effect of this scheme on patient attendance?

_____

_____

_____

10 What criteria is used for paying?

_____

_____

_____

_____

11. Have you had any instances when a patient has failed to settle the bills?

01. Yes 02. No

12. How often does this occur?

01. One patient out of 5

02. 1 patient out of 10

03. Give answer

13. Do you have a credit facility here?

01. YES 02. NO

14. If so, how does it operate? [Elaborate]

_____

_____

_____

_____

_____

_____

15. What do you do to those who fail to settle their debts?

_____

_____

_____

_____

_____

_____

16. Has the number of patients who fail to pay increased, decreased or remained the same for the last two years?

[Check records for percentages]

THE STATE OF HEALTH SERVICES IN THE DISTRICT.

(For The D.M.Os & Chairmen, District Health Management Committees)

1. How many health service units do you have in your district?

01. Hospitals

02. Health centres

03. Dispensaries/maternity units

04. Sub Dispensaries

05. Aide posts

2 How many of these mentioned above are:

01.Government run

02.Church run

03.NGO run

04.Private run

3. Do you think these units are enough for your district population? 01. YES 02. NO

If NO, what other alternative do people take?

_____

_____

_____

_____

_____

Do people have an alternative health service unit[be it formal or not] to turn to? 01. Yes. 02. No.

If yes, which are these?

_____

_____

_____

_____

4. How many district health service personnel do you have in your district?

5. What proportion of the population in your district covered by the existing formal health units? [approx. percentage.]

_____%

6. How many district health service personnel are recruited annually in your district?

Category	#
01. Consultants	
02. Medical officers	
03. Medical assistants	
04. Dental assistants	
05. Nurses/midwives	
06. Nursing aides	
07. Others (specify)	

7. Is this number on the increase or dropping?

01. Increase 02. Dropping.

8. If dropping, at what rate is it dropping?

[Approx. percentage.]_____%

9. How do you see this number visa vee the need of the people?

_____

_____

_____

10. What is the current stand and practice on the policy of cost sharing?_____

_____

_____

11. Since the cost sharing policy recommends that the community through the RC system should take part in decision making on matters of health services, what is the contribution of the community in this aspect?

12. What are the successes of the decentralization policy as regards cost sharing and local accountability in the health service sector?

13. What is the magnitude of the private practice in the delivery and provision of health services?

14. How many licensed health service units do you have in this district?

15. To you, how do you see the role of the unlicensed medical practioners, drug sellers,etc,?

16. Do you have health management committees at various levels? a)Sub-county b)County

c) District

17. What is your district health unit budget like(in real terms)?

18. How do you meet this budget?

19. What do you suggest for a better alternative of financing and delivering of health services?

Financing and Delivery of Health Services in Zambia

"Assessing user fee effects, community willingness and capacity to pay"

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For Eastern and Southern African Research Programme and The International Development Research Center, July, 1997

FINANCING AND DELIVERY OF HEALTH SERVICES IN ZAMBIA
"Assessing user fee effects, community willingness and ability to pay"

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List of Abbreviations and Acronyms

ANC	-	Antenatal Care
ADMs	-	Admissions
CSO	-	Central Statistical Office
DHMT	-	District Health Management Team
ESAURP	-	Eastern and Southern African Research Programme
FP	-	Family Planning
HIV/AIDS	-	Human-Immuno Virus/Acquired Immune Deficiency Syndrom
IDRC	-	International Development and Research Centre
IQ	-	International Questionnaire Development
LDC	-	Less Developed Countries
MOH	-	Ministry of Health
MMD	-	Movement for Multi Party Democracy
NCDP	-	National Commission for Development Planning
OPD	-	Outpatient Department
PHC	-	Primary Health Care
TBA	-	Traditional Birth Attendant
UFC	-	Under Five Clinic
UNICEF	-	United Nations Children's Fund
UNIP	-	United National Independence party
ZDHS	-	Zambia Demographic and Health Survey

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EXECUTIVE SUMMARY

Background

The protracted economic decline has negatively impacted on government's fiscal position and as a result expenditure on social services has declined over the years. The health sector like others has borne the brunt of this downward trend. For instance per capita expenditure declined from a high of K338 in 1984 to a meger K162 by 1990. As a result of the decline, the quality of health services has declined and is marked by among others run-down infrastructure, shortages of drugs, and poor remuneration of staff. It is because of these shortcomings, which are generalizable to other third world countries that the United Nations Children's Fund (UNICEF) convened a conference which resulted in the birth of the Bamako Initiative (BI).

Community Involvement

The health reforms that have been embarked upon by the Zambian government are couched within the framework of the BI. The basic premise of the reforms is the devolution of power to the district level. In addition, community participation will be enhanced whereby local people are now required to contribute towards the cost of health care. Other forms of participation include in-kind payments which is a predominant mode in rural areas.

User Charges and Outcomes

Willingness: The study established that urban dwellers were more willing to pay than their rural counterparts. The intermittent shortage of drugs, however, was noted to deter community willingness to pay. The relatively lower level of willingness to pay for rural communities was attributed to their lower economic capacity, that is a result of subsistence occupations from which they are not able to generate sufficient resources.

Capacity: Because of the differences in capacity to pay, respondents from rural areas said they were not able to pay the fees, while more of those from urban areas were able to. Unfortunately, despite the high proportion of respondents who said they were not able to pay, the portion of respondents who were knowledgeable of the social welfare scheme for exemptions was very low.

Social Welfare Scheme: A high proportion of respondents from both rural and urban areas were not knowledgeable about the social welfare scheme. Health workers too were not as knowledgeable as could have been expected. Because of the lack of knowledge, most of the respondents said they if they did not have money and fell ill, they would just stay at home.

Quality of care: All in all, the introduction of user fees has had a positive impact on quality of care. With the exception of availability of staff and adequacy of space, the following aspects of quality of care were noted to have improved:

Although there were still occasional shortages of drugs, the situation had generally improved;

A high proportion of the respondents noted and appreciated that the physical outlook of health facilities was now better;

Health staff were also reported to have become friendlier and better disposed towards patients.

Recommendations:

Given the low level of knowledge about the social welfare scheme, and consequent decline in utilization of services, there is need to popularize the scheme among both providers and the general public.

While urban respondents were relatively more willing to pay than their rural counterparts, the intermittent shortages of drugs discouraged them. It is, therefore, imperative that drugs are available most of the time.

The additional roles that health staff have assumed in the context of the decentralization of services has strained them. Hiring staff specifically for these functions could help alleviate these constraints.

It was reported that there were conflicts between DHMTs and health facilities mainly because of flaws in communication. The flow of information between the two entities should be improved. DHMTs should involve health centres as much as possible in their decision making processes.

The practice of by-passing health centres in preference for hospitals should be minimized by introducing prohibitive charges for all those that bypass the former.

The large number of respondents who reported utilizing informal drug peddlers is a source of worry and the government needs to institute measures to resolve this issue. Consumption of drugs from these sources could negatively impact on people's health status.

The diversion of public resources for personal use by health workers in government institutions ought to be checked, otherwise strides made in improving quality of health care will be negated.

Background Information

This study is part of six others commissioned by the International Development and Research Center (IDRC) on the "Financing and Delivery of Education and Health Services." The six studies which were conducted in Uganda, Tanzania and Zambia were coordinated by the Eastern and Southern African Research Programme (ESAURP) and were carried out over a period of one year from 1995 to 1996. The studies were intended to provide a comparison of the situation pertaining to health financing and user fees specifically across the three countries. Cost sharing is being undertaken under an increasingly hostile economic atmosphere whereby people's earning power has been tremendously reduced. In this context, people's willingness and ability to pay formed the core of these studies.

This specific study was on financing and delivery of health services in Zambia. It was necessitated by the reforms that have taken place in financing and delivery of health services in the country. From independence, the country has had a system of free medical services which were premised on an egalitarian ideology and supported by a relatively strong immediate post-independence economy. However, as the economy recorded consistently negative rates of growth for a long time, it became apparent that the free service approach was not sustainable. Attempts were, therefore, made to evolve better means of health financing. This subsequently led to the liberalization of the sale and purchase arrangements for private and to some extent public goods too. In the health sector, the consumers now have to pay fees for services provided and the private sector is being encouraged to enhance its participation in the delivery process.

While the need to share in meeting the costs of health services can not be disputed, poverty levels have also been increasing. Under this scenario, how can cost sharing be sustained while guaranteeing equity? In addressing this question, the study looks at the community's willingness, and capacity to pay for health services. It also assesses the impact that fees have had on the quality of services provided. These issues form the basis of this report. The report starts by looking at trends in health financing and outlines background information the health reforms after which survey results are presented, discussed and recommendations ensuing therefrom listed.

Economic decline and health expenditure

The past two decades have been years of extreme economic difficulties for most of SubSaharan Africa. Persistent negative rates of economic growth have reduced the capacity of African countries to meet their population's basis needs. While SubSaharan African economies are caught up in a crisis of no growth and at the worst negative growth, these countries have continued to experience consistently rapid rates of population growth and this has had negative effects on the states' ability to provide quality social services. Taking the Zambian case, while the economy has on average been recording negative rates of growth, the population has steadily been increasing at a rate of 3.2 percent per annum, leading to a mismatch between available resources and the number of people.

These unfavourable economic conditions have as a result led to the implementation of economic reforms aimed at achieving macroeconomic stability and subsequently economic growth . As part of stabilisation and structural adjustment policies, countries have had to reduce government expenditure through fiscal measures which almost invariably have resulted in reduced government spending (O. Osita, et al; 1992, 615). For instance the annual average per capita public expenditure growth rate for selected African countries was 3.2 between 1975-1979 but was only 1.9 between 1980-1985 (O. Ogbu, 1992, 615). In Zambia, health expenditure as a proportion of GNP was on average 2.1 percent during the period 1974-1984, but this declined to 1.5 percent in the subsequent years (Appendix 1).

The contraction in the country's economy, evident since the middle 1970s, and which is attributed to internal management lapses and adverse external factors, has generated fiscal constraints which have negatively impacted on the financing and delivery of health services. For instance the economic growth rate for the 1989/90 period was -0.4, those for the periods 1990/91, 1991/92 and 1992/93 were 0.3, -3.8 and 2.5 respectively. Real per capita expenditure on the health sector has also declined. It was estimated at K338 in 1984 and by 1990 had slumped down to K162 (Appendix 1).

In addition to the decline in expenditure for the health sector, the intra sector distribution of resources is inappropriate and has contributed to the contraction of quality of care. In a case study

of four African countries, O. Osita (1992, 616), note that "capital spending is generally a larger share of the budget in countries where total health spending is growing more rapidly and smaller where spending is slower or declining. At the same time, spending on drugs made up smaller proportions of government health expenditure in the 1980s than in 1975-79 (Osita, 1992; 616). With capital expenditure declining in share and slow growth in total health spending, the ability to provide current levels of health services is called into question." The World Bank (1994) argues that in many Less Developed Countries (LDCs), public money is spent on interventions of low cost effectiveness, the poor lack access to basic health services and low quality care and health workers are badly deployed and supervised"

The Zambian health system is also beset by inappropriate expenditure patterns, which are tilted in favour of urban based health institutions. A consistent pattern that cuts across all health facilities is that of higher "personnel emoluments" and recurrent expenses and very negligible proportions of resources accruing to capital items. Out of the total MOH headquarters expenditure, recurrent departmental charges were the largest proportion, (43.2%). Capital expenditure was the second lowest. Personnel emoluments for the provinces were three quarters those of recurrent departmental charges (Appendix 2).

The economic decline and concomitant unfavourable expenditure patterns has led to a stagnation and contraction of the quantity and quality of health services. For instance between 1985 and 1988 the stock of hospitals remained stagnant and only increased by two from 1988 to 1992 (Appendix 3). As far back as 1986, "the patient-provider ratio had fallen, recurrent and capital expenditure continued to decline, health coverage in rural areas in particular was deteriorating, drugs and equipment were in short supply and PHC implementation faced serious problems" (P. Freund, 1986). This deterioration in quality of health care set the stage for a more generalised reversal of welfare indicators in the country.

Changes in Health and Welfare Indicators

The stagnation and contraction in health facilities and quality of care have together with broad socio-economic factors resulted in worsening welfare indicators. An increase in infant, and under five mortality has been observed (ZDHS, 1992). The percentage of the population with access to safe water and sanitation were estimated at 70 and 76 % in 1985, but decline to 66 each by 1992 (ZDHS). Levels of immunization against all diseases with the exception of tetanus for women have also declined between 1986 and 1990 [World Bank and African Development Report; 1993 and 1992].

It is evident from the above account that health conditions in the country have deteriorated and this is indicative of adverse broad socio-economic factors at play. In addition to the above noted negative trends in indicators, a rise in malnutrition levels has also been noted. Loss of real income [in terms of both declining employment opportunities and effects of inflation and government policy on real wage levels], rather than inadequate food stocks at the national level per se explain why households are food insecure. [Saasa et al, 1994, 26]. The deterioration can largely be explained by the worsening economy which has pushed many people to the periphery as well as negatively affected the financing and delivery of health services. The constraints that have been experienced with the delivery of health services in Zambia, are generalisable to other developing countries too. Realising the grave situation that African countries found themselves in, UNICEF embarked on what has fashionably come to be identified as the Bamako Initiative (BI), aimed at strengthening Primary Health Care (PHC) by making more rational use of resources and encouraging community financing.

Bamako initiative

Under the BI, countries are encouraged to involve communities in the financing and delivery of services. Under the initiative, countries agreed to put their resources squarely behind the proven elements of PHC; make rational use of their slender health budgets and; examine creative approaches to community financing methods which had already enabled communities in a number of African nations to take charge of local health needs.

The idea of charging communities for health services is based on the premise that people already pay exorbitant fees for private sector provided care despite the poor quality of services. It is therefore assumed that if people are willing to pay for private sector provided services, they can equally be willing to pay for government services, so long as quality is assured. In addition to sharing in the costs of health provision, communities are also expected to be involved in identifying their needs so that appropriate care which meets the recipients' felt needs is provided. Community involvement may be defined as a "process in which local communities participate in planning, implementation and utilization of health activities in order to take responsibility for and benefit from improved health and an improved health care delivery system" [London School of Hygiene and Tropical Medicines, 1985;27].

Health reforms

The government's health reforms are couched within the broader framework of the BI already referred to above. The reform's health vision is expressed as a commitment "to the fundamental and humane principle in the development of the health care system to provide Zambians with equity of access to cost effective quality health care as close to the family as possible. This means provision of better management of quality health care for the individual, the family and the community. In order to facilitate the attainment of this vision, the government has readopted the PHC strategy as the most appropriate vehicle to achieve it" [MOH, 1991].

The MOH operations have until now mainly been centrally planned. The new structure is a departure from this and emphasizes the involvement of communities in the management of health services.

A Central Board of Health has been established at the national level and it has the responsibility of managing the process of health delivery on behalf of the ministry. Under the Board are Regional Health Advisors who provide advisory services to provinces. Within districts are District Health Management Boards (DHMT) which are responsible for managing local health services. This is a key structure withing the health system because it is the one that does the operational work. It was established right form the outset that some operational problems would be experienced because of the lack of technical competency at the district level. As a result a process of capacity building was embarked upon which saw selected district officials attending workshops to enhance their competency.

Under the new arrangement, the community will be involved not only as participants in the implementation of programs but will also be required to be actively participate in other processes, including the design of programs. "Integrated Health Plans developed out of the District Health Boards' Basic Health Programs shall constitute the PHC package. The boards shall develop these based on proposals transmitted by Area Boards of Health" [MOH, 1991; 64].

Health Financing

The government upholds the principle that all people should make a contribution towards the cost of health care. The government is currently the main stake holder in health financing, whose health facilities are represented in both rural and urban areas. Other actors in health financing include missionaries whose health institutions are mainly located in rural areas. Private health practitioners are predominantly in the urban areas. Until recently there was a large parastatal sector which ran quasi- government health services. The size of this sector has, however, dwindled over the years because of the privatisation of parastatal firms.

Within the public sector, the budgeting process has been decentralised with the district level having more control. To this end, a new Financial and Management System has been developed with the assistance of the Netherlands government. Besides helping the districts with a financing and

management system, the new system will also help coordinate activities of the various donors involved in the health sector. This will enable the harmonisation of donor activities by reducing the individual financial and management arrangements and therefore serving on time.

In tune with the general principal of liberalisation, the state encourages involvement of the private sector in the delivery of health care. By this arrangement, government hospitals shall be accessible to private practitioners and private practitioners shall be charged for utilising hospital services. Within government facilities, fee paying wings have been established from which patients who are able to pay receive care.

In order to enhance the sense of community involvement in the financing and delivery of health care, user fees have been introduced for outpatient (OPD) and in-patient care at all levels of the system. Charges for drugs have been instituted at all levels of health institutions too. Community financing schemes are also being encouraged. These will be linked to such services as resolving drug funds; contributions, in-kind donations by individuals and communities of either cash or labour to help provide a service or construct buildings.

Introduction of fees raises access and equity issues. Exemptions, therefore become imperative. According to the ministry, the exemptions will be done on the basis of the distinction between health services with public and private benefits, whereby public resources will accrue to the former and individuals will have to meet expenses for the latter [MOH, 1993]. "Exemptions are self-targeting and those individuals who are unable to contribute, identify themselves and are advised to see a social worker to determine their socio-economic status" [MOH, A]. At the moment, epidemics, chronic infections diseases and natural disasters shall be exempted from charges. Vulnerable population groups are also exempted [these include orphans, chronically ill and the disabled). Also exempted are children aged less than five and old people above the age of 65.

Objectives of the study:

Determine trends in the financing and delivery of Health Services.

Assess the various actors' views about the current financing and delivery of health services.

Examine Management and Control issues that will arise with the decentralization of Health Services.

Examine Community Willingness and ability to pay.

Find out views about community involvement in the delivery and management of health Services.

Determine the relationship between the public and private health providers.

Statement of the Problem

Zambia has experienced an economic recession since the middle 1970s and this has led to a plurality of reform policies. These policies have ranged from doses of liberalization mixed with centralized management during the United National Independence Party (UNIP) days, to a more radical structural adjustment programme under the Movement for Multiparty Democracy (MMD) government. The long years of economic decline coupled with negative offshoots of the reforms have had an adverse impact on the population. Employment opportunities have declined over the years, in the midst of a steady population growth. According to a World Bank Beneficiary Assessment (1992; 31), real earnings in the formal sector which rose by 2.7 percent per year during the 1965-1970 period, had by 1975 disappeared and after 1975, real wages fell sharply. In 1986 and 1991, average real earnings were 40 and 30 percent of the 1975 level. The World Bank Beneficiary Assessment (1994; 31) records show that , 51 percent of the population belong to the core poor and a further 14 percent are poor leaving only 32 percent as non-poor.

With the downturn in the economy, there have been corresponding repercussions on the social sectors. Expenditure to the Ministries of Education and Health have remained stagnant over the years and even declined in real terms. Since the 1970s, the central government budget allocation to the ministry of health has been less than 10 percent of the total budget. Most of the allocated funds are used for personnel emoluments and recurrent departmental charges (CSO, 1992; 46). In addition to absolute resource constraints, the situation has further been compounded by a skewed distribution of resources across levels of the health delivery system. The three central and special hospitals get almost an equal share of health funding as all the other hospitals and health centers put together.

In view of the downward trend in the financing of health services, measures of augmenting government resources have been implemented. Consumers of public health services are charged minimal fees for the services provided. As indicated however, this is being done in the context of increased vulnerability of the population. Given this scenario, how can cost -sharing be sustained in the context of declining economic opportunities ?.

Methodology

Data collection methods and Research tools

Multiple data collection methods were used which included a household level questionnaire, a focus group discussion guideline, and questionnaires for public and private clinics. Secondary data pertaining to trends in expenditure and utilization were also collected. It was decided to collect data from multiple sources so as to include all the major actors in the provision of health services. The community is the beneficiary and ultimate user of health services while the providers both in the public and private sector are the deliverers of services. The perceptions of both consumers and providers and their roles in managing and providing health were investigated in this study.

Interviews with heads of households enabled determination of the respondents' choice of health providers against their background characteristics. The survey of private and public health facilities was done in order to find out their performance in terms of management, private-public health sector collaboration and any operational constraints that were being faced. Focus group discussions were held with community groups in order to understand processes that made communities able/unable to meet their needs and understand how they were responding to the cost-sharing schemes and their perceptions about the impact of these on utilization patterns and quality of care.

Sampling process

At the household level, a random sample of 2000 was selected. The sample size was decided on the basis of temporal and financial constraints and was taken to be representative of the nation. The sample was proportionally divided into rural and urban areas corresponding with the level of urbanization estimated at 42%. This resulted in 1160 and 840 households being sampled from rural and urban areas respectively. During the process of data entry and analysis, about 116 cases were lost and could not be recovered. This report, therefore, only reflects a total of 1894 cases.

The two most urbanized provisions Copperbelt and Lusaka were included and one typical rural province (Luapula) was also covered. Within the two urban provinces, two districts were selected;

Chingola {Copperbelt province} and Lusaka Urban {Lusaka province). For the rural province, two districts, Mwense and Mansa were also selected. The former has a mission health facility, while the latter does not have.

A number of criteria were used to choose communities within each district. Lusaka Urban district has a large number of high density compounds and therefore it was decided to include these in the sample in addition to medium and low density areas. Chingola being a mine town was stratified into the mining townships and local government areas. After the selection of communities, a government clinic within each selected community was then surveyed. For each public/ mission facility sampled, a focus group discussion with users of health services was conducted within the facility and another one with the general population in each health facilities' catchment area.

Data analysis

The data was analyzed by use of the IQ software package. Before any examination of relationships among variables could be done, simple frequency distributions were run which enabled a descriptive presentation of the data. Subsequently, relationships of variables were determined by cross-tabulations. Analysis of the study units (for example health institutions) that were fewer was done manually by reading through the instruments and arranging the results according to recurring themes which were used to write the report. To safeguard against the possibility of missing out any information due to memory lapse, a strict schedule of activities was followed for the collection of data and the subsequent analysis. After each days' data collection activity, team members met in the evenings to go through the notes, transcribe were necessary.

Analysis of the qualitative data entailed the jotting of notes every evening after data collection so as to come up with recurring themes as well as take stock of the day's experiences with data collection. After this the whole research team meet for a debriefing session during which experiences in the field were shared. The notes arising from these meetings and the notes taken during field work guided the formulation of themes that constituted the focus group discussion findings.

Study Findings

Respondents Characteristics

Socio-demographic characteristics

The sex distribution of the sampled heads of households was weighed in favor of males who constituted 81% while the remaining were females. In rural areas, 22 % of the households were headed by females, whereas the corresponding percentaged in urban areas 17 (table 1) The higher proportion of female headed households in rural areas, which as a general rule are characterized by low economic opportunities, compounds the unfavorable position of females.

In terms of marital status, majority of the respondents (75%) were married, while those who were single and separated comprised 7 % each (table 1). Whereas 8% of the heads of households had been widowed, only 3% had been widowered. This finding implies that men tend to remarry faster than females. If the rate of remarriage was even among both males and females, there would have been an approximately equivalent proportion of widows and widowers. The finding is consistent with the experience in Africa where males find it relatively easier to remarry than females.

Heads of households in the sample had a reasonably high level of education (table 1). Most of them had attained secondary school level of education (38%), while 24% had attained "college and higher" and 29% had gone up to primary school level. There was a higher level of college education among household heads from urban than rural areas. Of the total number of heads of households who had never been to school, almost three quarters (72 %) were from rural areas. This is a reflection of the general lack of opportunities that obtain in rural areas and which push people towards urban sites.

Table 1
Socio-demographic, water and sanitation characteristics of heads of households and Housing

Characteristic	Total		Urban		Rural	
	n	%	n	%	n	%
Sex						
Male	1525	81	742	83	784	78
Female	368	19	153	17	215	22
Total	1894	100	895	100	999	100
Marital Status						
Single	127	7	70	8	57	6
Married	1412	75	682	76	730	73
Separated	142	7	56	6	86	9
Widow	158	8	64	7	94	9
Widower	50	3	20	3	30	3
NS	5	-	3	-	2	-
Total	1894	100	895	100	999	100
Education						
None	128	7	31	4	97	10
Primary	546	29	147	16	399	40
Secondary	720	38	377	42	343	34
College +	450	24	307	34	143	14
NS	24	1	17	2	7	1
DK	26	1	16	2	10	1
Total	1894	100	895	100	999	100
Type of toilet						
Flush	927	49	719	80	208	21
Pit Latrine	923	49	175	20	748	75
No toilet	3	0	1	0	2	0
Aqua privy	41	2	0	0	41	4
Total	1894	100	895	100	999	100
Source of drinking water						
Communal tap	385	20	202	23	183	18
Tap inside house	644	34	631	71	13	1
River	83	4	0	-	83	8
Protected well	26	1	1	-	25	3
Unprotected well	605	32	23	2	582	58
Borehole	6	-	1	-	5	1
Tap-outside-house	145	8	37	4	108	11
Total	1894	100	895	100	999	100

Water and Sanitation characteristics

An almost even proportion of households had "taps inside thc house" (34%) and unprotected wells (32 %) as their source of drinking water (table 1). In Urban areas, the most common source of drinking water was "tap in-side the house," while for rural areas, rivers and unprotected wells were widely used. A high percentage (80%) of the population in urban areas had flush toilets. An equally high proportion (75%) of the population in the rural areas had pit latrines. This is a reflection of the comparatively low standards obtaining in rural areas. Among the urban areas, Chingola had a higher proportion of households with flush toilets relative to Lusaka because of the better serviced copper mining company townships. Although Lusaka is the capital city, it had a high percentage (25 %) of households with pit latrines, placing it in second position to Mansa whose proportion was 49 %. Chingola had the lowest percentage of the households with pit latrines.

Morbidity and perceived causes

Malaria and diarrhoea were by far the most commonly reported illnesses, followed by coughing and HIV/AIDS in that order. It is interesting to note that HIV/AIDS was mentioned among the top four diseases. A relatively higher proportion of the urban respondents reported HIV/AIDS than their rural counterparts. The depicted disease pattern was observed for all the districts except Chingola, where coughing was the second most commonly reported disease after malaria. This is a result of the emissions from the mines, which if exposed to for a protracted time result in lung infections. Those that reported HIV/AIDS attributed it to promiscuous sexual behavior. Other reported causes of diseases included mosquitoes, stagnant water and dirty drinking water [51, 6 and 8 % respectively]. As a result of these causes malaria and other water borne diseases were prevalent as indicated above. Within the towns surveyed, these health conditions were more common in the high density areas of Lusaka.

Community Needs

The overriding need that was identified by the community was the improvement of water supply, which was said to be inadequate and people reported drawing drinking water from wells. Although urban areas could generally be expected to have better water facilities, they nonetheless, also experienced these problems because of the numerous unplanned and highly populated areas. The need for better water facilities also explains why most of the respondents reported diarrhoea as a major health problem.

For rural areas, other frequently cited needs included the provision of fertilizers and establishment of letter postage facilities. Urban respondents identified inadequate social amenities such as provision of electricity, garbage collection, and road infrastructure. These findings are a pointer to the degradation of social amenities in the country. The most commonly sited need for women from all the districts was the formation of clubs where they could learn skills for generating income. The majority of the women who requested for this were those from rural areas, because they are more disadvantaged than their urban colleagues. Socio-cultural factors have more negative effects on rural women than their urban counterparts.

Community Involvement

As indicated above, the cornerstone of the ministry of health's reforms is the decentralization of services to the district level. In addition to having health workers at the local level assume more roles in the management of these services, local communities are also encouraged to take additional roles in this regard. Traditionally, local communities have mainly been involved by way of financial contributions and also in-kind payments. Provision of labor for health projects has and still is a common mode of paying in-kind.

While these forms of contribution have continued, communities are now being encouraged to have a say in what services the health system is providing. Community participation in rural areas is done through Village Health Committees while the urban equivalent is the Neighborhood Health Committees. These committees act as conveyor belts between the community and the health center. Involvement of local people in the running of health facilities and identification of health problems ensures that the services thus provided are appropriate and respond to the felt needs of the communities.

The survey results showed that providers were in favor of the community participating in the delivery of health services. They stated that this tended to bind the community and workers together. By this arrangement, local people would also be able to share problems and disseminate health information to the wider community. Disadvantages pointed out about community participation was the tendency by the local people to sometimes frustrate health staff's by being too demanding and interfering in their work. Providers were, however, against the idea of communities contributing towards worker's salaries because people were too poor and hence could not afford. Unfortunately only a small proportion (15 %) of the community reported that they were involved in health planning. There was a higher level of community involvement in rural than urban areas. In rural areas, this mainly entailed in-kind contributions whilst cash payments predominated as forms of contributions in urban settings.

User Charges and Outcomes

User charges in government health facilities, mostly take the form of user fees and a prepayment scheme by which people pay in advance and obtain medical care when they fall within a predetermined range of time. To determine how much people were paying for health services, and the general health service utilization patterns, respondents were asked if they had an illness episode in the household in the last one month. They were also asked about any subsequent actions that were taken. For all the actions taken, respondents were also asked about their willingness and capacity to pay. In order to gain in-depth understanding about people's willingness, capacity to pay and any difficulties that were being faced, focus groups discussions were held with users of health services and the general community.

Levels of user charges by providers

Respondents were asked to indicate how much they paid to the various providers that they visited. The range of charges was varied, with private surgeries having the highest level and the public health centers having the lowest (Table 2). Although the charges at private surgeries was the highest, some of the private practitioners complained that they were only breaking even and not making any profits at all because of the generally weak economy and consequent low purchasing power for majority of the population. Traditional healers' charges were higher than those of government health centers, but were preferred especially in rural areas because of their flexible modes of payment. In kind payments were particularly common among traditional healers and most of their clients found it easy and affordable to pay.

Table 2:

Average amount of money paid at various health providers (In kwacha)

	Traditional healer	Private Surgery	General Hospital	Central hospital	Health Center
Average charge	3,235	9,462	1,500	2,725	500

Capacity and affordability to pay

The charges were generally found to be affordable by most of the respondents. Of those who took the first action, 85 % said the charges were affordable (table 3). A higher proportion (91%) of people in urban areas agreed that the fees were affordable than in rural areas for which the corresponding percentage was 81. The few urban respondents who said that the fees were not affordable, often referred to the lean economic times that the country was facing and resultant reduced opportunities for well paying employment opportunities. Others complained that being requested to pay for health care imposed a heavy financial burden on them because they aware already paying income tax which according to them ought to be used for the delivery of health and other services.

Most of the rural residents on the other hand said the fees were unaffordable, because of their meger earnings, and generally precarious means of livelihood. The liberalization of the agricultural marketing system, for instance had made it difficult for them to easily dispose of their produce and hence had very little incomes at their disposal. In addition to their relatively higher inability to pay for health services, rural respondents maintained that they were also unable to meet other basic needs such as food, housing and clothing. Because of their already very low purchasing power, they found it very difficult to pay for health services, especially since they had for a long time not been used to the tradition of paying for these services. If the cost sharing scheme is to succeed in rural areas,

other modes of payment like in-kind contributions ought to be encouraged.

Table 3
Responses to question on whether fees were affordable or not

Question and responses	Total		Urban		Rural	
	Number	%	Number	%	Number	%
Are fees affordable ?						
Yes	426	85	189	91	237	81
No	74	15	18	9	56	19
Total number of respondents	500		207		293	

Box 1

Views about community capacity to pay for their needs

During the second republic, incomes were adequate because although people were getting a little money, they were able to buy a lot of things. This is unlike nowadays when people get hefty salaries which can't enable one buy all the necessities in the home. The discussant went on to say that: nowadays it is even more difficult for a relative who works on the Copperbelt to remit money to a relative in the village. As this discussant was expressing her views, all other were nodding their heads in acknowledgment. [A 38 year old female at Kashiba Clinic].

Incomes were adequate during the second republic unlike nowadays when an individual's income is divided among various expenses such as education and health. Another discussant agrees and adds that people in formal employment nowadays are very few since some of those who were working during the second republic have been laid off and this makes it difficult for them to raise the money required for their children's education. [A 29 year old male and a 21 year old female of Kambaniya village, Mansa.

Views from the urban sites were mixed, with some people pointing out that although incomes have generally been raised the cost of living has also gone up resulting in low purchasing power. A 25 year old woman said: incomes are not all that adequate for all the requirements. Therefore priorities come into play when deciding what money should be spent on. Food is the first priority, followed by housing, health and then "other things".

Willingness to pay

In order to determine willingness to pay, respondents were asked whether public health institutions should continue charging fees or not. A high proportion (65 %) of the respondents were against the continuation of fee paying (table 4). Just as more rural people said they could not afford the fees, equally more of them were less willing to pay than urban dwellers. Those who were for the idea of health charges continuing, stated that the fees had helped improve general cleanliness and drug availability at health centers (table 5). They further stated that the revenues accruing from fees were augmenting government resources. Although people in rural areas were generally less willing to pay for health services, they actually contributed much more by way of in-kind payments than urban dwellers. In assessing the urban and rural communities' willingness to pay, attention should not just be on monetary payments but should include in-kind contribution as well. If the in-kind contributions of rural dwellers were converted into cash equivalents, it would become apparent that they actually pay more is presented.

Those who were against health fees gave their poor economic situation as reason for not being able to pay (table 5). This as indicated mostly applied to rural dwellers who, because of the subsistence nature of the occupations, are not able to generate sufficient resources. Other respondents said that they did not know what the money collected was spent on and suspected that it was misappropriated by staff at health institutions. This shows that there is lack of information about how the money collected from user fees is utilized. This has resulted in loss of confidence in health staff and undermined people's willingness to pay. The inconsistencies in the supply of drugs was also identified as a factor deterring peoples' willingness to pay. Sometimes people paid for health services without being given drugs and thus they wondered what the essence of paying was. This was also confirmed by workers at health centers who said that people were willing to pay for services so long as the supply pf drugs was ensured.

Table 4

Responses to question on whether fees should continue being paid or not (Expressed in Percentages)

Question and responses	Total	Urban	Rural
Should fees continue ?			
Yes	31	46	17
No	65	49	79
NS	4	5	4
Total number of respondents	1894	895	998

Table 5:

Reasons given for and against the continuation of user fees

(Expressed in percentages)

Reasons for and against fees	Total	Urban	Rural
Reasons given against fees			
People cannot afford	77	66	80
There are still drug shortages	4	8	3
Illnesses are unexpected	3	5	2
Money is just stolen by staff	1	2	1
People are dying in homes	6	9	6
Tax revenues should be used for running health facilities	2	1	3
To enable the poor access to services	3	5	3
Others	-	-	-
NS	2	1	2
	2	1	1
Total number of respondents	1196	536	760
Reasons given for fees			
To help meet the cost of health	19	21	15
Should be maintained at same level	5	2	12
To maintain cleanliness	12	16	6
Should not be compulsory	3	2	7
Should be reduced	11	9	14
Things are improving at facilities	13	17	3
Nothing is free	3	3	4
Helps the state acquire drugs	18	21	10
Should attend to patients quickly	7	1	20
Others	1	1	2
NS	8	7	8
Total number of respondents	588	403	185

Social Welfare Scheme for Exemptions

In view of the high poverty levels obtaining in the country, a social welfare scheme meant for helping those unable to pay has been designed and still undergoing refinement. This has been done by the MOH in collaboration with the Ministry of Community Development and Social Welfare (MCDSW). Those who are unable to pay at health centers are referred to the MCDSW for help. Included in the category of those exempted from paying fees are orphans, the disabled and retrenchees. While the importance of the scheme cannot be overemphasized in view of the abject poverty level in the country, the findings of the study show that this scheme is not widely publicized and as a result not well known by the public.

Household respondents were asked what they would do if they felt ill but had no money. Those who said they would just stay at home, constituted the majority for both urban and rural areas. The percentage of people who said they would just stay at home was higher in rural areas (62 %) than in urban areas (56%) (table 6). For urban respondents, the next largest category were those that said they would still go to the clinic and leave their registration cards as security (12%). For rural areas, in contrast, the second largest category of responses was "would borrow from friends" (11%) and "go to traditional healers and negotiate" (14%). Less than one percent of rural respondents said they would contact the MCDSW for assistance, whereas in urban areas, the corresponding percentage was only 1. Although knowledge levels about the social welfare scheme were found to be generally low among the respondents, urban areas showed a relatively higher level than rural sites.

The high percentage of respondents who said they would just stay at home and die for both urban and rural areas is particularly worrying and confirms results shown elsewhere in this report about communities being critical of user fees because "they have resulted in people failing to access health services and hence dying in homes". Unfortunately health staff who are supposed to be more knowledgeable and hence better placed to educate users of health services about the social welfare scheme were not very knowledge about the scheme too. This state of affairs has, therefore, resulted in people not utilizing health services because of lack of money even when they are exempt from paying under the criteria laid out above.

Table 6

Knowledge about the social welfare scheme for those unable to pay

What would you do if you fell ill and had no money	Total		Urban		Rural	
	no.	%	no.	%	no.	%
Stay at home and die	1065	56	447	50	618	62
Borrow money from friends/ relatives	252	13	143	16	109	11
Buy medicine from Make-shift-stores	18	1	17	2	1	-
Use traditional herbs at home	145	8	41	5	144	14
Go to clinic and leave registration card as security/ negotiate at clinic	230	12	149	17	81	8
Go to traditional healer and negotiate	18	1	5	0	13	-
Get help from the Social Welfare Scheme.	16	1	16	2	0	-
Ask for medicine from neighbors	27	1	8	1	19	2
Get help form employers	16	1	12	1	4	-
Do not pay (member of staff/ too old)	14	1	3	-	11	-
Others	21	1	13	1	8	-
NS	72	4	41	5	31	3
Total	1894	100	895	100	999	100

Utilization of health services

To get a better picture of utilization dynamics, data on returns for various service outputs was collected (table 7). The data show that on average, there was a decline in utilization of health services from 1990 to 1995. In 1991 there was a decline in the utilization of five service outputs. In 1992, four service outputs registered a decline. The number of service outputs which experienced a decline increased to 9 by 1993, then to 7 in 1994 and reverted back to 9 in 1995. The noted decline in utilization of health services coincides with the introduction of user charge which became effective in 1992.

Nchanga which is a mine facility registered more decline than the other facilities. This could be a reflection of the retrenchment exercise embarked on by the mining company which has reduced the number of employees and hence led to a decline in utilization. Given the decline in utilization of mine health services, it means that resources in these institutions are lying unutilitised at the same time when there is pressure on public institutions. The imminent privatization of the mines is likely to be accompanied by the shedding off of social services. The state has to evolve means and ways of sustaining these health institutions to meet the needs of the population while at the same maintaining the standard of services that has become a hallmark of mine facilities. Embarking on this exercise and achieving positive results is not likely to be easy.

Staff at health facilities were also asked to state what they do in helping people who are unable to pay. Most of them said that, they refer them to the Social Welfare department. When asked to state what they had done to publicize the scheme, the majority of them reported that they liaised with other organizations which were charged with the responsibility of publicizing the scheme. These ranged from churches, DHMTs, Neighborhood Health Committees, to political leaders. Health centers were not themselves physically involved in these exercises. The observed low knowledge of the scheme could, therefore, partly be explained by the lack of a well organized system for informing the public.

Table 11:
Health Service Utilisation during the period 1990-1995 for Selected health Institutions

SERVICE OUTPUT	YEARS					
	1990	1991	1992	1993	1994	1995
LUSAKA (Chongwe HC)						
OPD	16103	25816	26279	**18566**	5368	-
ANC	3329	**2910**	3608	**2682**	**2216**	-
U5C	4556	4732	6025	4899	3011	-
COPPERBELT (Nchanga north)						
OPD	122139	**111563**	**110394**	**77481**	**57008**	**28160**
DELIVERIES	1593	1888	2251	2275	**1919**	**1390**
ADMNS.	12054	**10350**	13827	**12381**	**10872**	**10089**
(Chiwempala)						
OPD	80843	122612	149706	**94111**	-	**34651**
ANC	7830	8945	**11539**	**8785**	-	4799
F.PLNG	1743	**1381**	1509	1800	-	2609
U5C	9096	14822	15685	16325	-	**12056**
LUAPULA (Mambilima)						
OPD	13577	**13281**	**9071**	15873	**11998**	**10915**
ANC	2653	3651	3750	**3048**	**2525**	2711
DELIVERIES	361	453	**432**	471	515	**312**
U5C	5817	6263	7170	8571	10767	11143
(Kashiba)						
OPD	-	13353	28243	34724	**27475**	**18697**
ANC	-	1632	1856	**1645**	1198	**1113**
DELIVERIES	-	152	189	**157**	170	184
U5C	-	2387	2533	2869	3989	5419

U5C: Under Five Clinic
OPD: Out Patient Department
ANC: Antenatal Care
F.PLG.: Family Planning
ADMNS.: Admissions

Box 2

Views against and for the continuation of user charges

Against charges:
There were more people in rural areas who disapproved of user fees than in urban areas. The major reason given for opposing the fees was their low purchasing power. The following quotations illustrate this point.

"Free medical fees were good because they enabled everybody to have access to medical treatment, unlike now when people are failing to go to hospital because of lack of money" (A 31 year old man of Kasaba Village, Mwense, Luapula Province).

"The failure of a person to pay an amount even as small as K200, is good evidence that incomes are not adequate. There are very few people in this community who earn an income" (A 41 year old Fisherman of Kasaba Village, Mwense, Luapula Province).

At Buntungwa clinic in Kombaniya, Mansa, Luapula Province, discussants were of the view that incomes were so low that people were not even able to save and send money to the parents. They, therefore, considered the requirement that they pay for health services as being unrealistic.

For charges:

A discussant at Kasaba Village in Mwense noted that the idea of free medical services was not an entirely good idea, because it tended to encourage wasteful consumption habits. People could go to health centre and obtain medicines even when they were not sick and this resulted in drug shortages."

Because of the fees that people were now paying, clinics had become cleaner, drugs were relatively more available and attitudes of medical staff had improved. [A 35 year old businessman of Chikola transport, Chingola].

A man in Kabwata suggested that fees should continue but, the amount paid should differ according to people's socio-economic status. Those in highincome brackets should pay more so that the money thus raised can be used to subside the poor. (A 52 year old businnesman in Kabwata, Lusaka

Quality of health care

The ultimate goal of user charges is to improve the quality of health services. To gauge community views about any changes in the quality of care over the years, respondents were asked if they had noticed any changes in various aspects of quality of care since the introduction of user fees. The results show that some positive changes have indeed been scored. It should be mentioned at the outset that not all these changes are attributable to user charges and this will pointed within the text.

One direct way by which revenues collected from user fees have directly impacted on quality of care is through the use of this money to buy basics such as cleaning utensils and other requirements. From the money collected, health facilities can also engage casual workers who can be used in maintaining cleanliness. Overall, most of the people were of the view that positive improvements had taken place at the health facilities. Out of the household sample, 61.4% said there have been noticeable improvements while only 34 said there had not been any.

Those who said there had been noticeable improvements in health facilities mainly mentioned the cleanliness that health facilities had now attained. The rehabilitation of health facilities which was embarked upon at the outset of health reforms has also positively impacted on the new image. The health reforms have now been operational for a number of years. From the study results, it is evident that the changes that have taken place in the health sector have had a positive impact on the people's perception about quality of health care. Overall people are of the view that the quality has improved.

As indicated above, the improvements scored with regard to the physical state of facilities has been the most noted. While only 23% and 4% of the respondents agreed and strongly agreed that the clinics were clean before the introduction of user fees, 50% and 37% said this happened after the introduction of user fees (table 8). This positive change regarding the physical state of the health facilities has also positively impacted on other facets of quality of care. One such attribute is "staff attitudes" which more respondents rated as being better in the fee paying era than before.

Table 8

Opinions about quality of care before and after the introduction of fees

(Expressed in percentage of respondents)

Statement	A	SA	D	SD	NS
Before introduction of fees					
Attitudes of staff were good	44	4	40	5	7
Drugs were readily available	32	7	45	6	10
The Clinic was clean	23	4	51	18	4
There was adequate privacy	63	6	20	3	8
There was enough staff	45	17	26	4	8
After introduction of fees					
Attitudes of staff are good	63	8	20	2	7
Drugs are readily available	53	14	26	2	5
The Clinic is clean	50	37	8	1	4
There is adequate privacy	67	8	15	2	8
There are enough staff	49	11	25	8	7

Key:

A: Agree; SA: Strongly agree; D: Disagree; SD: Strongly disagree; NS: Not Stated

The proportion of respondents who agreed and strongly agreed that staff attitudes were good before user fees was 44 and 4% respectively (table 8). Those who said this was so after user fees were 63 and 8% respectively. As indicate in the immediate preceding paragraph, the change in attitudes could be due to changed physical conditions at the health facilities, and the subsequent decent working environment, which is a far cry from the dilapidation associated with health centres before the fee paying era..

Although most respondents acknowledged the improved physical state of health institutions, they observed that other facets of care had not improved as much. These included the availability of drugs for which 37 and 7% of the respondents agreed and strongly agreed that drugs were more readily available before, while 53 and 14% said this was so after introduction of the cost sharing scheme (table 8). It was also noted that there had not been much change in terms of the privacy of patients at health facilities. Improving these attributes entails high expenditure levels which cant not still be availed because of the meger resources at the state's disposal.

Private / Public Sector Collaboration and Utilization

The country's typology of the private sector, includes Employer, Non-Governmental Organisation based and For-profit health institutions. For-profit facilities are mainly concentrated in urban areas, whereas the non-governmental based facilities (like missions) mainly cater for rural communities. Mine facilities dominate Employer-based facilities. For-profit facilities could be broken down into three major categories: Modern formal (Private clinic and hospitals); Pharmaceutical Retailers (Pharmacies, Drugs stores, market vendors); Traditional healers under which fall, herbalists, Spiritualists and Traditional Birth Attendants. As indicated above parastatal sector-supported health facilities too, constituted a major portion of employer- based facilities. However, their share has progressively declined as state enterprises are privatized. Non-governmental organizations mainly include the mission, and Islamic organizations.

The government is encouraging the setting up of private facilities and increased collaboration between the private and public facilities. The study determined the current patterns of collaboration between the two sectors, and perceptions of providers from both sectors about the link. The results of this exercise are partially summarized in table 9 below. Some private for-profit practitioners on the Copperbelt, told the research team that although collaboration between them and the public sector is desirable and is in effect, health workers in public health institutions tend to be use public facilities for their own personal benefits. This involved the use of labs facilities for their own purposes and the pilfering of drugs for dispensation to private patients. For the collaboration to fulfil its role of augmenting government resources, there is need to monitor and correct these abuses.

Chingola the Coppperbelt town that was included in the study, does not have a well equipped government referral hospital. As a result non-miner patients who need further medical attention are referred to mine hospitals. Since non-mine patients are, under normal circumstances supposed to be attended to by government health facilities, an arrangement has been worked out between the district council and the mine company whereby the former pays the latter any amount accruing from services rendered to non-mine patients. It was established that the DHMT did not usually have enough money to pay the mining company and as a result, appealed to the MO H to help resolve this

issue.

Table 9:

Pro and cons of public/ private sector collaboration

Type of collaboration	Pros and Cons
Referring very ill patients form government to mine hospitals	Enhanced cooperation between ministry and mine Required to pay mine company from district budget which is not enough.
Health worker in Public facilities doing part time work in private practice	Enable public workers to aim more and hence remain in service Tendency to spend too much time in private practice and less effective time in public facilities
Private for-profit clinics utilizing lab, x-ray, and other equipment in public health institutions Private for-profit clinics referring patients to Consultants in public health Institutions	Reduces cost of providing private health care Health in public institutions sometimes use public facilities (drugs, time and equipment) for their own businesses.

In order to get an insight about the utilization of health services, respondents were asked if there was anyone who had been ill in the household in the past one month. More than two thirds of the respondents said that somebody had been ill. The majority of the people who had been ill were children of heads of household (29%) followed by the respondents themselves (22%). After establishing who had been ill in the past month, they were asked for the series of actions that had been taken. This enabled determination of health service utilization patterns of the respondents.

Majority (30 %) of the respondents said the first thing that was done was to take the sick person to a government health centre, while the second largest category (14 %) of respondents said they administered self-medication. The third largest (7%) category were those who sought hospital services. The relatively large proportion of respondents who went to the hospital as first action, however, suggests that by-passing the first point of call for health care is common practice.

The equally high proportion of people who took self medication is a disconcerting finding because of the quality implications that it carries. Most of those who took self medication said they did that because they thought the illness was not very serious. Nonetheless, the percentage is too large and should concern policy makers in the ministry. Other people said they took self medication because they had no money for paying at the health center and hence decided to take medicines that they had at home.

A high proportion (12 %) of those whose first action was the health center, followed it up with seeking hospital services (table 7). Majority of those whose first action was self medication, visited the health centre as a second course of action. There is need to encourage the conventional uptake of health care so that by-passing the health centre is kept to the very minimum. This would intensify utilization of basic health services and ensure dispensation of the required health care at the appropriate level. The high level of self medication as first action is also a cause for concern, and further studies focussing on this issues would be worthwhile.

Table 7

First and second actions taken for an illness episode

FIRST ACTION TAKEN	SECOND ACTION TAKEN							
	Went to private surgery	Went to clinic	Went to hospital	Went to trad. Healer	Self medication	Did nothing	Don't know	Total
Went to private Surgery	6	3	6	-	2	-	83	182
Went to Clinic	3	1	12	1	4	-	79	575
Went to hospital	2	3	2	3	1	-	89	128
Went to trad. healer	-	-	-	-	-	-	100	20
Self medication	2	11	9	-	3	-	75	270
Did nothing					-	-	100	32
Just Prayed							100	5
Don't know					-		100	675
Not Stated							100	5
Total								1894

Note

"-": Less than 1 %

(n): Total

Discussion

The general economic decline and resultant fiscal constraints has led to a decline in the levels of expenditure accruing to the social sectors. Within the health sector, these financial constraints have resulted in a plurality of operational constraints such as shortages of drugs, poor remuneration of staff and the subsequent staff demoralisation. Because of the protracted economic decline and steady decline in the quality of health services, it became imperative to device ways of maximising the use of available resources, while at the same time making in-roads towards raising the quality of health care.

This has been operationalised through the implementation of health reforms by which government has undertaken to put resources behind proven elements of PHC, streamline the administration of the whole spectrum of the health delivery system with the district assuming more power in the management of health services. Although capacity building workshops from which many districts benefited, have been held, the scarcity of staff at most health centres has impended the full realisation of the reforms' objectives. Health staff complained that they have had to take on additional roles besides the conventional task of delivering health care.

While the decision making process has been decentralised to the district, some operational problems are being experienced with regard to the relationship between the DHMTs and health facilities. While the running costs of the health system could have been reduced through the process of decentralisation, some of the problems that were common at the provincial level seem to have been transferred to the districts. A number of staff at health centres complained that DHMTs often made unilateral decisions without due regard for lower levels of the health system. These unilateral decisions especially prevalent with regard to the utilisation of financial resources, some of which was raised from user fees. These tendencies were frustrating staff at health centres, since they were responsible for raising the monies from the user fees charged on people seeking health services. If the state of affairs were left as they are now, the spirit of staff at health centres would be dampened and this would in turn negatively impact on the success of the health reforms.

Community Participation

As a one of the key elements of the reform process, community participation is being encouraged. Community have traditionally been involved in the delivery of health services, but under the reforms, it is recognised that the involvement of communities ought to move further than was the practise earlier on and should transcend mere labour and monetary contribution towards meeting the needs of the health system. This is being done by involving communities in the design of programmes being carried out at health institutions. In order to realise this, there ought to be a deliberate move to involve them in the monitoring process too also, so that changes could be effected to any aspects of health care that are perceived not to be responding to the needs of the community.

The results showed that there is a higher practice of community participation by way of in-kind contributions in rural areas than urban settings. This is a reflection of the rural/ urban differentials in the costs of the different media of contribution towards health services. In rural areas, people have relatively more time at their disposal than their urban counterparts and therefore tend to spend more of their time on providing physical labour as contributions towards health institutions than is the case for urban dwellers. The costs of providing labour contributions towards health project for urban dwellers on the other hand, is high and as a consequent they prefer monetary contribution.

Staff at health facilities were asked for their views about community participation. They were generally agreeable that communities ought to be involved in meeting the costs as well as participating in the delivery of health services. This, they maintained would result in communities developing more congenial working relationships with the staff. They were, however, opposed to letting communities contribute towards the payment of staff salaries, because of the high poverty levels obtaining in the which would not make it possible for communities to do so. Apart from the general inability of communities to contribute towards workers salaries, allowing communities to contribute towards salaries of staff would compromise their professional status. The staff thought that letting local people contribute towards paying salaries would leave them at the mercy of these communities since they would tend to be too demanding and expect too much from the staff.

Willingness and capacity to pay

While user charges have been introduced in both rural and urban areas, more of rural dwellers said they were less capable of paying than their urban counterparts. This is a reflection of the subsistence nature of the economic occupations in rural areas and poor returns for the same. It should, however, be pointed out that ability to pay was gauged on the basis of respondents' financial capacity to pay for the services provided. If some other mode of payment was used, it could turn out that rural populations contribute much more than is represented by their cash payments. The monetary equivalent of their labour contributions might for instance turn out to be just as much, if not even more than the labour contribution.

Although in-kind contributions have been identified as a possible way of ensuring that rural communities specifically participate in meeting the costs of health care, the system has not really been tried and followed through. As a result there is no basis on which to determine the feasibility of the medium of paying. In-kind contributions are an attractive and equitable option for rural communities. However, misgivings have been recorded about the accompanying costs of administering such a system. One argument is that the administrative costs would far outweigh the resultant benefits. While this may be true, ways of minimising these costs once the system has been in place could be evolved. One option would be to allow communities contribute items that could be utilised within the health centres or nearby facilities. Contributions in the form of food items, and labour would allow the procurement of needed resources with minimum financial constraints and enhance community participation in meeting the costs of health care.

In like manner, the rural population were less willing to contribute towards the costs of health care than their urban counterparts. As noted above the lower degree of willingness on the part of the rural population was attributed to their incapacity to pay. Urban dwellers were more willing to contribute. Their willingness was, however, qualified by the recurrent demand made about the need to ensure the availability of drugs. Drug availability is, therefore, an essential criteria by which communities judge the standard of services and consequently determines wether they pay for these services or not. Shortages of drugs act as an impediment to the willingness of communities to

contribute towards the cost of health care and ought to be minimised.

Social Welfare Scheme

While a large proportion of respondents were aware of the fee paying scheme at health facilities, a lesser proportion of the respondents were knowledgeable about the social welfare scheme which is meant to help those unable to pay under a specified set of criteria. The lack of knowledge about this scheme resulted in people opting to "stay at home and die" if they fell ill, when they could have been helped under the scheme. There has not been much publicisation of this scheme and as such people do not utilise health services even when they could if they had the right information about the scheme.

Unfortunately, some health staff also expressed ignorance about the social welfare scheme. This compounds the problem even further, since the people who ideally are supposed in the fore front in publicising the scheme are themselves not knowledgeable about it. In such a situation, the local communities would not be expected to be aware of the scheme in a situation where the conduits of such information, the staff are themselves not well informed. The ministries of health and community development have not done much to publicise the scheme and efforts have to be stepped up to improve on this score.

The need to do this is urgent especially when it is appreciated that Zambians have for a long time been used to obtaining free health services, and the hence the fee paying system and accompanying structures are new phenomenon. The fee paying scheme and lack of knowledge about condition under which exemptions can be offered have in part led to a decline in the utilisation of health services. Although there is a noticeable reversion to higher levels of utilisation, the current levels are still lower. The observed reduction in the number of people utilising health care is disconcerting since it has negative implications for the populations health status. It may imply that people are increasingly turning to the use self medication and thus compromising on the quality of health services thus obtained. The decline in utilisation is observable even for services that are exempt from fee paying (for instance antenatal care). This further underscores the urgent need to enhance

publicisation of the scheme.

Quality of Care

The ultimate aim of the reintroduction of fee paying in health facilities is to improve the quality of care provided by these health institutions. As the results have shown, people generally appreciate the positive developments that have taken place in health institutions over the years. The state of cleanliness was particularly heralded by the respondents. It is important that the momentum is maintained, so that the positive perception that people have about the current state of health institutions is maintained.

In tandem with the findings on the noted state of cleanliness at health institutions, most of the respondents interviewed also acknowledged that there had been a positive change in the attitudes health staff. This could probably be attributed to the general improvements that have taken place in the facilities. The improvement have to some extent created an enabling and friendly environment were both users and providers of health services can meet under a good setting. In addition to the general cleanliness now obtaining at the health facilities, the user fee collection bonuses that health workers obtain has also helped improve staff attitudes. And it is important the bonuses are consistently paid out to the workers, because cases of delays in their payment were reported. If sustained and in conjunction with improvements in the quality of care, the bonus could be used to retain staff public service. There are already indications that workers in public institutions, could even be getting better remuneration than some sections of the private sector.

The availability of drugs, a major yardstick for determining the quality of health services was noted to have improved since the introduction of fees. Although this is the case, there are still reports of intermittent drug shortages and concern was raised about this by both consumers and providers of health care. While the intermittent drug shortages could be said to be as a result of the poor state of the economy, there are constraining factors that could be easily resolved with just a rationalisation of the management of drug supplies. For instance cases of oversupply in one part of the country while other more needy areas are without any abound. Rationalisation of the supply of drugs in such

situation could improve the situation. And it is imperative that this be resolved soon since drug availability is the single most important criteria by which quality is determined.

While the household survey generally showed that various attributes of quality of care had improved, respondents were of the view that there was still not enough privacy in health institutions and the number of health staff was still low. Improving on privacy and number of staff is a major exercise which entails the consumption of vast amounts of resources and this would explain why there has not been much change in perceptions regarding these aspects. Most of the positive development that have taken place, have largely been out of a reallocation of resources within the sector.

Recommendations

Community participation and cost sharing are major ingredients of the health reform process. While the fees are very minimal, the study has shown that a number of people are unable to afford health the charges. To cushion those that are not able to, government has evolved a social welfare system for helping vulnerable groups. Unfortunately, as has been shown by the study, majority of the respondents as well as health workers are ignorant of the scheme. There is, therefore, need to publicize the system to both the community and health workers. Health workers are especially key since they would be able to disseminate the information through their contacts with people who come for services and subsequently the wider community.

There is much more willingness to pay for health services in urban than rural areas. However, the intermittent drug shortages tend to discourage people from paying. In order to sustain cost sharing, the availability of drugs should be improved. While increasing the quantities of drugs may be an expensive and hence difficult undertaking, rationalization of drug use by way of rationalization of the distribution on the basis of want would help improve the distribution process.

Because of the additional functions that district health workers have had to assume under the health reforms, capacity building workshops for these staff were carried out. Although these workshops have enhanced district staff capacities, the devolution of power and consequent additional roles has outstretched the limited personnel in health institutions. Book keeping functions in health centre were for instance being undertaken by the health workers who are at the same time supposed to dispense health care. Other staff should be recruited to specifically handle these additional roles. One way of avoiding compounding the consequent cost implications, would be to use revenue collected form, user fees pay these staff.

While the management of health services has been decentralized to the district under the District Health Management Team (DHMT), mistrust has developed between DHMTs and health facilities. DHMTs were constantly accused of making unilateral decisions about how collected money should be spent. These differences should be resolved so that DHMTs and health centers work amicably.

DHMTs ought to be as transparent as possible and include institutions under their jurisdiction in major decision making processes so that sources of conflict are minimized.

From the utilization patterns investigated by study, it was shown that some people still visit hospitals as their first point of health care. This creates inefficiencies and diverts hospital resources from being used for specialized care towards the treatment of minor ailments that can be handled at health centers. One way of solving this problem is by creating disincentives for bypassing health centers and where this is already in place, reviewing the levies. This could be done by imposing higher charges for people seeking health care from hospitals without being referred by health centres.

The high number of the respondent reported utilizing informal drug peddlers is a worrying finding. This practice was especially prevalent in high density areas. The observed utilization of informal drug peddlers, means that these is no strict enforcement of laws targeted at regulating the pharmaceutical industry. In addition, consumption of drugs from these sources poses a health hazard for the consumers. Law enforcement in this regard should be strengthened.

As private/ public sector linkages are being encouraged, it will become necessary to improve the government's ability to monitor these linkages so that the possibility of resource abuse is kept to the minimum. The observed delays by the DHMT in remitting payments to the mine facilities for the public sector's use of these facilities also needs to be addressed. Since these management teams generally face financial constraints, other means of payment could be tried. These may take the form public health institutions providing mine areas with services in which they have a comparative advantage. The exact type of in-kind payments can be decided upon after taking into account the respective teams relatively abundantly resources which may be specialized personnel, or specific type of health services provision.

Both users and the secondary data reviewed have revealed that there has been a decline in utilization of health services. The ministry needs to address this issue with the emergence that it deserves, because it is apparent that some people are not accessing health care, even when they could had they

had the right information. Action in this areas could start with the dissemination of adequate information to staff in health institutions about the welfare scheme and how it can be accessed. These would then impart the knowledge to the patients that they come in contact with. In addition to this, community based dissemination activities through already established media such as the Neighborhood Health Committees and Village Health Committees could help.

Although the patterns of health service utilization shows the expected pattern of the health centre as the first point of call, there was still a major proportion of the respondents who bypassed the health centre and sought care from hospitals. Disincentives ought to be instituted to curb this practice. One way of doing this would be by imposing prohibitive fees for people who seek care from hospitals without being referred by a health centre. While this is being done, it ought to be ensured the basic facilities for provision of care at health centre are availed, otherwise people will still be drawn towards hospitals for perceived quality better services.

Bibliography

Berman, Peter, K. Nwuke, R. Rannan-Eliya, A. Mwanza, **Zambia: Non-Governmental health care provision**

CSO (Central Statistics Office), 1974, **Housing and Population Census, (1969)**

CSO, 1992, **Country Profile**

CSO, 1992, **Selected Economic Indicators**.

Freund, Paul, 1986, "Health care in declining economy: the case of Zambia", in **Journal of Social Science and Medicine**, 23 (9)

Geest, Van der Sjaak, 1992, "Is paying for health care culturally acceptable in Sub-Saharan Africa ? Money and Tradition", in **Journal of Social Science and Medicine,** 34 (6)

International Labour Organisation, 1981, **Basic Needs in an economy under pressure**

London School of Hygiene and Tropical Medicine, 1985, **Health of the Urban Poor in Developing countries**.

Ministry of Finance, **Financial Reports, 1986/87/88/ and 1990.**

Ministry of Health, **Government Health Statistical Reports**.

Ministry of Health, 1992, **National Health Policies and Strategies**.

Ministry of Health, 1993, **Health Reforms Implementation Guidelines Handbook, Paying for care: Community co-financing**

Mwanza, Allast and Jolly Kamwanga, 1994, **Assessment the Private Health Sector in Zambia.**

National Commission for Development Planning, **Economic Reports**

Office of the President, **Economic Review;** January-March 1992

Osita, Ogbu, and Mark Gallagher 1992, "Public Expenditures and health care in Africa", in **Social Science and Medicine**, 34 (6)

Saasa, Oliver, and Jolly Kamwanga, 1994, **An update on the Situation of children and Women,**

Sheshamani, Venkatarach, O. Saasa, Bhat, M. Milimo, C. Osborne, 1994, **Constraints to Social Delivery.**

United Nations Children's Fund, 1992, **National Plan of Action for the Children in Zambia,**

University of Zambia, Macro International Inc., **Zambia Demographic and health Survey**

World Bank, 1994, **Poverty Assessment final report,**

Appendix 1
Ministry of Health Expenditure, 1985-1984, Zambia.

Year	Total expenditure (millions of kwacha)	Proportion of govt. Expenditure	Proportion of GNP	Expenditure per capita
1984	121.2	8.0	1.9	338
1985	146.1	6.7	1.6	262
1986	223.5	4.2	1.3	211
1987	352.0	6.0	1.6	269
1988	648.1	7.8	2.1	340
1989	860.5	8.9	1.5	231
1990	1267.3	4.3	1.0	162
1991	3612.3	7.2	1.5	*
1992	6672.0	4.2	*	*
1993	20060.0	6.6	*	*
1994	56510.0	8.2	*	*

Sources: Peter Berman et al., 1995, Zambia: Non-governmental Health Care Provision,
* Data unavailable

Appendix 2

Proportions of Ministry of Health Expenditure by type of institution, 1985, 1988, 1993, Zambia.

Institution	Personal Emoluments	Recurrent Dept. Charges	Grants and other payments	Capital Expenditure
Headquarters				
1985	10.5	43.2	26.8	19.5
1988	0.73	24.8	22.2	52.27
1993	1.24	23.4	10	5.3
Provinces				
1985	74	25.7	-	0.3-
1988	74	26	-	-
1993			-	-
UTH				
1985	59	41	-	3.4
1988	-	-	-	-
1993	16	31.9	48.7	-
Central hospitals				
1985	67	32	-	-
1988	60.7	39.3	-	-
1993	16.2	31.5	47.8	4.5

Sources: Ministry of Health Annual reports, CSO Statistical reports and NCDP reports.

Appendix 3
Number of health facilities, hospital beds and total population for 1985, 1988, 1992, Zambia

HEALTH FACILITY	1985	1988	1992
Hospitals	82	82	84
Govt	42	42	-
Mission	29	29	-
Mine/Other	11	11	-
Health Centres and Clinics	856	923	1,037
Rural H.C.			-
Govt	629	647	-
Mission	65	64	
Urban/Dept./Industrial Clinics			-
Government	135	128	-
Mine/Other	75	84	
Number of Beds in			
Hospitals	15062	16806	17,507
Health Centres	6222	7691	8,195
Total Population	6,642,754	7,322,203	8,352,848 (intercensal growth rate of 3.28%, per annum)

Source: CSO, Country Profile reports

The Effect of Cost Sharing on Management, Financing and Delivery of Primary Health Care Services in Tanzania: With Particular Reference to Outpatient Services in Public District Hospitals in Morogoro and Tanga Regions.

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by

Eastern and Southern African Universities Research Programme (ESAURP),

Dar es Salaam,

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Abbreviations

DANIDA	-	Danish International Development Agency
DED	-	District Executive Director
DMO	-	District Medical Officer(s)
EDP	-	Essential Drugs Programme
EPI	-	Expanded Programme for Immunisation, Tanzania
GDP	-	Gross Domestic Product
GNP	-	Gross National Product
HESAWA	-	Health Sanitation and Water
MCH	-	Maternal and Child Health
MCHA	-	Maternal and Child Health Aid
NGOs	-	Non-Governmental Organisations
PHC	-	Primary Health Care
PMO	-	Prime Ministers Office
SIDA	-	Swedish International Development Authority
TFNC	-	Tanzania Food and Nutrition Centre
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organisation

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Secondly, we are very grateful to the Eastern and Southern African Universities Research Programme (ESAURP) from which the financial support and coordination of the study were obtained.

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St. Raphael's Mission Hospital, Korogwe; and Usagara Private dispensary, Kilosa and Mr. John Kyaruzi (the data analyst).

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Executive Summary

This paper presents empirical results obtained after carrying out a cross-sectional study, coordinated by the Eastern and Southern African Universities Research Programme (ESAURP), which broadly set out to explore the relationship between the introduction of cost sharing and the management, financing and delivery of primary health care services in public district hospitals in Tanzania. Particular reference, however, was heavily placed to outpatient services in public district hospitals in Morogoro and Tanga regions. The aim of this presentation, therefore, is to draw conclusions on:

a) The relationship between the management of outpatient services in public district hospitals before and after the introduction of cost sharing;

b) The relationship between the financing position of outpatient services in public district hospitals before and after the introduction of cost sharing;

c) The relationship between the delivery of outpatient services in public district hospitals before and after the introduction of cost sharing; and

d) Other factors than the introduction of cost sharing that affect outpatient services management, financing and delivery in public district hospitals.

Ultimately, the paper gives directions by recommending measures which can best address the identified problems of effective management, financing and delivery of outpatient services in public district hospitals in terms of equity and sustainability.

For the empirical results obtained to be clearly understood, the following were the essentials. Utilization of outpatient services (basic curative and preventive services) was the dependent variable. This was basically referred to as the annual total number of: outpatients made visits at each hospital consulted for basic curative services; homes delivered with health education; underfives whose growth rate was monitored using the growth chart; and pregnant women received antenatal care during pregnancy. As such, the level of utilization per hospital before and after the introduction of cost sharing in public district hospitals was determined by analyzing the hospital performance data collected using the Health Facility Questionnaire. Explanatory variables, on the other hand,

comprised affordability, quality, access and equity variables plus individual and household characteristics. These were determined by analyzing outpatients and household heads data which was obtained using Outpatient and Household Head Questionnaires. For the study population sample to be representative two objective sampling methods were used. The stratified random sampling and the systematic sampling methods. The data obtained was analyzed using the SPSS package and descriptive statistical analysis. Summary sheets were used to analyze manually data obtained using open-ended questions. The SPSS package was also used to test the three hypotheses which were set to guide the study using a paired t-test. In this regard, however, a word of caution should be given. Since there was no any hospital that was able to provide information on contributions made by each source of funds for the two periods (1991/92 - 1992/93 and 1993/94 - 1994/95) the study could not determine in measurable terms the relationship between the financing position of outpatient services in public district hospitals before and after introduction of cost sharing. As a result, the second hypothesis was not tested using a paired t-test. Instead simple descriptive statistical analysis was made.

Test results for the first hypothesis which was set to determine the relationship between management of outpatient services in public district hospitals before and after the introduction of cost sharing reveal there was no significant difference. Hence the management of outpatient services in public district hospitals even after the introduction of cost sharing is not yet improved. This is because public hospitals as opposed to private hospitals lack autonomy which in turn can enable them to ensure, among other things, their charging system reflects both the buying prices per supply dispensed. There is also poor supervision over user fees collection and expenditure. In these hospitals there is inadequate supply of essential supplies e.g. drugs on a regular basis and their control. Poor staff salaries which do not take into account risks they are exposed to during work is another contributing factor. There is too much bribery in public district hospitals and some of the staff have bad attitude towards patients.

With the second hypothesis, although the results obtained seem to conclude that there has been a slight notable improvement in the financing position of outpatient services in public district hospitals, yet in practice this conclusion becomes questionable. This is because there is revenue

loss in public district hospitals due to automatic exemptions, the used rigid charging system and through poor supervision over user fees collection and expenditure. Also meagre budget is still allocated to public district hospitals.

Test results for the third hypothesis which was used to determine the relationship between the delivery of outpatient services in public district hospitals before and after the introduction of cost sharing reveal there was no significant difference. Hence the delivery of outpatient services in public district hospitals even after the introduction of cost sharing is not improved yet. This conclusion is justified by a fall by 5% of outpatients attendance for basic curative services in public district hospitals. But for preventive services which are entirely delivered free of charge to pregnant women and children under five years old in public hospitals there has been an increase in the annual total number of outpatients delivered with these services.

The fall of outpatients attendance for basic curative services in public district hospitals is associated with: lack of essential supplies and equipment and their control especially drugs; too much bribery in that 'no money no care'; unaffordable user fees and bad attitude towards patients among some staff.

Although the results obtained reveal that charged user fees are affordable, yet the average monthly income earned by outpatients and household heads interviewed makes this conclusion questionable. The quality of delivered outpatient services in public district hospitals has remained either constant or decreased. And with too much bribery in the midst of inadequate supply of essential supplies in public district hospitals, delivered outpatient services are both inaccessible and not equitable.

For the management, financing and delivery of outpatient services in public district hospitals to be effectively improved in terms of equity and sustainability:

- Public district hospitals should run themselves for more autonomy.
- There must be strict supervision over user fees collection and expenditure.

- Essential supplies and equipment should be in place on a regular basis and these should be properly controlled.
- Staff salaries should be increased taking into consideration risks they are exposed to during work.
- Dishonest staff should be fired immediately.
- Only caring staff should be appointed.
- Since chronic diseases are too expensive to treat, sufferers must contribute part of the total cost.
- The used charging system should reflect both the buying price(s) per supply dispensed and the type of disease attended.
- Number of outpatient services charged for should be increased.
- Budget allocated to public district hospitals should be increased.
- Exemptions should be granted on proven grounds.

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1. Background to The Study

1.1 The Problem:

As shown in Appendix A, the United Republic of Tanzania comprises of the Mainland and the two islands of Zanzibar and Pemba. It covers a total square of 945,000 Km. It is situated on the Eastern Coast of Africa. Administratively it is divided into 20 regions which are further subdivided into 106 districts. Its population in 1988 was 23.2 million with an annual growth rate of 2.8%. Hence its current population is estimated to be 27 million[1].

The country has a mixed economy with the agricultural sector playing the leading role in that the primary export commodities include coffee, sisal, cotton and diamonds. Since the country has a Gross National Product per head (GNP) of US $ 100.00 and an inflation rate of 30% the World Bank[2] has ranked Tanzania the second poorest country in the world.

Before independence, health services (mainly curative) were established in urban areas due to the colonial government attention to these areas. However, after independence in 1961, health service plans were considered to be an integral part of the overall national development plans. To this end, the first section on health was approved by the government during the First Five Year Plan (1964-1969). The goal of this section was to establish regional hospitals which had to provide specialist and surgical medical care in all regions although the emphasis was placed on improving hygiene, environmental sanitation and child nutrition[3].

The Second Five Year Plan, (1969-1974)[4] which was developed after the 1967 Arusha Declaration, put much emphasis on the self-reliance policy, equity and accessibility to various social services throughout the country. Due to this shift, the delivery of health services was geared to preventive services like elimination of the major infectious diseases e.g. leprosy. In order to realise this move the government during this plan period intended to construct 80 new health centres and 100

dispensaries per subsequent five year plan the target being one health centre per every 50,000 people and one dispensary for every 10,000 people by the year 1985.

The Third Five Year Plan (1976-1981)[5] on the other hand aimed at providing clean water and health services in urban and rural areas. These objectives were vital in implementing the primary health care (PHC) approach which was internationally declared in 1978 in Alma Alta. However, in Tanzania the approach had been adopted since 1972[6,7] due to the fact that the decentralisation of the government in 1972 and 1975 provided new opportunities to reach and involve the majority of the people in the country. It was during this plan period that the Ministry of Health (MOH) began to cooperate with other sectors in implementing PHC through Multisectoral PHC Committees. It was in 1983 that MOH issued guidelines on how to implement PHC.

Since the implementation of PHC programme is done by various sectors including regional and local governments, voluntary agencies, parastatals and the private sector, District PHC Committees are the ones responsible for preparing district health plans. The District Medical Officer (DMO) at this level is the PHC Manager responsible for the co-ordination and supervision of all health activities in the district assisted by the district health management team. He/she is also the warrant holder of the health fund. At the national level the PHC Steering Committee provides guidelines for PHC programmes implementation at all levels.

Following he adoption of the World Health Organisation Alma-Alta declaration of Health for All by the Year 2000, Tanzania witnessed a massive expansion of the public health sector particularly in peripheral areas (See Appendix B). Consequently, the number of such workers as Medical Assistants and Rural Medical Aides increased tenfold while the number of doctors increased three times[8]. With these developments in the health sector, over the years Tanzania was able to develop a strong and comprehensive health care delivery system going right to the village level. Village health services, dispensary services and rural health centres form the lowest levels of health care delivery at the village or peripheral level, whereas district hospitals form a very important element at the

district level in that they offer referral services to village health services and it is at this level that national policy on PHC is put into practice[9]. At regional level, regional hospitals form another element in the national health system offering similar services to those provided at the district level with additional specialised services. Referral/consultant hospitals and MOH form the highest level of hospital services at the central level. These facilities are meant to provide referral and specialised health care on a zonal basis throughout the country[10,11].

Alongside these public health services, PHC programmes have been operationalised through health services delivered by other approved bodies including voluntary agencies and religious organisations; parastatal organisations; private health care services and traditional healers[12].

As a result of these efforts, **health status indicators** had improved by early 1990 as revealed in Appendix C although the indicators are still similar to those in other poor countries. Life expectancy at birth was 54 years whereas the Infant Mortality Rate was 104 per 1000 live births and the Underfive Mortality Rate was 176 per 1000 [13]. Maternal Mortality Rate, on the other hand, ranges between 200 and 400 per 100,000 live births in different regions[14]. From the diagnosis of outpatient statistics reported by 20 districts in Tanzania mainland in 1995, top ten diseases making very significant contribution to the country mortality for all ages include: malaria; URTI; diarrhoeal diseases; eye infections; pneumonia; intestinal worms; skin infections; pregnancy-normal; minor surgery; and urinary tract infections in that order [15].

Also as revealed in Appendix D there has been a steady increase in the number of both outpatients and inpatients using available health care services between 1980 and 1994. While the number of outpatient attendances in public hospitals, rural health centres and dispensaries had increased by 44.6%, 36.5% and 66.4% respectively, inpatient attendances in public hospitals, rural health centres and dispensaries had increased by 38.9%, 50.6% and 49.0% respectively during this period.

As for the funding of the above mentioned health services, the following arrangements have been being used since independence[16-20]. The central government has been the main contributor of funds to the public health sector in two main ways. Through MOH, referral/consultant hospitals, medical schools, all MOH parastatals e.g. Tanzania Food and Nutrition Centre (TFNC) and designated hospitals owned by religious organisations have been being funded, whereas through the Prime Minister's Office (PMO), funds have been being made available for running regional and district hospitals: especially for their employees' salaries. Subventions have also been being offered through PMO to local councils for health centres' and dispensaries' personnel salaries. Local governments which normally get their funds from local taxes and subventions offered by the central government, have been providing funds to dispensaries and rural health centres for purchasing medicine and equipment, salaries, training and development of their employees, and construction and maintenance of these district hospitals.

Voluntary agencies and religious bodies form another source of funds required to run health care services particularly in rural areas. These organisations not only depend on subsidies they receive from the central government but they also obtain funds through user charges and their parent organisations overseas.

Funds also flow in through donors like the Danish International Development Agency (DANIDA), Swedish International Development Authority (SIDA), World Health Organisation (WHO), the United Nations Children's Fund (UNICEF) etc. In fact in early 1980s[21] donor funding was estimated to account for about 70% of the development budget. This contribution was primarily made in support of rural health services. Other ways used by donors include provision of funds in support of PHC programmes e.g. the Essential Drugs Programme (EDP), AIDS Control and Family Planning. They also provide experts, medical equipment and medicines. Contributions are also made by private employers, non-governmental organisations (NGOs), and some parastatals. For the period 1992/93 Tanzania's total health expenditure as a percent of the Gross domestic Product (GDP) was 8.5% of which 2.5% was contributed by the government, 2.7% was

contributed by donors whereas private sources contributed 3.3% [22]. However, with the poor economic performance which Tanzania experienced during 1980s there was a serious decline in social sector spending and in the living standards of its population. A number of factors contributed towards this situation. They included drought, war with Uganda in the late 1970s, the break-up of the then East African Community, increased price of oil and other imports, the steady decline of the Tanzanian Shilling against the US dollar, inflation, reduction in domestic production and the present economic recession.

In aftermath of this situation the recurrent cost needs of the extensive health infrastructure which had been established became increasingly difficult to be met owing to declining public expenditure on health. As a result operationalising the PHC strategy in Tanzania also became difficult in terms of coverage and equity; health resources; facilities and finances; and in terms of delivery of services[23]. Broadly speaking, these problems are of three kinds: managerial, financial and constraints associated with the delivery of available services.

In terms of management of PHC programmes, a number of constraints have been experienced. Multisectoral co-operation is still difficult to realise in that PHC Committees, where they are existing, tend to meet irregularly and committee members also are not fully aware of their roles in these committees. Inadequate resources including manpower and means of transport have limited efficient management of PHC programmes in several regions, districts and peripheral health services. The tendency of posting Maternal and Child Health Aids (MCHA) to hospitals or town councils have for instance, caused maldistribution of MCHA, whereas supervision of peripheral health services has also been limited due to lack of sufficient and reliable means of transport. The Expanded Programme for Immunisation (EPI) vehicles are the only available and reliable means for ferrying EPI and EDP supplies and for use by district Maternal and Child Health (MCH) Co-ordinators for supervision. In addition to these constraints, most DMO and their teams not only lack the skills they require in

maintaining the scarce resources and supplies at their disposal, but they also lack adequate information management skills they require in using locally generated health information for improved delivery of services. Besides that, due to structural problems DMO's power to hire and/or fire any staff and to have control over funds granted by the central government for running rural health services is limited. This latter constraint proceeds from the DMO's duality of responsibility to MOH and to the District Executive Director (DED). Although the DMO is the district PHC Manager responsible for the district hospital and rural health services, administratively the district hospital is under the central government, yet the rural health services are under the district councils. Consequently there has been lack of transparency, and the way information on financial flows and use are spread across many authorities and actors does not lend itself easily to control and accountability [24].

Financially, Tanzania used to provide to the people free health care in government run facilities and subsidised health care in district hospitals under voluntary organisations funded by the central government. This means that the funding of these services has been very much dependent on the budgetary allocation to the health sector from central government funds. Such resources are scarce and have been declining over the years as evidenced by the declining share of the government budget allocated to the health sector falling from 7.1% in 1976 to 3.7% in 1986/87[25]. There has also been a decline in the recurrent budget in real terms. In actual fact the real per capita government expenditure on health declined by 460% between 1978/79 and 1988/89. Of todate Tanzania is estimated to expend a total health expenditure of US $7.34 per capita yearly [26]. The financing of PHC programmes becomes even worse when inequity exists in resources allocation between interventions Tanzania like other countries in the Eastern African zone have health care budget weighted heavily to curative services overall accounting more than half of the total health spending. Whilst community interventions absorb 10.7%, preventive services account for 32.2%. The remaining 57.1% is received by curative interventions[26].

However an entire dependence on donor support by key PHC programmes threatens sustainability of established programmes in that once this support is withdrawn, the programmes are likely to collapse. Misuse of allocated funds at district level is another constraint that has been experienced. District councils instead of using full grants given by the central government as directed they tend to use allocated funds for other programmes than PHC programmes. As put by Mogedal, Steen and Mpelumbe [24], an extremely weak local financial base in Tanzania, makes the District Councils very dependent on transfer of central government resources and donor funds.

This financing position has had some serious implications for the whole health sector. The health system has been starved not only of the requisite number of trained health professionals, facilities and equipment but also of essential drugs coupled with rapidly disintegrating hospitals, rural health centres and dispensaries buildings. Another related consequence has been poor remuneration and lack of incentives for health professionals resulting in low morale and motivation.

Although there are some good examples of community involvement in the delivery of available PHC services e.g. in the Health, Sanitation and Water (HESAWA) a lot remains to be done in an effort to mobilise the general public to take informed health actions. Also owing to the dependence syndrome, individual donors' conditions tend to spark off the problem of verticality which hinders all efforts geared to integrating various PHC programmes initiatives. Hence there is unnecessary and uneconomic duplication of efforts and the waste of resources available[27].

In an effort to rectify this situation a number of steps have been taken and some are still underway. From the PHC stand point the plan was underway to launch a new PHC strategy in the early 1990s which would be based on: community involvement; intrasectoral collaborations; multisectoral collaboration; district health services; community-based health care and appropriate technology[27]. Also major reforms in the health sector were initiated in the early 1990s. Although the government was still strongly committed to its egalitarian role of delivering free equitable and accessible health

services it became aware of the need to effect change in financing public health services. As a result, a public/private mix in health care provision and financing was encouraged by lifting the ban on private practice in the delivery of health services. This new move as shown in Appendix E led to the rapid expansion of private district hospitals especially in urban areas.[28]. Another step has been the decision to abandon the policy of offering free health care at referral/consultant hospitals, regional hospitals and district hospitals by introducing cost sharing through user charges in public district hospitals in 1994 as part of the national programme to recover health sector costs[28]. Nevertheless for the delivery of health services in public district hospitals to guarantee equity exemptions were to be given to patients with AIDS, cancer, and inpatients suffering from mental illness, tuberculosis and leprosy. All preventive services are also exempted from paying user charges. Full exemption is also granted on grounds of poverty[29]. In this context, the main problem which this study sought to address was to provide a definite answer to the question: **"Does the introduction of cost sharing in public district hospitals in Tanzania affect the management, financing and delivery of primary health care services in these hospitals?"**

1.2 LITERATURE REVIEW

Although the adoption of PHC strategy since the late 1970s was received as a way forward to ensuring equity and guaranteeing sustainability of delivered health services particularly to those in greatest need, several studies in other countries have identified various problems which threaten to wipe out the remarkable achievements which were made during the first decade after PHC implementation. For the purpose of this study, we will address ourselves to managerial, financial and constraints related to health services utilization that proceed from implementing the policy of cost sharing in public hospitals in particular.

However an entire dependence on donor support by key PHC programmes threatens sustainability of established programmes in that once this support is withdrawn, the programmes are likely to collapse. Misuse of allocated funds at district level is another constraint that has been experienced. District councils instead of using full grants given by the central government as directed they tend to use allocated funds for other programmes than PHC programmes. As put by Mogedal, Steen and Mpelumbe [24], an extremely weak local financial base in Tanzania, makes the District Councils very dependent on transfer of central government resources and donor funds.

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Although there are some good examples of community involvement in the delivery of available PHC services e.g. in the Health, Sanitation and Water (HESAWA) a lot remains to be done in an effort to mobilise the general public to take informed health actions. Also owing to the dependence syndrome, individual donors' conditions tend to spark off the problem of verticality which hinders all efforts geared to integrating various PHC programmes initiatives. Hence there is unnecessary and uneconomic duplication of efforts and the waste of resources available[27].

In an effort to rectify this situation a number of steps have been taken and some are still underway. From the PHC stand point the plan was underway to launch a new PHC strategy in the early 1990s which would be based on: community involvement; intrasectoral collaborations; multisectoral collaboration; district health services; community-based health care and appropriate technology[27]. Also major reforms in the health sector were initiated in the early 1990s. Although the government was still strongly committed to its egalitarian role of delivering free equitable and accessible health

services it became aware of the need to effect change in financing public health services. As a result, a public/private mix in health care provision and financing was encouraged by lifting the ban on private practice in the delivery of health services. This new move as shown in Appendix E led to the rapid expansion of private district hospitals especially in urban areas.[28]. Another step has been the decision to abandon the policy of offering free health care at referral/consultant hospitals, regional hospitals and district hospitals by introducing cost sharing through user charges in public district hospitals in 1994 as part of the national programme to recover health sector costs[28]. Nevertheless for the delivery of health services in public district hospitals to guarantee equity exemptions were to be given to patients with AIDS, cancer, and inpatients suffering from mental illness, tuberculosis and leprosy. All preventive services are also exempted from paying user charges. Full exemption is also granted on grounds of poverty[29]. In this context, the main problem which this study sought to address was to provide a definite answer to the question: **"Does the introduction of cost sharing in public district hospitals in Tanzania affect the management, financing and delivery of primary health care services in these hospitals?"**

1.2 LITERATURE REVIEW

Although the adoption of PHC strategy since the late 1970s was received as a way forward to ensuring equity and guaranteeing sustainability of delivered health services particularly to those in greatest need, several studies in other countries have identified various problems which threaten to wipe out the remarkable achievements which were made during the first decade after PHC implementation. For the purpose of this study, we will address ourselves to managerial, financial and constraints related to health services utilization that proceed from implementing the policy of cost sharing in public hospitals in particular.

1.2.1 Management constraints associated with cost sharing implementation

Effectiveness of exemptions and revenue use to benefit the poor relies heavily on good administrative practice, but in reality administrative failure is common[30]. Poor management has led to:

- lack of guidance on how to determine who is eligible for exemptions, deterring their consistent administration[31];
- failure to monitor and adjust exemption practice over time e.g. in Zimbabwe households earning cash incomes of less than Z$ 150 per month were exempted from paying fees in 1980 but inflation caused the number of people who qualified for exemption to fall sharply over the following decade, and by the end of the decade fewer than 5% of non-agricultural and domestic workers qualified[32];
- contradictory practice undermining the use of exemptions e.g. at St. Lucia, free care can be obtained at hospital level both with and without formal exemption[33];
- limited effectiveness in collecting fee revenue which undermines its use for service improvements, e.g. in Papua New Guinea the proportion of estimated revenue actually collected ranged from 14 to 88% between district hospitals[34];
- reversion of revenue to the central level, undermining both the incentives to collect it and its use for coverage and quality improvements[35];
- inappropriate use of revenue collected, e.g. in Ghana half the revenue collected accrues to the national Treasury and it is not clear how the revenue is used. The revenue sent to MOH was found to remain unused in non-interest bearing accounts, and although 25% is retained at point of use, "there was considerable reluctance at health centres and health posts to spend their percentage of the fees revenue"[36];
- uneven implementation of cost recovery policies between areas, with consequences for inter-area equity, e.g. not all district hospitals exempt the poor in Papua New Guinea[37];

- the potential or actual breakdown of policy implementation e.g. in the Dominican republic two contradictory laws are in force and so the policy's legality is dubious[38], whereas in Kenya, problems in implementation resulting from weak guidelines led to the suspension of outpatient fees[39].

A common response to these problems is an emphasis on the need to enhance management skills and capacities. But from experience with water programmes in Kenya, Yacob[40] argues that cost recovery requires a focus on capacity building in terms of the development of institutions, skills and abilities to sustain a community project and to manage fees competently. The World Bank on the other hand stresses the potential of decentralisation in addressing management problems[41;42].

However, health sector experience suggests that decentralisation is not a panacea for existing administrative weaknesses. Experience has shown in Zimbabwe, for instance, that decentralised screening procedures, in which revenue clerks decide whom to exempt, have been criticised in that the broader context of revenue collection and revenue-use decisions is very centralised. Thus the clerk "exercises considerable power but not accountability"[43].

Basic skills and motivational problems must also be addressed before initiating decentralised screening if it is to be effective. Common weaknesses include poor planning, weak financial management, and infrequent and ineffective supervision[44-46]. Community financing experience illustrates these problems. Although community groups have been involved in fee-related decision making and financial management, they have suffered both from too little support in terms of training, supervision, materials and supplies, undermining community motivation, whereas too much support "threatens to stifle community initiative"[47].

Experience has also shown that decentralisation is itself fraught with problems. It may generate inequities by undermining the power of the centre to re-distribute resources from more to less wealthy

areas[48]. Yet central resource re-allocation is likely to be particularly important where fee systems are introduced which allow revenue to be retained at the local level, and so exacerbate differences in resource availability between areas. Failure to achieve a balance of power between central and local levels may, therefore, undermine effective management within decentralised systems[49].

Other problems which can arise include: lack of political support; inadequate resource availability at national and local levels; insufficient administrative capacity to design and implement decentralised management; cultural traditions which favour hierarchical decision making; and limited participation in decision making outside the health sector[50-52].

An underlying problem though is that decentralisation requires a redistribution of power and control of finances away from the vested interests placed at the central level, and so may be blocked by central level bureaucrats as has been the case in Tanzania[53] and in Papua New Guinea[54].

In this context it is indicated that the institutional and management context of a country and its health sector should be considered in policy development so as to ensure that administrative procedures do not become a source of targeting error[55].

1.2.2 Financial Constraints Associated with Cost Sharing Implementation

Revenue use benefiting the poor will only be possible within cost recovery policies if the revenue raised through user charges is sufficient to remedy the existing quality and coverage weaknesses of the health system. However, data from national cost recovery schemes from 21 different countries[56] suggest that a recovery rate of about 5% of total government health sector recurrent expenditure, gross of administrative costs, is a reasonable expectation.

Cost recovery rates are constrained by low fee levels necessary in a context of low household income and limited risk-sharing capacity or mechanisms. They will also be undermined by the additional costs of exempting especially the revenue lost by reducing the pool of those required to pay[57]. In Ghana experience, the cost of the free care dispensed at primary district hospitals to health staff and their families (one eligible group) was estimated to represent 0-35% of the revenue collected at each facility the mean being 13%[58]. These costs will be particularly high in less wealthy areas where a greater proportion of the population will require exemption. Able to generate even less revenue than elsewhere, these areas will require additional resource allocations from the centre to protect the quality of available services[59].

The World Bank[60] has suggested that the needs of the poor go beyond strengthening existing services and require the provision of a minimum package of public health and "clinical interventions" at primary and secondary facilities. These interventions have been selected because they are highly cost-effective, and have the potential to generate the greatest savings in terms of "disability adjusted life years". The package is estimated to cost US$ 12 per head in a low income country. Political obstacles, however, seem likely to undermine the resource reallocations proposed as an alternative source of funds for this minimum package.

1.2.3 Available Options for Sources of Finance

As summarised in Appendix F, different options of generating the required revenue for funding health care services have been tried out[61]. In Sub-Saharan Africa[62], user fees are emphasised because out-of-pocket expenditures for health account for nearly one half of total expenditures. In the past, user fees have been viewed simply as a way of raising money for governments, without improving health systems in the process. Such an approach, however, could lead to the exclusion of the poor from access to health care. Hence the need to rethink user fees policies in view of having them designed to improve both quality and equity in the delivery of health care.

Self-financing health insurance is also emphasised in that this type of insurance enables many people to pool their resources to provide coverage for catastrophic illness or injury. In the past, positive aspects of this option in Sub-Saharan Africa have been overlooked and underestimated. Nevertheless the potential for self-financing insurance programmes is critical because they offer an alternative to tax-based publicly funded health care systems and because they can foster private sector development and can help free up governments funds that are currently allocated disproportionately to hospitals. In the process, this option can facilitate greater funds for public goods and services, as well as through subsidies targeted to the poor.

Broadly though, WHO[63] identifies four principal sources of finance for the health sector:

- **government financing** which includes health expenditure at all levels of government, together with the expenditure of public corporations. Hence certain services, especially those with public-good characteristics e.g. provision of safe water and sanitation and some preventive measures for infectious and parasitic diseases should be seen as core responsibilities of government and be government-financed;

- **private financing** for health care can either be direct or indirect. Direct payment includes: personal payments made directly to a wide range of providers including private practitioners, traditional healers and private pharmacists. In this context, user fees, whether for government-provided or for privately-provided health services, are an out-of-pocket payment and are therefore considered as health finance from a private source. Similarly, charges, contributions or prepayments by members of community financing schemes are also considered as coming from private (non-government) sources. Indirect payment comprises payments for health care services by employers e.g. payment by large and privately owned industrial complexes in developing countries or sharing of health care costs by employers in industrialised countries and health financing by NGOs e.g. local charity fund-raising for health care;

- **health insurance** is a mixed source of finance as it often draws contributions from both employers and employees and sometimes from government. Contributions to such schemes are often mandatory. They comprise: government or social insurance which provide compulsory or, to a lesser extent, voluntary coverage for people employed in the formal sector. Premiums or contributions are generally based on the individual's income, regardless of actuarial risk.

  Private insurance forms the second type of insurance. This type of insurance provides coverage for groups or individuals through third-party payer institutions operating in the private sector. This option is generally not income-related and varies with age and sex.

  Employer-based insurance is the third type. This insurance refers to coverage falling between the other two types, in which employers or parastatal or private bodies serve as the third-party payer or collection agent. Eligibility in this insurance is based on employment status. Hence those schemes are often required by national labour codes;

- **external sources** have also become important as financing agents especially in certain developing countries where governments have been unable to meet their health needs and commitments from internal sources. These comprise multilateral and bilateral aid donors and, to a lesser extent, NGOs.

Experience with **user fees** suggest that they lead to greater use of health services where there is: increased availability of essential supplies at the health facility level; greater accountability of the provider to the population; higher perceived quality; a phased-in rather than sudden increase in fees; local management of resources; and competitiveness with services with other providers[64]. Hence before any policy change, governments should not only assess the likely revenue potential of fee changes, but also carefully review the possible negative effects e.g. that different strategies will be

appropriate for different types of service; that there is a difference between nominal charges designed to deter unnecessary use of services and more substantial user fees designed to recover the cost of the service; and that policies on charges for public services should take into account the opportunities the user may have of opting for the private sector instead[65].

1.2.4 Determinants of Health Care Services Utilisation

The effect of cost sharing on utilisation of health care services have been considered by several studies. Although their study findings seem contradictory, they permit sharper insights into determinants of health care services utilisation patterns. According to Shaw and Griffin[66] the studies may be classified as follows: studies making use of time-series data on health facility utilisation rates before and after introduction of user fees; studies using multivariate statistical analysis of cross-sectional household data to separate out the effects of price and distance on utilisation and also to control selected personal characteristics of users; studies using multivariate statistical analysis of cross-sectional household data and facility characteristics as a determinant of utilisation; and studies which involve real-world experience as well as the scientific imperative of a control group. So far multivariate analysis reveals that many factors aside from price, including distance to district hospitals, personal characteristics, and the quality of care, play an important role in deciding which type of health care services to use.

1.2.5 Limitations of Previous Studies

Although a preliminary survey of the literature indicated that a number of studies have dealt with the effects of cost sharing on management, financing, available options for sources of finance and determinants of utilisation of health services, no study had been able to provide an answer to the question:

"Has the introduction of cost sharing in public district hospitals in Tanzania affected the management, financing and delivery of primary health care services in these district hospitals?"

Besides that, most of these studies had varied in terms of purposes, research methods, complexity of variables explored, study focus as well as models adopted in data analysis and interpretation of results. It was in the light of this background that the present study intended to achieve in the context of Tanzania objectives outlined below:

1.3 Research Hypothesis

In the light of related literature reviewed, the following were the hypotheses for this study:

- There would be no significant difference between the management of outpatient services in public district hospitals in Tanzania before and after the introduction of cost sharing.
- There would be no significant difference between the financing position of outpatient services in public district hospitals in Tanzania before and after introduction of cost sharing.
- There would be no significant difference between the delivery of outpatient services in public district hospitals in Tanzaniabefore and after the introduction of cost sharing.

1.4 Justification of the Study

This study was justifiable on the grounds that:

- It was timely in that, despite the economic hardships that Tanzania is going through, a number of donor agencies had recently threatened to withdraw their development aids to the country [67,68]. Hence an immediate need to look for dependable ways which could ensure sustainable funding and delivery of PHC services in future.

- It was a response to one of the further research needs which were recommended by a Report of a WHO Study Group[69].
- It was also hoped that the study would provide relevant data which would in turn be used by decision makers in PHC services delivery process at all levels in course of implementing the ongoing Health Sector Reform.
- Lastly, it was the conviction of the researchers that this study would stimulate other researchers to explore further the problem from different angles for an improved PHC strategy in this country.

1.5 Research Objectives

1.5.1 General Objective

Broadly the study set out to explore the relationship between the introduction of cost sharing and the management, financing and delivery of outpatient services in public district hospitals in Tanzania.

1.5.2 Specific Objectives

Specifically though the study set out:

- To determine the relationship between the introduction of cost sharing in public district hospitals and their management of outpatient services.
- To determine the relationship between the introduction of cost sharing in public district hospitals and the financing of outpatient services in these hospitals.
- To determine the relationship between the introduction of cost sharing in public district hospitals and their delivery of outpatient services.

- To investigate other factors which might be affecting the management, financing and delivery of outpatient services in these public district hospitals.
- To identify measures which can best address the problems of effective management, financing and delivery of outpatient services in these public district hospitals in terms of equity and sustainability.

1.6 Definition of Terms

For the purpose of this study, the following terms need clarification on how they were used.

1.6.1 Accessibility

This term was used to refer to possibilities of any outpatient to use essential sought care including those who might be unable to pay in that people cannot access the sought care because of a variety of factors including an individual's poverty; his/her geographical location, age or sex; and unavailability of services.

1.6.2 Affordability

This term was used to denote the level at which the outpatient was able to part with the charged fee in order to obtain an essential sought care at a given visit made for basic curative service without serious loss.

1.6.3 Cost Sharing

In Tanzania context, this term was used to refer to a system of paying for care where the patient is required to pay a proportion of the actual cost of the delivered care while the remaining proportion is met by a third party e.g. the government through tax-revenues.

This system began to be implemented in public hospitals in July 1993. Its implementation was done in phases by level and type of services delivered as revealed in Appendix G. Phase 1 which comprised public referral, regional and district hospitals which had Grade I and II facilities began on the 1st of July 1993. During this phase, user fees for Grade I and II services were increased. Phase 2 began on the 1st of January, 1994 comprising public referral and regional hospitals. During this phase Grade III services were charged user fees. Phase 3 which began on the 1st of July, 1994 comprised public district hospitals. It was during this phase that user fees for Grade III outpatient services were introduced. The last phase which is not yet implemented will involve introduction of user fees in public health centres and dispensaries [70]. This system broadly aims:

(a) To generate additional revenues for covering costs of providing care services.
(b) To improve the quality of delivered care services in public hospitals.

1.6.4 Delivery of Outpatient Services

The term was basically used to denote delivery of basic curative and selected preventive services to outpatients between 1992 and 1995.

1.6.5 Equity

In the context of health care delivery, this notion was used to denote that all outpatients (able and unable to pay) gain equal access to sought care.

1.6.6. Financing of Outpatient Services

This notion, on the other hand, was used to refer to the trend of funding of outpatient services in public district hospitals between 1991/92 and 1994/95 financial years.

1.6.7 Health Professionals

These were selected professionals who for the purpose of this study could answer questions on the management of cost sharing implementation and delivery of outpatient services, the funding of outpatient services, medical records, and MCH services. In this context, from each public district hospital visited, professionals interviewed included: the DMO or his representative; the Hospital Health Secretary or a Health Administrator; the Hospital Accountant; the Medical Records Officer; and the MCH - Coordinator or her representive.

1.6.8 Management of Outpatient Services

Basically this term was used to refer to the management of cost sharing implementation process in course of delivering basic curative and the selected preventive services to outpatients in public district hospitals.

1.6.9 Outpatient Services

These were basic curative and the following selected preventive services (Health Education, Underfives Growth Rate Monitoring, and Antenatal Care).

1.6.10 Primary Health Care Services (PHC)

According to the WHO [71] PHC is essential health care made accessible at a cost the country and community can afford with methods that are practical, scientifically sound and socially acceptable. Every one in the community must have access to it, and everyone should be involved in it. In addition to the health sector, related sectors should also be involved.

At the very least, PHC should include education of the community on the health problems prevalent and on methods of preventing health problems from arising or of controlling them; the promotion of adequate supplies of food and of proper nutrition; sufficient safe water and basic sanitation; maternal and child health care including family planning; the prevention and control of locally endemic diseases, immunization against the main infectious diseases; appropriate treatment of common diseases and injuries; and the provision of essential drugs.

PHC is the central function and the main focus of a country's health system, the principal vehicle for the delivery of health care system stretching from the periphery to the centre, and an integral part of the social and economic development of a country.

In Tanzania context, PHC Implementation Guidelines were formulated in 1983[72]. A PHC Steering Committee was thereafter formed to oversee their implementation. PHC

committees at national, regioal, district and village levels were also formulated in order to facilitate decision making, implementation and monitoring of PHC activities. In 1992, these guidelines were reviewed and in their stead the PHC Strategy was formulated in order to motivate and sensitise communities towards multisectoral approaches to health care. However since from January 1996 the MOH has charged the PHC Secretariat with the responsibility of coordinating the implementation of the ongoing Health Sector Reform, the Secretariat is likely to be reorganised in the near future. The reorganisation will be in terms of its organisation, structure, functions, roles and responsibilites.

Nevertheless for the puprose of the present study, PHC has been particularly used to refer to outpatient services delivered in public district hospitals in Morogoro and Tanga regions between 1992 and 1995.

1.6.11 The period After the Introduction of Cost Sharing in Public District Hospitals

This is the period between 1993/94 and 1994/95.

1.6.12 The Period Before the Introduction of Cost Sharing in Public District Hospitals

This is the period between 1991/92 and 1992/93.

1.7 Limitation of the Study

Due to limited funds which were available for the study and the time factor only 10% of the 20 regions in Tanzania Mainland were involved in the study. Also because the data collection was done during harvest season, the turn up of household heads was poor especially in Morogoro. Since no hospital was able to provide information on contributions made by each source of funds

for the two periods (1991/92-1992/93 and 1993/94 - 1994/95) the study could not determine in measurable terms the relationship between the financing position of outpatient services in public district hospitals before and after the introduction of cost sharing.

2. The Study Methodology

2.1 The Methods

2.1.1 For the study to determine the relationship between the management of outpatient services in public district hospitals in Tanzania before and after the introduction of cost sharing, hospital performance data was collected on cost sharing implementation management and outpatient services management during health facility survey.

From each public hospital, the Hospital Health Services Secretary or a Health Administrator was consulted to answer questions primarily set on cost sharing implementation management. The questions raised in this regard sought for information on:

a) Whether there were prior preparations before introducing cost sharing in public district hospitals;

b) Who decided on the currently used user fees structure;

c) Whether user fees in public district hospitals were fixed or not;

d) Who has the right to revise these rates, if they were fixed;

e) Which outpatient services are delivered;

f) Which services among these outpatient services were charged for and how much was the charge per services;

g) Whether outpatient services were allocated any share from revenues generated through user fees;

h) Which other sources of funds were used to finance these services, if they were not allocated any share;

i) Whether the hospital had an instance when an outpatient was unable to pay for the sought care;

j) Which corrective measure(s) were taken where the hospital experienced such an instance;

k) Whether the granted exemption affects the type of care sought by the outpatient exempted from paying the user fees he/she was owed;

l) Which changes should be made in order to improve the existing exemption mechanism;

m) How the quality of outpatient services was compared in 1996 and before 1994 given the then cost sharing implementation management trend;

n) Which indicators were used to measure the noted improvement in case the quality was viewed to have had improved;

o) Which were the contributing factors if the quality was either viewed to have had remained constant or to have had decreased;

p) Which measures should be taken to solve each factor.

For questions focusing on outpatient services management, the DMO or his representative was consulted at each public hospital in order to seek for data on:

a) Number of staff by category;

b) The annual staffing position before and after 1994;

c) Whether staff were satisfied with their work schedule;

d) Which were the contributing factors, if they were not satisfied;

e) Which corrective measure(s) should be taken per each factor in order to improve the situation;

f) The physical facilities position before and after 1994 by type;

g) Whether outpatients bought prescribed drugs from within the respective hospital;

h) Where do they purchase prescribed drugs if they were not bought from within;

i) How the management of outpatient services was compared before and after 1994;

j) Which indicator(s) were used to measure improvement in case the management of outpatient services was perceived to have had improved;

k) Which were the contributing factors if the management of outpatient services was either perceived to have had remained constant or to have had decreased;

l) Which measure(s) should be taken to solve each factor.

2.1.2 For the study to determine the relationship between the financing position of outpatient services in public district hospitals before and after the introduction of cost sharing, hospital performance information was collected from the Hospital Accountant during health facility survey on:

a) Sources of finance used to fund outpatient services;

b) The share contributed by each source between 1991/92 and 1994/95;

c) How the financing position of outpatient services was compared before and after the introduction of cost sharing;

d) Which indicator(s) were used to measure noted improvement in case the financing position of outpatient services was perceived to have had improved;

e) Which were the contributing factors if the financing position of outpatient services was either viewed to have had remained constant or to have had decreased;

f) Which measures should be taken to solve each factor.

2.1.3 For the study to determine the relationship between the delivery of outpatient services in public district hospitals before and after the introduction of cost sharing hospital performance data was collected during health facility survey on: the annual total number of outpatients made visits at each hospital for basic curative services; homes delivered

with health education, underfives whose growth rates was monitored using growth chart; and pregnant women received antenatal care during pregnancy. These latter outpatient services are preventive. From each public hospital, the Hospital Medical Records Officer was consulted for the annual total number of outpatients made visits for basic curative services between 1992 and 1995. Whereas for the annual total number of: homes delivered with health education, underfives whose growth rate was monitored using growth chart and pregnant women received antenatal care during pregnancy was obtained from the MCH Co-ordinator.

Five questions which were set for the Hospital Medical Records Officer sought for information on:

a) The annual outpatients attendance by sex between 1992 and 1995;
b) How was the delivery of curative services compared before and after 1994;
c) Which indicator(s) were used to measure the noted improvement in case the delivery of curative services was viewed to have had improved;
d) Which were the contributing factors if the delivery of curative services was either viewed to have had remained constant or to have had decreased;
e) Which measures should be taken to solve each factor.

For the MCH Co-ordinator, on the other hand, seven questions were set in order to obtain data on:

a) The annual number of homes delivered with health education between 1992 and 1995;
b) The annual number of underfives whose growth rate was monitored using growth chart between 1992 and 1995;
c) The annual number of pregnant women received antenatal care during pregnancy between 1992 and 1995;

d) How was the delivery of these preventive services compared before and after 1994;

e) Which indicator(s) were used to measure the noted improvement in case the delivery of these services was perceived to have had improved;

f) Which were the contributing factors if the delivery of these preventive services was either viewed to have had remained constant or to have had decreased;

g) Which measures should be taken to solve each factor.

2.1.4 For the study to investigate extra factors which might be affecting the management, financing and delivery of outpatient services in public district hospitals, the data was collected on other contributing factors from outpatients and household heads, during outpatient and household surveys.

2.1.5 For the study to identify appropriate measures which can best address the problems of effective management, financing and delivery of outpatient services in public district hospitals in terms of equity and sustainability, opinions were sought from the health professionals, outpatients and household heads on which corrective measure(s) should be taken to solve each contributory factor mentioned during health facility, outpatient and household surveys.

2.1.6 Lastly, for the study to verify some of the hospital performance data on: cost sharing implementation management; outpatient services management; and delivery of both basic curative services and preventive services, outpatients and household heads were consulted during outpatient and household surveys.

2.2 Research Tools

2.2.1 For the study to collect information on cost sharing implementation management and outpatient services management parts II and III of the Health Facility Questionnaire, were

used. Each of the two parts contained open and closed- ended questions (see Appendix H). However, it should be noted that this information was collected for two periods (two years before the introduction of cost sharing in public district hospitals that is 1992-1993 and two years after the introduction of cost sharing in these hospitals that is 1994-1995).

2.2.2 For the study to collect data on the trend of financing position of outpatient services for the two periods part IV of the Health Facility Questionnaire was used (see Appendix H).

2.2.3 For the study to obtain data on the trend of the delivery of outpatient services (basic curative and preventive) for the two periods, part V of the Health Facility Questionnaire was used (See appendix H).

2.2.4 For the study to collect information on extra factors which might be affecting the management, financing and delivery of outpatient services in public district hospitals and appropriate measures which can best address the problems of effective management, financing and delivery of outpatient services in these hospitals in terms of equity and sustainability, a set of three questionnaires was used. They included the Health Facility Questionnaire, the Outpatient Questionnaire (see Appendix I), and the Household Head Questionnaire (see Appendix J). In order to ensure standardization, both the outpatient and the household head questionnaires were translated into Kiswahili the national language in Tanzania.

2.2.5 For the study to supplement the data obtained using other tools:

a) It reviewed published and unpublished documents.

2.3 The Sampling

For the study population sample to be representative two objective sampling techniques were used.

2.3.1 The stratified random sampling was used to select:

a) Four public district hospitals consulted and four control hospitals.

From each region the list of all hospitals by ownership was obtained from the respective Regional Medical Officer. As shown in Appendix K, from each region the first public district hospital was the one which collected the highest amount through cost sharing in 1994. Whereas the second public district hospital was the one which collected the lowest amount through cost sharing in 1994. One private or voluntary hospital in the proximity of each of the two selected public district hospitals was also randomly included in the study as a control hospital. Hence a total of 8 hospitals. This sample was representative mainly on two grounds. The two regions have an average number of public district hospitals exclusive of district designated hospitals. Ecologically, the two regions have an ecology which covers all zones in Tanzania.

b) The following health professionals from each hospital consulted: DMO or his representative; MCH Co-ordinator or her representative; Hospital Health Services Secretary or a Health Administrator; Hospital Accountant; and the Hospital Medical Records Officer. These professionals were interviewed during health facility survey in order to collect data on: cost sharing implementation management; outpatient services financing; basic curative services delivery; and preventive services delivery. Hence a total of 40 health professionals were interviewed in 8 hospitals. It must be noted that given the focus of this study only five health professionals were consulted from each hospital visited owing to the role each professional was playing in cost sharing implementation . As such, this sample was representative.

c) The nearest village to each hospital consulted for household survey.

2.3.2 The systematic sampling method, on the other hand, was used to select:

a) 30 outpatients (15 being male patients aged 18+ years old and the remaining 15 being female patients aged 18+ years old) from each hospital consulted for exit interviews. For each sex, every third patient was interviewed until the required number was attained. This age group was chosen on the following grounds: in Tanzania, adulthood is legally marked by this age; and adults can decide where to seek for care and in most cases they pay for it themselves. Hence a total of 240 outpatients were interviewed in 8 hospitals.

This sample was representative in that in the light of the annual outpatients attendance during 1995:

a) 30 outpatients was 100.17% of the daily outpatients attendance of 29.95 during 1995 for Kilosa public district hospital;

b) 30 outpatients was assumed to be the average daily outpatients attendance for Usagara Private dispensary which was opened in early 1996;

c) 30 outpatients was 24.87% of the daily outpatients attendance of 120.64 during 1995 for Ulanga public district hospital;

d) 30 outpatients was 135.69% of the daily outpatients attendance of 22.11 during 1995 for Kwiro Mission dispensary;

e) 30 outpatients was 35.5% of the daily outpatients attendance of 84.37 during 1995 for Handeni public district hospital;

f) 30 outpatients was 14.97% of the daily outpatients attendance of 200.43 during 1995 for St. Francis Mission hospital Kwamkono;

g) 30 outpatients was 737.10% of the daily outpatients attendance of 4.07 during 1995 for Korogwe public district hospital; and

h) 30 outpatients was 20.91% of the daily outpatients attendance of 143.45 during 1995 for St. Raphael's Mission hospital.

b) 30 household heads from each nearest village to the hospital consulted. However since the nearest village to Kilosa district hospital was also the nearest village to the private dispensary visited and since in Ulanga district, household heads in this district from the nearest village to the public district hospital could not turn up for the interview, a total of 180 household heads were interviewed during household surveys. Every third household head was included in the study until the required number was reached per village. This sample was also representative in that this study has used the upper bound of 30 household heads per village while several surveys in Tanzania including agricultural, income and expenditure, demographic, health and social surveys use between 15 and 30 households per village.

2.4 Data Collection and Analysis

2.4.1 Data Collection

A cross-sectional study was conducted in Morogoro and Tanga regions between 5th June and 12th July, 1996. There were three determining factors for selection of this study area. Given the time and seasonal factors the two regions would be more accessible to the study team. The district level, on the other hand, was given much focus by this study in that. "It is at this level of the health services that the national policy on PHC is put into practice" [73]. Lastly, in Tanzania context, the study would not go beyond this level because the introduction of cost sharing policy, which was introduced in three phases in the public health sector since 1993/1994 financial year, was not yet introduced beyond district and district designated hospitals [74].

2.4.1.1 In order to validate the research tools which were used in data collection drafts were pre-tested at Morogoro Regional Hospital in Morogoro so as to spot in

advance causes of difficulties which might arise during data collection. This hospital was preferred because it serves as both a district and a regional hospital.

2.4.1.2 The three sets of questionnaire were administered by researchers in collaboration with two research assistants during health facility, outpatient and household surveys.

2.4.2 Data Analysis

For the purpose of this study, the following were the essentials to understanding empirical results obtained. Utilisation of outpatient services (basic curative and preventive) was the dependent variable which in this study was referred to as the annual total number of: outpatients made visits at each hospital consulted for basic curative services; homes delivered with health education, underfives whose growth rate was monitred using growth chart; and pregnant women received antenatal care during pregnancy. Hence the level of utilisation per hospital (public and private) before and after the introduction of cost sharing in public district hospitals was determined by analysing hospital performance data. Explanatory variables, on one hand, comprised affordability, quality, access, and equity variables. Whereas, on the other hand, they consisted individual and household characteristics. These were determined by analysing outpatients and household heads data.

Data entry in computer was done using the SPSS statistical package using a fixed field format. Questionnaires from different hospitals were summarised and given serial numbers. All questions were coded prior to data entry in the computer. Data from each survey was entered separately. In order to validate data entry, checking for consistency and for unwanted entries was done. Frequency print out for

different questions was also done. If there was any missing information or unwanted entries, a search for questionnaire(s) using serial number(s) was done and the information was verified by cross checking the actual questionnaire(s). The data obtained was subsequently analysed using the SPSS package and descriptive statistical analysis. For data obtained using open-ended questions, summary sheets were used to analyse it manually. In order to accept or reject the research hypothesis, a paired t-test was performed on selected aspects of outpatient services management and delivery using the SPSS package.

3. The Study Results

3.1 The Relationship Between the Management of Outpatient Services in Public District Hospitals Before and After the Introduction of Cost Sharing

3.1.1 Cost Sharing Implementation Management

100% of 4 health professionals interviewed in public hospitals on whether there were prior preparations before introducing cost sharing in public district hospitals confirm there were preparations in advance. With the question on who decided on the currently used user fees structure, again 100% of 4 health professionals interviewed in public hospitals in this regard confirmed it was the MOH.

The question as whether user fees in public district hospitals are fixed or not, 100% of 4 health professionals interviewed in public hospitals confirmed user fees per service charged for have been fixed since the introduction of cost sharing in 1994. Whereas 66.7% of 3 health professionals responded to this question in private hospitals show that user fees in private hospitals fluctuate.

In order to establish who has the right in public district hospitals to revise these rates, findings reveal that it is the MOH which has the right. This was confirmed by 75% of 4 health professionals interviewed in this regard. On the contrary the findings reveal that the charging system in private hospitals is flexible enough to allow respective hospitals to revise used rates in order to meet their local needs. This finding is confirmed by 100% of 4 health professionals interviewed in private hospitals.

In both types of hospitals findings reveal there are basically two types of outpatient services. Basic curative and preventive services. However, not all basic curative services are charged for by both types of hospitals. Hence as shown in Table 1 below, while both types of hospitals charge for medication, medical examination on special request, consultation, and laboratory investigation, yet their user fees differ.

Table 1: Services Charges in US $ by Type of Hospital

Services	Public Charges	Private Charges
Medication fee	0.09	0.17-0.34
Student medical examination fee	0.86	-
Civil servant medical examination fee	2.59	-
Medical examination fee on special request	2.59	0.17
Medical examination fee on compensation	5.17	-
Medical examination fee for Medical Board consideration	17.24	-
Grade I and II consultation fee	0.34	0.34
Grade III consultation fee	0.17- 0.25	0.34
Laboratory investigation fee	0.17	0.17-1.72
Optical examination fee	2.59	-

Source: Data obtained using the Health Facility Questionnaire

Note: Exchange rate used was 580TShs. per US $

With preventive services, the findings reveal that while in public hospitals their delivery is entirely free of charge to pregnant women and children under five years old, in private hospitals some of preventive services are charged for lower rates depending on the age and the level of the care. Children under five years old, for example, pay fee ranging from 50% to 75% of the adult fees in order to recover some care expenses.

With regard to whether outpatient services are allocated any share from revenues generated through user fees, the results show that in practice there is no demarcation between basic curative and preventive services. The line items which have been benefiting from collected revenues in both types of hospitals include: staff salaries, essential supplies and equipment, renovation of hospital buildings and running costs. In order to finance outpatient services, findings reveal there are four main sources of funds used including: donations; user fees in public hospitals or hospital fees in private hospitals; warrants of funds from the central government and grants for hospitals with aided staff.

100% of 4 health professionals interviewed in private hospitals visited confirm they had experienced several cases where outpatients were unable to pay for the sought care. Whereas 50% of the 4 health professionals interviewed in public hospitals confirm they had only experienced a few instances. In response to outpatients who were unable to pay for the sought care, the results obtained from the same respondents in both types of hospitals reveal that such outpatients are normally exempted from paying the fee they are owed.

The exemption scheme, however, is practiced differently by the two types of hospitals. Findings show that while public hospitals automatically grant exemptions on two main grounds (type of disease and one's poverty level), in private hospitals one is granted exemption either upon provision of a dependable proof of inability to pay or on meeting agreed condition(s) e.g. one can be attended on credit.

The question on whether the granted exemption affects the type of care sought by the outpatient exempted from paying the user/hospital fee he/she was owed, the results reveal that in both types of hospitals once the exemption has been granted it does not affect at all the type of care delivered to the recipient.

For the existing exemption mechanism to be improved in public districts hospitals, 100% of 4 health professionals interviewed in public hospitals, suggest that instead of automatic exemptions, they should be granted on proven grounds. For example, the community from which the exemption applicant comes should be involved in proving one's inability to pay for the sought care. Also the results suggest that since chronic diseases are too expensive to treat, sufferers should contribute part of the total cost.

Given the current trend in cost sharing implementation management in public district hospitals, the findings obtained from 100% of 4 health professionals interviewed reveal that the quality of outpatient services in these hospitals has remained constant as before the introduction of cost sharing. Whereas 100% of 4 health professionals interviewed in private hospitals acknowledges there has been a very remarkable improvement in the quality of their services after the introduction of cost sharing in public district hospitals.

According to findings obtained from 75% of health professionals interviewed in public hospitals, the quality of outpatient services in these hospitals has remained constant as before the introduction of cost sharing due to the following factors:

a) Public hospitals have no right to revise fixed user fees by the MOH. As a result, the charging system in these hospitals is not only rigid, but also it does not reflect the buying prices per essential supply dispensed or the type of disease attended;
b) Few outpatient services are charged for;
c) There has been poor supervision over user fees collection and expenditure;

d) Meagre budget is still allocated to public district hospitals; and

e) Consequently, there has been inadequate supply of essential supplies e.g. drugs on a regular basis.

For these factors to be solved, the findings recommend the following measures:

a) Public district hospitals should run themselves so that they may have more autonomy in ensuring their charging system reflects both the buying price(s) per essential supply dispensed and the type of disease attended;

b) Number of outpatient services to be charged should be increased;

c) There must be strict supervision over user fees collection and expenditure;

d) Budget allocated to public district hospitals should be increased;

e) Ensure essential supplies are in place on a regular basis and they are properly controlled.

3.1.2 Outpatient Services Management

According to findings obtained after cross tabulating the responses on the number of staff by category and the annual staffing position before and after 1994 in public district hospitals, 66.7% of 3 health professionals responded in public hospitals reveal that the staffing level by category has been on decrease both before and after 1994 as shown in Table 2 below.

Table 2. Public district Hospital Staffing Level: Before and After 1994.

		After		
		On Increase	On Decrease	Constant
Before	On Increase	-	-	-
	On Decrease	-	66.7% (n=2)	33.3% (n=1)
	Constant	-	-	-

Source: Data obtained using the Health Facility Questionnaire

The question on whether staff were satisfied with their work schedule, the results reveal that staff are not satisfied due to failure to pay them call allowances, no payment in case one is injured during work, and poor staff salaries. For this situation to be improved, the findings recommend that staff salaries should be increased taking into consideration risks staff are exposed to during work.

As shown in Table 3 below, findings reveal that although physical facilities in public district hospitals were expected to be on increase as a result of the introduction of cost sharing, they did not. Instead for most facilities remained constant as before the introduction of cost sharing while the shortage for motor vehicles increased by 2.

Table 3: Difference in Shortages of Physical Facilities in Public District Hospitals: Before and After 1994

Type of Facility	Shortage Level
Beds	Remained Constant
MCH Vaccines	Remained Constant
Essential drugs	Remained Constant
Laboratories	Remained Constant
Blood banks	Remained Constant
X-ray sections	Remained Constant
Theatre	Remained Constant
Inpatient wards	Remained Constant
Kitchen	Remained Constant
Laundries	Remained Constant
Technical Carpentries	Remained Constant
Tailoring workshop	Remained Constant
Mortuaries	Remained Constant
Motorcycles	Remained Constant
Motor vehicles	Increased by 2

Source: Data obtained using the Health Facility Questionnaire

The question on whether outpatients buy prescribed drugs from within the respective hospital, 75% of 4 health professionals interviewed in public hospitals in this regard said yes they do. However, 25% of these respondents put clear that sometimes, when drugs are available in public pharmacies, they buy prescribed drugs from within the respective hospital whereas sometimes not. On the contrary, 100% of 4 health professionals interviewed in private hospitals confirm that outpatients buy prescribed drugs from within their hospitals. In an effort to verify findings obtained using the Health Facility questionnaire, responses of outpatients and household heads responded to this question were analyzed. Results obtained after the analysis reveal that 64% of 113 outpatients responded to this question in public hospitals they claims they normally do not get prescribed drugs from within these hospitals in that they are normally not available.

A similar remark was made by 60% of 133 household heads who answered this question. 25% of 4 health professionals interviewed in public hospitals mention private pharmacies as the main source of prescribed drugs. This finding is confirmed by 64% of 113 outpatients interviewed in public hospitals and 60% of 133 household heads interviewed. Two more sources are added in by 13.2% of 113 outpatients responded to this question in public hospitals. They include self-medication and traditional healers once the patient finds the fee is unaffordable in private pharmacies.

3.1.3 Accepting or Rejecting the Research Hypothesis

In regard to the management of outpatient services in public district hospitals before and after the introduction of cost sharing, the following was the hypothesis which was tested using a paired t-test using the SPSS package:

> **"There would be no significant difference between the management of outpatient services in public district hospitals in Tanzaniabefore and after introduction of cost sharing".**

As revealed in Table 4 below, the test which placed much emphasis on the staffing position and shortage of physical facilities, reveal that this hypothesis was accepted. The two variables were chosen in that they reflect the two periods of interest to this study.

Table 4: **Test Results for the Hypothesis Used to Determine Relationship Between Management of Outpatient Services in Public District Hospitals Before and After Introduction of Cost Sharing**

Variables	t-value	Degree of freedom	2-tailed Probability	Conclusion
Staffing Position	-1.00	2	0.423	Accept the Hypothesis
Shortage of Physical facilities	0.00	2	1.000	Accept the Hypothesis

Source: Data obtained using the Health Facility Questionnaire

3.2 The Relationship Between the Financing Position of Outpatient Services in Public District Hospitals Before and After the Introduction of Cost Sharing.

100% of 4 health professionals interviewed in public hospitals said the main sources of finance used to fund outpatient services include donations, user fees, and warrants of funds from the central government. Unfortunately since there was no hospital which was able to provide information on the share each source did contribute between 1991/92 and 1994/95, this variable was ignored in the analysis. Nevertheless, the comparison of the financing position of outpatient services before and after the introduction of cost sharing as shown in Table 5 below reveal there was a notable improvement.

Table 5: Financing Position of Outpatient Services by Type of Hospital: Before and After Introduction of Cost Sharing

Type of Hospital	Financing Position	
	Improved	Decreased
Public	66.6% (n=2)	33.3% (n=1)
Private	100% (n=3)	0%
Total	83.3% (n=5)	16.7% (n=1)

Source: Data obtained using Health Facility Questionnaire

With the indicators used to measure the noted improvement in the financing level of outpatient services, the results reveal that 25% of 4 health professionals interviewed in public district hospitals in this regard use the increased number of staff in these hospitals while 50% use the increased financing position in these hospitals. The remaining 25% use the increased attendance rate of outpatients.

3.3. The relationship Between the Delivery of Outpatient services in Public district Hospitals Before and After the Introduction of Cost Sharing.

3.3.1 The Delivery of Basic Curative Services.

As revealed in Table 6 below, the analysis of hospital routine performance data reveal that there has been a fall of outpatients attendance for basic curative services by 5% in public hospitals while in private hospitals there has been a slight increase by about 1% after the introduction of cost sharing in public hospitals.

Table 6: Outpatients Attendance for Basic Curative Services: Before and After Introduction of Cost Sharint by Year, Type of Hospital and Sex

Year	Type of Hospital	Male	Female	Total
1992/93	Public	109,363	54,124	163,487
	Private	?	?	275,914
1994/95	Public	69,412	85,485	154,897
	Private	?	?	278,543

Source: Data obtained using the Health Facility Questionnaire

Note: ? = Not all private hospitals were able to provide data by sex

Findings obtained from 100% of 4 health professionals interviewed on which might have been the contributing factors to the decreased level of delivery of basic curative services in public district hospitals reveal that poor supervision over user fees collection and expenditure has been the basic factor. For these findings to be verified, responses given by outpatients interviewed in public hospitals and those which were given by household heads were analyzed. The results obtained reveal that 70% of 103 outpatients and 81% of 119 household heads who answered this question associate the decreased level of delivery of basic curative services in public hospitals with:

a) Lack of essential supplies and equipment and their control especially drugs;

b) Too much bribery in that *'no money no care'*;

c) Unaffordable user fees; and

d) Bad attitude toward patients among some of services providers.

For this situation to be improved, the three groups suggest the following measures. Health professionals suggest there must be strict supervision over user fees collection and expenditure. Whereas both outpatients and household heads add in the following measures:

a) Dishonest staff should be fired immediately;

b) Staff salaries must be increased;

c) Essential supplies and equipment should be in place on a regular basis and properly controlled.

3.3.2 The Delivery of Preventive services.

As shown in Table 7 below, the results reveal that while the annual total number of outpatients delivered preventive services has been on decrease in private hospitals, it has been on increase in public hospitals. This finding is confirmed by 75% of 4 health professionals interviewed in public hospitals and 33.3.% of 3 health professionals responded to this question in private hospitals.

Table 7: Delivery of Preventive Services: Before and After Introduction of Cost Sharing by Type of Service, Hospital, and Year

Type of Preventive Services	Type of Hospital	1992/1993	1994/1995	Total
Homes Delivered with Health Education	Public	1,376	1,552	2,928
	Private	168	133	301
U5 Whose Growth Rate was Monitored Using Growth Chart	Public	352,547	603,863	956,410
	Private	38,741	41,341	80,082
Pregnant Women Received Antenatal Care During Pregnancy	Public	174,709	232,113	406,822
	Private	21,041	19,829	40,870

Source: Data obtained using the Health Facility Questionnaire

Note: U5 = children under five years old

According to findings obtained from the above respondents (75% of 4 health professionals interviewed in public hospitals) the main indicator used to measure the noted improvement in delivery of preventive services even after the introduction of cost sharing is the increased attendance of homes delivered with health education, underfives and pregnant women.

3.3.3 Accepting or Rejecting the Research Hypothesis

The hypothesis which was put forward in regard to outpatient services delivery in public district hospitals before and after the introduction of cost sharing was:

"There would be no significant difference between the delivery of outpatient services in public district hospitals in Tanzania before and after introduction of cost sharing".

In this context, a paired t-test was used to test this hypothesis using the SPSS package where the variables involved in the test included: outpatients attendance for basic curative services; homes delivered with health education; underfives whose growth rate was monitored using growth chart; and pregnant women who received antenatal care during pregnancy for the two periods. As revealed in Table 8 below, the above stated hypothesis was also accepted.

Table 8: Test Results for the Hypothesis Used to Determine Relationship Between Delivery of Outpatient Services in Public District Hospitals Before and After Introduction of Cost Sharing

Variable	t-value	Degree of Freedom	2-tailed Probatility	Conclusion
Outpatients Attendance for Basic Curative Services	1.00	4	0.372	Accept the Hypothesis
Homes Delivered with Health Education	-0.83	4	0.453	Accept the Hypothesis
Underfives Whose Growth Rate was Monitored Using Growth Chart	-1.68	6	0.144	Accept the Hypothesis
Pregnant Women Who Received Antenatal Care During Pregnancy	-1.03	6	0.343	Accept the Hypothesis

Source: Data obtained using the Health Facility Questionnaire

3.4 Other Factors Affecting Outpatient Services Management, Financing and Delivery in Public District Hospitals

For the study to identify other factors that might be affecting the management, financing and delivery of outpatients services, data was collected from outpatients and household heads on:

affordability of delivered services, the quality of delivered services, accessibility to delivered services, and the equity of delivered services.

3.4.1 Factors Proceeding from Affordability of Delivered Outpatient Services

Results obtained seem to confirm that affordability is not a contributing factor in that 89% of 93 outpatients responded to this question in public hospitals regard charged user fees affordable whereas 63% of 147 household heads responded to this question had a similar observation. This finding was justified further by the commonly used method in raising the required funds for the sought care by both groups. 60.5% of 93 outpatients responded to this question in public hospitals and 52% of 147 household heads regard out- of- pocket money as their major source. The rest use other sources including sale of one's crops, borrowing money and payment being made by the third party e.g. one's spouse or employer.

3.4.2 Factors Proceeding from the Quality of Delivered Outpatient Services

As it has been discussed earlier, 70% of 103 outpatients and 81% of 119 household heads who answered this question confirm there has be no any notable improvement in the quality of delivered outpatient services in public hospitals because of:

a) Lack of essential supplies and equipment and their control especially drugs;
b) Too much bribery in that *'no money no care';*
c) Unaffordable user fees; and
d) Bad attitude towards patients among some of services providers.

3.4.3 Factors Proceeding from Accessibility to Delivered Services

Results obtained also seem to rule out the question of accessibility to delivered outpatient services as a contributing factor because 90% of 113 outpatients responded to this question in public hospitals live between 0.5 and 2 kms from the hospital they prefer to seek care from. This finding was confirmed further by 81% of 147 household heads responded to this question in that they live between 0.5 and 3 kms from the hospital they usually go to for the sought care.

3.4.4 Factors Proceeding from Equity of Delivered Services

Too much bribery seems to threaten equity of delivered services in that one is delivered service on production of money short of that no care. 70% of 103 outpatients responded to this question in public hospitals confirm this finding whereas 81% of 119 household heads responded to this question had a similar remark.

4. Discussion and Conclusions

This study was guided by three hypothesis which were used to determine:

a) The relationship between the management of outpatient services in public district hospitals in Tanzania before and after the introduction of cost sharing;

b) The relationship between the financing position of outpatient services in public district hospitals in Tanzania before and after the introduction and cost sharing.

c) The relationship between the delivery of outpatient services in public hospitals in Tanzania before and after the introduction of cost sharing in view of investigating other factors which might be affecting outpatient services management, financing and delivery in public district hospitals and identify appropriate measures which can best address the problems of effective management, financing and delivery of outpatient services in public district hospitals in terms of equity and sustainability.

For the empirical results obtained to be understood, the following were the essentials. Utilization of outpatient services (basic curative and preventive) was the dependent variable which was basically referred to as the annual total number of: outpatients made visits at each hospital consulted for basic curative services; homes delivered with health education; underfives whose growth rate was monitored using growth chart; and pregnant women received antenatal care during pregnancy. As such, the level of Utilization per hospital (public and private) before and after the introduction of cost sharing in public district hospitals was determined by analyzing hospital performance data collected using the health facility questionnaire.

The data obtained was analyzed using the SPSS package and descriptive statistical analysis. Summary sheets were used to analyze manually data obtained using open-ended questions. In order to accept or reject the research hypothesis a paired t-test was performed on selected aspects of outpatient services management and delivery before and after the introduction of cost sharing in public district hospitals using the SPSS package. However a word of caution must be given before getting into the details of discussion. Since there was no hospital which was able to provide information on contributions made by each source of funds for the two periods (1991/92 - 1992/93 and 1993/94 - 1994/95), the study could not determine in measurable terms the relationship between the financing position of outpatient services in public district hospitals before and after the introduction of cost sharing.

4.1 Discussion

4.1.1 The Relationship Between the Management of Outpatient Services in Public District Hospitals Before and After the Introduction of Cost Sharing

Test results for the first hypothesis which was used to determine the relationship between management of outpatient services in public district hospitals before and after the introduction of

cost sharing reveal there was no significant difference as shown in Table 4 above. Although results obtained reveal there were prior preparations before cost sharing was introduced in public district hospitals, a number of factors seem to be associated with the noted inadequate improvement in the management of outpatient services in these hospitals.

While in private hospitals their hospital fees fluctuate in order to reflect the buying price(s) of dispensed supplies and the type of disease attended, in public hospitals user fees per service charged for have been fixed since the introduction of cost sharing in 1994. Ever since one course of drugs regardless of the type of disease attended in public hospitals costs US $ 0.09. For the study to establish why public hospitals has such a rigid charging system it was discovered that the MOH is the sole body which has the right to revise the user fees structure. This charging system, however, threatens both the quality and sustainability of outpatient services management, financing and delivery in these hospitals in that it cannot guarantee generation of sufficient revenues which in turn can ensure availability of essential supplies and equipment on a regular basis unless there is another dependable source of income.

Another factor is that although in both types of hospitals there are two main types of outpatient services (basic curative and preventive services) yet not all services are charged for by both types of hospitals. Besides that their charges differ. For example, while medication fee in public hospitals is US $ 0.09, in private hospitals it ranges between 0.17 and 0.34. Also while such preventive services as MCH services are delivered entirely free of charge in public hospitals to pregnant women and children underfive years old, in private hospitals some of preventive services are charged for lower rates depending on the age and the level of care. In order to recover some basic care expenses, for instance, private hospitals charge children under five years old fees ranging between 50% and 75% of the adult fees.

A different setback springs from the response made by public hospitals to outpatients unable to pay for the sought care. Although the results show there are fewer cases in public hospitals than

in private hospitals, yet eligible applicants are automatically granted exemption in public hospitals on two grounds. The type of disease one is suffering from and one's poverty level. Whereas in private hospitals, one is only granted exemption upon provision of a dependable proof of inability to pay or on meeting agreed conditions e.g. one can be attended on credit. However, an interesting research question which remains unanswered in this regard is how additional costs proceeding from reduction of the pool of those required to pay are met?

The results also reveal that the staffing level in public hospitals by category has been on decrease both before and after the introduction of cost sharing. This might also justify why staff have not been satisfied with their work schedules. Other factors causing staff dissatisfaction include failure to pay them call allowances, no payment in case one is injured during work, and poor staff salaries. Also according to findings obtained, although physical facilities in public hospitals were expected to be on increase as a result of the introduction of cost sharing, yet they did not. Instead for most facilities remained constant as before the introduction of cost sharing while the level of shortage of motorvehicles increased by 2.

In order to verify the above findings an additional question was posed to health professionals, outpatients and household heads interviewed on what was their perception on the quality of outpatient services in public district hospitals before and after the introduction of cost sharing. In common, results obtained from these three groups also reveal that the quality has either remained constant as before the introduction of cost sharing or it has decreased due to:

a) Public hospitals have no right to revise fixed user fees by MOH;
b) Poor supervision over fees collection and expenditure;
c) Inadequate supply of essential supplies e.g. drugs on a regular basis and their control;
d) Too much bribery; and
e) Bad attitude towards patients among some of services providers.

4.1.2 The Relationship Between the Financing Position of Outpatient Services in Public District Hospitals Before and After the Introduction of Cost Sharing

Although the results show that there has been a notable improvement in the financing position of outpatient services in public district hospitals after the introduction of cost sharing, this finding becomes questionable on the following grounds:

a) The analysis of responses given to the question on whether outpatient services are allocated any share from revenues generated through user fees show that in practice there is no demarcation between basic curative and preventive services. Also although the results reveal that the only items benefitting from collected revenues include staff salaries, essential supplies and equipment, renovation of hospitals buildings and running costs, one wonders why there is inadequate supply of essential supplies in public hospitals as opposed to private hospitals? In this context, indicators used to measure the noted improvement in the level of financing outpatient services become unjustifiable;

b) Although findings obtained also show there are four main sources of funds including donations, user fees, warrants of funds from the central government and grants for hospitals with the aided staff, yet lack of data on contributions made by each source for two periods (1991/92 - 1992/93 and 1993/94 - 1994/95) could not allow this study to determine in measurable terms the above drawn relationship;

c) There is revenue loss through automatic exemptions granted in public hospitals. This in turn threatens sustainability of the financing position of outpatient services in these hospitals in that such an exemption scheme reduce the pool of those required to pay;

d) There is revenue loss through the rigid charging system used in public hospitals because this system does not take into consideration local needs of the respective public hospitals, buying price(s) per supply dispensed and the type of disease attended; and

e) There is also revenue loss through poor supervision over user fees collection and expenditure.

4.1.3 The Relationship Between the Delivery of Outpatient Services in Public District Hospitals Before and After the Introduction of Cost Sharing

Test results for the third hypothesis which was used to determine the relationship between the delivery of outpatient services in public district hospitals in Tanzania before and after the introduction of cost sharing reveal there was no significant difference as shown in Table 8 above.

This finding is justified by the fall by 5% of outpatients attendance for basic curative services in public hospitals. Health professionals interviewed in this regard strongly associate this fall with poor supervision over user fees collection and expenditure. Whereas both outpatients and household heads firmly associate this fall with:

a) Lack of essential supplies and equipment and their control especially drugs;
b) Too much bribery in that *'no money no care'*;
c) Unaffordable user fees; and
d) Bad attitude towards patients among some of services providers.

In establishing why the above mentioned were the burning issues among outpatients and household heads the results show that indicators they use to measure quality services are basically three. Availability of essential supplies in the hospital on a regular basis, dependable professionalism in treating them, and affordability of user fees. But in practice they normally do not get prescribed drugs from within public hospitals in that they are normally not available. Instead they usually resort to private pharmacies. For those who find the fees unaffordable they normally either go for self-medication or traditional healers. The danger of self-medication,

however, is that physicians and pharmacologists who have studied the consequences of self medication report a wide variety of hazards including delaying the recognition of serious disorders. Persistent of headaches dosed with asprin, for instance, have hidden brain and eye disorders [75].

Too much bribery, which was also recently confirmed by the preliminary findings of the Anti-Corruption Committee in Tanzania in all key sectors [76], threatens both equity of and accessibility to delivered outpatient services because those most in need of the care may be deprived of their right at the expense of those who have the cash.

With affordability of user fees, although the results obtained show that charged fees are affordable in that out- of- pocket money is the commonly used method in raising the required funds for the sought care by both groups, yet as revealed in Table 9 below the average earned monthly income by one group makes the above finding questionable. 92.6% of 216 outpatients disclosed their monthly average income in both types of hospitals earn the lowest income level ranging between US$ 8.62 and 51.72 monthly. After cross tabulating this monthly income with the total amount spent in seeking for care during the most recent consultation, findings reveal that outpatients seem to spend between US$1.72 and 3.45 on health care which represents about 7.5% of their average income level. This level might have risen even higher if the annual total number of visits made by each outpatient were determined. Whereas to households spending between US$ 1.72 and 3.45 on health care to them it represents around 6.7% of their average income level.

Table 9: Income Levels for Outpatients by Type of Hospital.

Patient Category	Type of Hospital	Income Levels in US $				
		Uncertain	8.62 – 51.72	51.72 – 94.83	94.83 – 137.93	137.93+
Outpatients	Public	-	93	4	-	3
	Private	1	108	4	1	2

Source: Data obtained using Outpatient Questionnaire

For preventive services like delivery of health education, underfives growth rate monitoring and delivery of antenatal care to pregnant women findings show that these services are entirely delivered free of charge to pregnant women and children underfive years old in public hospitals. In private hospitals, however, some of these services are charged for lower rates depending on the age and the level of care. The results also reveal that although in private hospitals there has been a decrease in the total annual number of outpatients delivered with preventive services, in public hospitals it has been on increase. The increased attendance of homes delivered with health education, underfives and pregnant women was the main indicator used to measure the noted improvement in delivery of preventive services.

4.1.4 Other Factors Affecting Outpatient Services Management, Financing and Delivery in Public District Hospitals

Inspite of introduction of cost sharing in public district hospitals, the results obtained reveal the

following as additional contributing factors for an unimproved management, financing and delivery of outpatient services in these hospitals.

4.1.4.1 Managerial Factors

These include:

a) Lack of automnomy among public district hospitals which could enable them to ensure their charging system reflects both the buying price(s) per supply dispensed and the type of disease attended;

b) Poor supervision over user fees collection and expenditure;

c) Inadequate supply of essential supplies e.g. drugs on a regular basis and their control;

d) Poor staff salaries which do not take into account risks staff are exposed to during work;

e) Too much bribery; and

f) Bad attitude towards patients among staff.

4.1.4.2 Financial Factors

These include:

a) Revenue loss due to automatic exemptions, the used rigid charging system in public hospitals, and through poor supervision over user fees collection and expenditure; and

b) Meagre budget allocated to public district hospitals.

4.1.4.3 Delivery Factors

These include:

a) Lack of essential supplies and equipment and their control especially drugs; and

b) Too much bribery.

4.2 Conclusions

4.2.1 The management of outpatient services in public district hospitals even after the introduction of cost sharing is not yet improved.

4.2.2 Although the results obtained seem to conclude that there has been a slight notable improvement in the financing position of outpatient services in public district hospitals, in practice this seems not to be the case.

4.2.3 For basic curative services, there has been a slight fall of outpatients attendance in public district hospitals. For preventive services, which are entirely delivered free of charge to pregnant women and children under five years old in public district hospitals there has been an increase in the annual total number of outpatients delivered with these services even after the introduction of cost sharing.

4.2.4 Although the results obtained reveal that charged user fees are affordable, yet the average monthly income earned by outpatients and households interviewed makes this conclusion questionable.

4.2.5 Quality of delivered outpatient services in public district hospitals has either remained constant or decreased.

4.2.6 With too much bribery in the midst of inadequate supply of essential supplies in public hospitals, delivered outpatient services are both inaccessible and not equitable.

5. Recommendations

For the management, financing and delivery of outpatient services in public district hospitals to be effectively improved in terms of equity and sustainability:

5.1 Public district hospitals should run themselves for more autonomy.

5.2 There must be strict supervision over user fees collection and expenditure.

5.3 Essential supplies and equipment should be in place on a regular basis and these should be properly controlled.

5.4 Staff salaries should be increased taking into consideration risks they are exposed to during work.

5.5. Dishonest staff should be fired immediately.

5.6 Only caring staff should be appointed.

5.7 Since chronic diseases are too expensive to treat, sufferers must contribute part of the total cost.

5.8 The used charging system should reflect both the buying price(s) per supply dispensed and the type of disease attended.

5.9 Number of outpatient services charged for should be increased.

5.10 Budget allocated to public district hospitals should be increased.

5.11 Exemptions should be granted on proven grounds.

References

1. Bureau of Statistics (1990). 1988 population census and Dar es Salaam region profile. Dar es Salaam: Ministry of Finance, Economic Affairs and Planning

2. World Bank (1993). World development report: investing in health. Washington, DC: World Bank

3. The United Republic of Tanganyika and Zanzibar (1964). Five year plan for economic and social development 1st July 1964 - 30th June 1969 Volume 1. Dar es Salaam: The Government Printer

4. The United Republic of Tanzania (1969). Second five-year plan for economic and social development 1st July 1969 - 30th June, 1974: volume IV. Dar es Salaam: The Government Printer

5. United Republic of Tanzania (1976). First volume: third five-year plan for economic and social development 1st July 1976 - 30th June 1981: general perspectives (part one): regional perspective (part two) Dar es Salaam: National Printing Co. Ltd

6. Jonsson, Urban (1986). Ideological framework and health development in Tanzania 1961-2000, Social Science Media Vol. 22(7), 745-753

7. Chiduo, A.D (1991). "Health services in Tanzania: future perspectives and policy options" in Health and disease in Tanzania, pp. 296-308. Edited by G.M.P. Mwaluko et al. London: Harper Collins Academic

8. Mujinja, P.G.M. (1990) "Meeting health costs: is there a need for an alternative?" Proceedings of the Tanzania Public Health Conference, Dar es Salaam

9. Anonymous (June 1991). Strengthening the district, Health Action 1st Issue, 6

10. Chiduo, A.D.(1991). Op.cit

11. United Republic of Tanzania, Ministry of Health (1990). National health policy. Dar es Salaam: Ministry of Health

12. Gottlieb, Manuel (1979). "The health care sector in Tanzania" in Papers on the political economy of Tanzania, pp 288-294. Edited by Kwann S. Kim, Robert B. Mabele and Michael J. Schultheis. Nairobi: Heinemann Educational Books

13. Bureau of Statistics (1990). Op. cit

14. Ministry of Health (1990). Maternal health in Tanzania. Dar es Salaam: Ministry of Health

15. The United Republic of Tanzania, Ministry of Health (1996). Health statistics abstract 1996. Issue No.4. Dar es Salaam: Health Information Systems (HIS) Unit, Planning Department, Ministry of Health

16. United Republic of Tanzania, Ministry of Health (1990). Op. cit

17. Gottlieb, Manuel (1979). Op.cit

18. Mujinja, P.G.M. (1990). Op. cit

19. Mandara, M.P. (1991). "Health services in Tanzania: a historical overview" in Health and disease in Tanzania, pp 1-7. Edited by G.M.P. Mwaluko et al. London: Haper Collins Academic

20. Kavishe, Festo P. (1990). "Access to 'free' health services in Tanzania". A Desk Study Report prepared for the World Bank. TFNC Report No. 1287. Dar es Salaam

21. USAID/Tanzania (1980). "Tanzania health sector strategy". A Joint Paper by USAID and the United Republic of Tanzania. Washington, D.C.: USAID

22. Population and Human Resources Eastern Africa department, Africa Region (1995). Health policy in Eastern Africa: a structured approach to resource allocation volume 1: main report. Report No. 14040 AFR. Africa Region: Population and Human Resources Eastern Africa Department

23. Magari, F. et al. (1991). Planning and management of primary health care in Tanzania: a manual for district health teams. Dar es Salaam: Ministry of Health, Government of United Republic of Tanzania

24. Mogedal, Sigrun; Steen, Sissel Hodne and Mpelumbe, George (May - June, 1995). Health sector reform and organizational issues at the local level: lessons from selected African countries, Journal of International Development Vol. 7(3) 349-367

25. Chiduo, A.D.(1991). Op.cit

26. Population and Human Resources Eastern Africa Department, Africa Region (1995). Op.Cit

27. Magari, F. et al (1991).. Op. cit

28. Hussein, Asia Kassim (1995). "The effect of user charge policy and other non-price factors on the utilisation of health services in Dar es Salaam region, 1994". M. Med. (Community Health) dissertation, University of Dar es Salaam

29. Meghji, Zakia H. (14th - 16th December, 1995). "Implementation of cost-sharing and options available to improve health services for the poor and vulnerable groups in the society (Tanzania)". Paper presented at the ESAURP Conference on the Future of Tanzania, Arusha, Tanzania

30. Gilson, Lucy; Russell, Steven and Buse, Kent (May-June, 1995). The political economy of user fees with targeting: developing equitable health financing policy, Journal of International Development Vol. 7(3), 369-401

31. Thomason, J.; Mulou, N. and Bass, C. (1994). User charges for rural health services in Papua New Guinea, Social Science and Medicine Vol. 39, 1105-1115

32. Hecht, R.; Overholt, C. and Holmberg, H. (1993), Improving the implementation of cost recovery: lessons from Zimbabwe, Health Policy Vol. 25, 213-242

33. Trisolini, M.G. et al.(1992). Methods for cost analysis , cost recovery and cost control for a public hospital in a developing country: Victoria hospital, St. Lucia, International Journal of Health Planning and Management Vol. 7, 103-132

34. Thomason, J.; Mulou, N. and Bass, C. (1994). Op. cit

35. Gilson, Lucy; Russell, Steven and Buse, Kent. (May - June, 1995). Op.cit

36. Waddington, C. and Enyimayew, K.A. (1990). A price to pay, part 2: the impact of user charges in the Ashanti-Akim Region of Ghana, International Journal of Health Planning and Management Vol. 4, 17-47

37. Machray, C. (1994). Effective fee collection, Health Action Issue 9, 10

38. La Forgia, G. (1992). "Means testing in health ministry facilities in the Dominican Republic" in From platitudes to practice: targeting social programs in Latin America Vol. II. World Bank Latin America and the Caribbean Technical department Regional Studies Program Report No. 21. Washington: World Bank Latin America and the Caribbean Technical Department Regional studies Program

39. Huber, J.H. (1993). Ensuring access to health care with the introduction of user fees: a Kenyan example, Social Science and Medicine Vol. 36, 485-494

40. Yacoob, M. (1990). Community self-financing of water supply and sanitation: what are the promises and pitfalls? Health Policy and Planning Vol. 5, 358-366

41. International Bank for Reconstruction and Development (IBRD). (1987). Financing health services in developing countries: an agenda for reform. Washington: World Bank

42. International Bank for Reconstruction and Development (IBRD). (1993). World development report 1993: investing in health. Washington, D.C.: World Bank

43. Hecht, R; Overholt, C. and Holmberg, H. (1993). Op.cit

44. Bossert, I.; Soebekti, R. and Nyoman, Kumarc Rai (1991). Bottom-up planning in Indonesia: decentralisation in the Ministry of Health, Health Policy and Planning Vol. 6, 55-63

45. Cassells, A. and Janovsky, K. (1992). A time for change: health policy, planning and organisation in Ghana, Health Policy and Planning Vol. 7, 144-154

46. Gilson, L. (1995). Management and health care reform in Sub-Saharan Africa, Social Science and Medicine Vol. 40, 695-710

47. McPake, B.; Hanson, K. and Mills, A. (1992). Implementing the Bamako Initiative in Africa: a review and five case studies. PHP Departmental Publication No. 8. London: PHP Departmental Publications

48. Collins, C. and Green, A. (1994). Decentralisation and primary health care: some negative implications for developing countries, International Journal of Health Services Vol. 24, 459-475

49. Mills, A. (1994). Decentralisation and accountability in the health sector from an international perspective: what are the choices? Public Administration and Development Vol. 14, 281-292

50. Cheema, G.S. and Rondinelli, D.A. (1983). Decentralisation and development: conclusions and directions' in Decentralisation and development: policy implementation in developing countries. Edited by G.S. Cheema and D.A. Rondinelli. London: Sage

51. Mills, A. et al. (1990). Health system decentralisation: concepts, issues and country experiences. Geneva: World Health Organisation

52. Rondinelli, D.A.; McCullough, J.S. and Johnson, R.W. (1989). Analysing decentralisation policies in developing countries: a political economy framework, Development and Change Vol. 20, 57-87

53. Gilson, L.; Alilio, M. and Heggenhougen, K. (1994). Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro region of Tanzania, Social Science and Medicine Vol. 39(6), 767-780

54. Thomason, J.; Newbrander, W.C. and Kolehmainen-Aitken, R-L. (eds.) (1991). Decentralisation in a developing country: the experience of Papua New Guinea and its health services. Pacific Research Monograph No. 25. Canberra: The Australian National University

55. Gilson, Lucy; Russell, Steven and Buse Kent (May- June, 1995). Op.cit

56. Ibid

57. Nolan, B. and Turbat, V. (1993). "Cost recovery in public health services in Sub-Saharan Africa" (Draft Paper). Washington: Economic Development Institute, Human Resources Division

58. Waddington, C. and Enyimayew, K.A. (1990). Op.cit

59. Colclough, C. et al. (19?.). Education in Zimbabwe: issues of quantity and quality. SIDA Education Division Documents No. 50

60. International Bank for Reconstruction and Development (IBRD). (1993). Op.cit

61. Shaw, R. Paul and Griffin, Charles C. (1995). Financing health care in Sub-Saharan Africa through user fees and insurance. Washington, D.C.: The World Bank

62. Kanbur, Ravi. (1995). "Foreword" in Shaw, R. Paul and Griffin, Charles C. Ibid

63. World Health Organisation (1993). Evaluation of recent changes in the financing of health services WHO Technical Report Series 829. Report of a WHO Study Group, Geneva: World Health Organisation

64. Parker, D. and Knippenberg, R. (1991). Community cost-sharing and participation: a review of the issues. Bamako Initiative Technical Report Series No. 9. New York: United Nations Children's Fund.

65. de Ferranti, D. (1985), Paying for health services in developing countries: a call for realism, World Health Forum Vol. 6, 99 - 103

66. Shaw, R. Paul and Griffin, Charles C. (1995). Op.cit

67. Kizigha, Charles (November 16, 1994). Norway freezes 8.1 bn/- Dar aid, Daily News No. 6041, 1

68. Kizigha, Charles (November 18, 1994). Sweden suspends 7.3 bn/- Dar aid, Daily News No.3810,1.

69. World Health Organisation. (1993). OP. cit

70. The United Republic of Tanzania, Ministry of Health (1996). Implementation of health services user fees in Tanzania: an evaluation of progress and potential impact. Dar es Salaam: Ministry of Health, Cost Sharing Implementation Team

71. World Health Organisation. (1984). Glossary of terms used in the 'Health for All! Series No.1-8. Geneva: World Health Organisation

72. The United Republic of Tanzania, Ministry of Health (1996). Reorganisation of the primary health care secretariat in view of the health reform process. Dar es salaam: Ministry of Health

73. Anonymous (June 1991). Op.cit

74. Jamhuri ya Muungano wa Tanzania, Wizara ya Afya. (1994). Mwongozo wa utekelezaji utaratibu wa wananchi kuchangia gharama za huduma za afya. Dar es Salaam: Wizara ya Afya.

75. Everitt, Don. (July, 1969) The dangers of being your own doctor: do's and don'ts of self-treatment - as prescribed by leading medical authorities, Reader's Digest Vol. 3(6), 57 - 60

76. Shayo, Joseph. (August 11, 1996), Warioba probe confirms: no bribe no service, Sunday Observer Issue No. 47, 1

77 Kavishe, Festo P. (1993). Nutrition-relevant actions in Tanzania. Tanzania Food and Nutrition Centre 20th Anniversary, 1973-1993 Monograph Series No. 1 Adelaide: ACC/SCN

78. Ministry of Health. (1994). Health statistics abstract. Dar es Salaam: MOH

79. Ministry of Health. (1990). Maternal health in Tanzania. Dar es Salaam: MOH

80. Tanzania, Bureau of Statistics (1992). Health statistics: 1990. Dar es Salaam: Bureau of Statistics, President's Office, Planning Commission

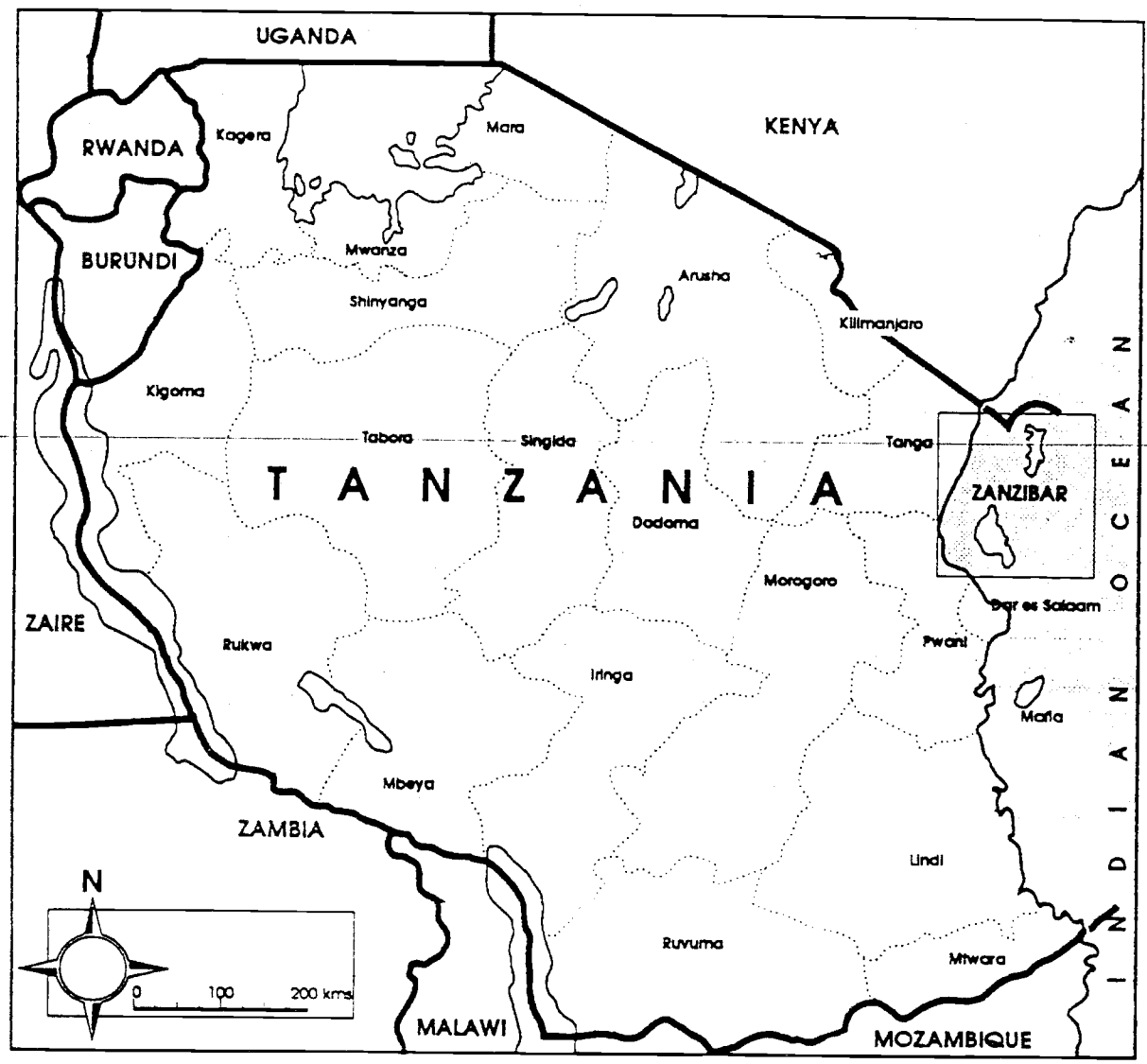
81. Ministry of Health. (1994). Health statistics abstract: 1991-1994. Dar es Salaam: Ministry of Health

82. Table 1.3.1 in The United Republic of Tanzania, Ministry of Health. (1995). Health statistics abstract 1995. Dar es Salaam: Ministry of Health

83. Shaw R. Paul and Griffin, Charles C. (1995). Op. Cit

84. The United Republic of Tanzania, Ministry of Health. (1996). Op. Cit

Appendix A: Tanzania and Regional Boundaries



SOURCE (77)

Appendix B: Number of Health Facilities by Region and Ownership: Tanzania Mainland

REGION	HOSPITALS					HEALTH CENTRES					DISPENSARIES				
	A	B	C	D	TOTAL	A	B	C	D	TOTAL	A	B	C	D	TOTAL
Arusha	7	7	-	-	14	11	-	-	-	11	115	39	18	8	180
Coast	4	1	1	-	6	10	-	-	-	10	90	8	15	-	113
Dar es Salaam	4	6	1	2	13	4	-	2	-	6	66	27	42	11	146
Dodoma	5	1	-	-	6	16	1	-	-	17	148	21	3	-	172
Iringa	5	6	2	-	13	16	-	-	-	16	91	44	4	2	141
Kagera	1	9	1	-	11	12	-	-	-	12	132	13	-	-	145
Kigoma	3	2	-	-	5	10	-	-	-	10	94	14	1	-	109
Kilimanjaro	5	7	1	-	13	13	3	-	1	17	93	37	5	-	135
Lindi	4	3	-	-	7	12	-	-	-	12	88	8	4	-	100
Mara	3	4	-	-	7	11	-	-	-	11	92	25	4	2	123
Mbeya	5	6	-	-	11	17	-	-	-	17	149	24	10	3	186
Morogoro	4	4	3	-	11	16	-	-	-	16	131	38	12	2	183
Mtwara	3	2	-	-	5	13	-	-	-	13	99	13	-	-	112
Mwanza	4	7	-	-	11	26	-	-	-	26	204	24	7	3	238
Rukwa	2	1	-	-	3	11	1	-	-	12	73	15	-	-	88
Ruvuma	2	5	-	-	7	13	-	-	-	13	93	35	1	-	129
Shinyanga	5	2	-	-	7	18	-	-	-	18	143	31	2	-	176
Singida	2	4	-	-	6	11	1	-	-	12	97	32	-	-	129
Tabora	4	3	-	-	7	10	1	-	-	11	84	21	1	-	106
Tanga	5	5	-	2	12	15	-	-	-	15	136	16	46	5	203
TOTAL	77	85	9	4	175	265	7	2	1	275	2218	385	175	36	2914

KEY TO OWNERSHIP:
A = Government Health Facilities including Referral Hospitals
B = Voluntary Health Facilities
C = Parastatal Health Facilities
D = Other Health Facilities

Appendix C: Country Disease Summary from District Reports for 1990

NAME OF DISEASES	ITS OCCURRENCE IN %
Diarrhoeal diseases	7.32
Malaria	31.52
Measles	0.16
Acute poliomyelitis	0.00
Whooping cough	0.02
Neonatal tetanus	0.01
Adult tetanus	0.01
Intestinal worms	4.20
Skin diseases	3.19
Nutritional disorders	0.69
Anaemia	1.34
Normal pregnancy, minor complication	1.21
Complication of pregnancy at child birth and pueparium	0.29
Gonorrhoea	1.62
Upper respiratory infection	11.61
Pneumonia	4.99
Accidents including burns, fractures	2.24
Schistosomiasis	0.55
Eye diseases	4.03
Ear diseases	1.15
Mental disorder	0.25
All other diagnosed diseases	14.38
Symptoms and ill-defined conditions	9.22
TOTAL	100

SOURCE: [79)]

Appendix D: Outpatients and Inpatients Attendance in '000' per Type of Health Facility 1980 - 1994

HEALTH FACILTY TYPE	YEAR														
	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94
OUTPATIENTS IN '000'															
Hospitals including special hospitals	33768	35254	38779	42304	45829	49357	52121	55040	57580	60790	64006	66818	69753	72688	75623
Rural H/Centres	12973	13115	14427	15739	17051	18376	19938	21633	23700	25600	27500	29405	31442	33479	35516
Dispensaries excluding parastal and private dispensaries	60628	62645	63909	65173	66437	67706	69873	72109	75100	78160	81208	83691	86229	88777	91325
INPATIENTS IN '000'															
Hospitals including special hospitals	922	925	927	929	931	936	962	989	1020	1340	1660	1825	2007	2189	2371
Rural H/Centre	275	279	285	289	295	310	327	346	350	398	437	463	490	517	504
Dispensaries excluding parastatal and private dispensaries	178	180	183	186	189	193	199	206	250	226	226	203	323	343	363

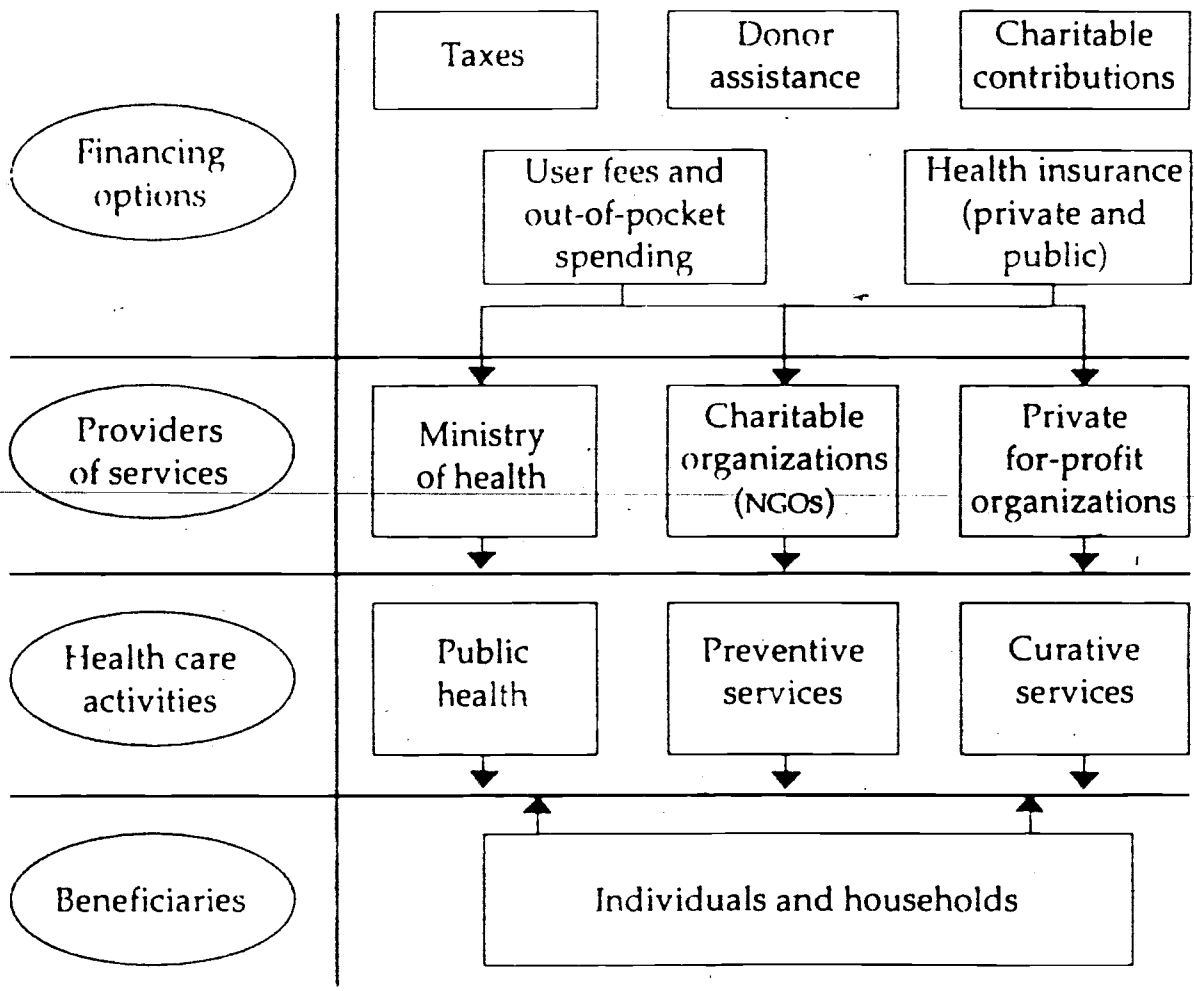
SOURCE: [80,81]

Appendix E: Number of Health Facilities in Tanzania Mainland: 1990-1995

YEAR	TYPE OF HEALTH FACILITY			TOTAL
	Hospitals	Health Centres	Dispensaries	
1990	173	276	2840	3289
1991	174	276	2851	3301
1992	174	276	2858	3308
1993	175	276	3014	3465
1994	175	276	3014	3465
1995	183	291	3286	3760

SOURCE:[82]

Appendix F: Sources of Financing in a Typical Health Care System



SOURCE (83)

Appendix G: **'Cost Sharing Implementation in Public Hospitals in Tanzania by Type of Service, Service Description, Facility Leval and Charge in US $***

Type of Service charged	Description	Referal Hospitals	Regional Hospitals	District Hospitals
1. Consultation	Grade I & II Grade III	0.86 0.52	0.52 0.34	0.34 0.26
2. Drug for outpatient	-	0.07	0.07	0.07
3. Medical Examination for:				
3.1 Students	-	0.86	0.86	0.86
3.2 Civil Servants	-	2.59	2.59	2.59
3.3 Special Examination test	-	5.17	5.17	5.17
3.4 Workman's compensation	-	5.17	5.17	5.17
3.5 Medical Board	-	17.24	17.24	17.24
4. Gate toll for:				
4.1 Motor vehicles	-	0.17	0.17	0.17
4.2 Motor bikes	-	0.07	0.07	0.07
4.3 Bicycles	-	0.03	0.03	0.03
5. Mortuary Fees for:				
5.1 Post-mortem	-	1.72	1.72	1.72
5.2 Storage	-	0.34	0.34	0.34
6. Hospitalization fees for:				
6.1 Grade I	Daily fee excluding food, drugs, laboratory services, or other tests	3.45	2.59	1.72
6.2 Grade II		1.72	1.29	0.86
6.3 Grade III	For the whole period of admission including food, drugs, and laboratory services or other tests	0.86	0.52	0.26

7. Other Services:				
7.1 Laboratory and eye tests	Grade I & II	1.72	1.72	-
7.2 General major surgery	Grade I & II	25.86	25.86	-
7.3 General minor surgery	Grade I & II	5.17	5.17	-
7.4 Major Ophthmology	Grade I & II	25.86	25.86	-
7.5 Minor Ophthmology	Grade I & II	3.45	3.45	-
7.6 Major ENT	Grade I & II	12.93	12.93	-
7.7 Minor ENT	Grade I & II	2.59	2.59	-
7.8 Major Orth/Trauma	Grade I & II	25.86	25.86	-
7.9 Minor Orth/Trauma	Grade I & II	5.17	5.17	-
7.10 Major Neurosurgery	Grade I & II	68.97	68.97	-
7.11 Minor Neurosurgery	Grade I & II	17.24	17.24	-
7.12 Major Urosurgery	Grade I & II	13.79	13.79	-
7.13 Minor Urosurgery	Grade I & II	5.17	5.17	-
7.14 Major Obst/Gynaec.	Grade I & II	25.86	25.86	-
7.15 Minor Obs/Gynaec.	Grade I & II	6.90	6.90	-
7.16 Normal delivery	Grade I & II	0.69	0.52	0.17
8. Foreigners fees for:				
8.1 Consultation	-	20	20	20
8.2 Appointment Consultation	-	20	20	20
8.3 Hospitalization	-	30	30	30
8.4 Ordinary laboratory tests	-	10	10	10
8.5 Special tests	-	50-200	50-200	50-200
8.6 Major Surgery	-	200-2000	200-2000	200-2000
8.7 Minor surgery	-	50	50	50
8.8 Mortuary	-	100	100	100
8.9 Post-mortem	-	30	30	30

NB: Please, note that some of the 'other services' are not delivered by public district hospitals.

* Original user fees in Tshs. were coverted in US $ at the exchange rate of 580 Tshs. per US $.

SOURCE: [84]

Appendix H: **HEALTH FACILITY QUESTIONNAIRE**

NOTE: **Dear health professional, may you answer ALL APPLICABLE questions according to given instructions.**

Day/Month/Year

Questionnaire Number

Name of Hospital

Type of Hospital

Title of the Health Professional

CIRCLE OR FILL IN ANSWERS

I. BACKGROUND INFORMATION

1. Your Sex
   - 01 Male
   - 02 Female

2. Your Age (completed years)
   01

3. Your highest educational qualification
   - 01 No formal education
   - 02 Primary education
   - 03 Secondary education
   - 04 Post secondary education -certified

4. Your highest professional qualification
   01

II. COST SHARING IMPLEMENTATION MANAGEMENT

5. Were there prior preparations for the cost sharing implementation team in this hospital before implementing this policy?

01 Yes

02 No

6. Who decided on the user fee structure you are using?

01

7. Are these rates fixed since you began to implement the policy of cost sharing?

01 Yes

02 No

8. If Yes, who has the right to revise them?

01

9. Which outpatient services do you deliver in this hospital?

01

02

03

04

05

06

07

08

10. Which services among these are charged for and how much is the charge per service?

	Service	**Charge in Tshs.**
01		
02		
03		
04		

05

06

07

08

09

010

---

11. Do you allocate any share to outpatient services you mentioned from revenues generated through user fees?

01 Yes

02 No

12. If No, which other sources of funds do you use to finance them?

01

02

03

13. Have you had an instance where an outpatient was unable to pay for sought care?

01 Yes

02 No

14. If Yes, which corrective measure(s) were taken?

01

02

15. For outpatients exempted from paying the user fees, does the granted exemption affect the type of care sought by the patient?

01 Yes

02 No

16. In your opinion which changes should be made in order to improve the existing exemption mechanism?

01

17. How do you compare the quality of outpatient services in this hospital now and before 1994?

C1 Improved

02 Remained constant

03 Decreased

18. If, in your opinion, the quality of outpatient services have improved, which indicator(s) do you use to measure the noted improvement?

01

02

19. If, in your opinion, the quality of outpatient services has either remained constant or it has decreased, which are the contributing factors?

01

02

03

20. For each factor, you have mentioned, which ways do you propose should be used to solve it?

Factor	**Proposed solution(s)**
01	001
	002
02	001
	002
03	001
	002

III OUTPATIENT SERVICES MANAGEMENT

21. How many staff do you have by category?

	Category	**Number of Staff**
01	Medical Officer(s)	
02	Assistant Medical Officer(s)	
03	Nurses	
04	Pharmacist(s)	
05	Laboratory Technician(s)	
06	Radiologist(s)	

07 Health Officer(s)

08 Health Services Secretary(ies)

09 Medical Records Officer(s)

22. What was the annual staffing position in this hospital before 1994?

01 It was on increase

02 It remained constant

03 It was on decrease

23. What has been the annual staffing position in this hospital after 1994?

01 It has been on increase

02 It has remained constant

03 It has been on decrease

24. Are your staff satisfied with their work schedule?

01 Yes

02 No

25. If no, explain why?

01

26. In order to improve the situation, which corrective measure(s) should be taken?

01

02

27. Which was the physical facilities position in this hospital in 1993?

		Number	
	Facility type	**Required**	**Actual**
01	Beds		
02	MCH Vaccines		
03	Essential drugs		
04	Laboratory(ies)		
05	Blood bank(s)		

06 X-ray section(s)
07 Theatre(s)
08 Inpatient ward(s)
09 Kitchen(s)
10 Laundry(ies)
011 Technical capentry(ies)
012 Tailoring work shop(s)
013 Mortuary(ies)
014 Motorcycle(s)
015 Motorvehicle(s)

28. Which is the physical facilities position in this hospital now?

Facility type		Number Required	Actual
01	Beds		
02	MCH veccines		
03	Essential drugs		
04	Laboratory(ies)		
05	Blood bank(s)		
06	W-ray section(s)		
07	Theatre(s)		
08	Inpatient ward(s)		
09	Kitchen(s)		
010	Laundary(ies)		
011	Technical capentry(ies)		
012	Tailoring workshop(s)		
013	Mortuary(ies)		
014	Motorcycle(s)		
015	Motorvehicle(s)		

29. Do patients purchase prescribed drugs from within?
01 Yes
02 No

30. If no, where do they purchase them?

01 Public pharmacies

02 Private pharmacies

31. How do you compare the management of outpatient services in this hospital now and before 1994?

01 Improved

02 Remained constant

03 Decreased

32. If, in your opinion, the management of outpatient services has improved, which indicator(s) do you use to measure the noted improvement?

01

02

03

33. If, in your opinion, the management of outpatient services has either remained constant or it has decreased, which are the contributing factors?

01

02

03

34. For each factor, you have mentioned, which measures do you propose should be taken to solve it?

Factor	**Proposed Solution(s)**
01	001
	002
02	001
	002
03	001
	002

IV. OUTPATIENT SERVICES FINANCING

35. Which sources of finance do you use to fund outpatient services in this hospital?

01

02

03

04

36. How much share has been contributed by each source between 1991/92 and 1994/95?

Source	Contribution Made by Each Source by Year			
	1991/92	1992/93	1993/94	1994/95
01				
02				
03				
04				

37. In the light of available sources of finance, how do you compare the financing position of outpatient services now and before 1994?

01 Improved

02 Remained constant

03 Decreased

38. If, in your opinion, the financing position of outpatient services has improved in this hospital, which indicator(s) do you use to measure the noted improvement?

01

02

39. If, in your opinion, the financing position of outpatient service has either remained constant or it has decreased, which are the contributing factors?

01

02

03

40. For each factor, you have mentioned, which measures should be taken to solve it?

Factor	Proposed Solution(s)
01	001
	002

02	001
	002
03	001
	002

V. OUTPATIENT SERVICES DELIVERY

V.1 CURATIVE SERVICES DELIVERY

41. What was the annual outpatients attendance for basic curative services by sex between 1992 and 1995?

Year	Attendance by Sex		
	Male	Female	Total
1992			
1993			
1994			
1995			

42. In your opinion how do you compare the delivery of basic curative services in this hospital now and before 1994?

01 Improved

02 Remained constant

03 Decreased

43. If, in your opinion, the delivery of basic curative services has improved, which indicator(s) do you use to measure the noted improvement?

01

02

44. If, in your opinion, the delivery of basic curative services has either remained constant or it has decreased which are the contributing factors?

01

02

03

45. For each factor, you have mentioned, which measures should be taken to solve it?

Factor	Proposed Solution(s)
01	001
	002
02	001
	002
03	001
	002

V.2 PREVENTIVE SERVICES DELIVERY

46. What was the annual number of homes delivered with health education between 1992 and 1995?

Year	Number of Homes Visited
1992	
1993	
1994	
1995	

47. What was the annual number of underfives whose growth rate was monitored using the growth chart between 1992 and 1995?

Year	Number of Underfives Whose Growth was Monitored Using the Growth Chart
1992	
1993	
1994	
1995	

48. What was the annual number of pregnant women received antenatal care during pregnancy between 1992 and 1995?

Year	Number of Women Received Antenatal Care During Pregnancy
1992	
1993	
1994	
1995	

49. In your opinion how do you compare the delivery of these preventive services in this hospital now and before 1994?

01 Improved

02 Remained constant

03 Decreased

50. If, in your opinion, the delivery of these preventive services has improved, which indicator(s) do you use to measure the noted improvement?

01

02

51. If, in your opinion, the delivery of these preventive services has either remained constant or it has decreased which are the contributing factors?

01

02

03

52. For each factor, you have mentioned which measures should be taken to solve it?

Factor	Proposed Solution(s)
01	001
	002
02	001
	002
03	001
	002

THANK YOU FOR ANSWERING THESE QUESTIONS

Appendix I: OUTPATIENT QUESTIONNAIRE

NOTE: **Dear patient, may you answer ALL APPLICABLE questions according to given instructions.**

Day/Month/Year

Questionnaire Number

Name of Hospital

Type of Hospital

CIRCLE OR FILL IN ANSWERS

I. BACKGROUND INFORMATION

1. Your sex
   - 01 Male
   - 02 Female
2. Your age (completed years)
   - 01
3. Your marital status
   - 01 Single
   - 02 Married
   - 03 Divorced
   - 04 Separated
   - 05 Widowed
   - 06 Cohabiting
4. Your highest educational qualification
   - 01 No formal education
   - 02 Primary education
   - 03 Secondary education
   - 04 Post secondary education
5. Your occupational status
   - 01 Full time salaried employee
   - 02 Business

03 Self-employed

04 Part-timer

05 Peasant

06 Housewife

6. If you are married, state your spouse's occupational status

01 Full time salaried employee

02 Business

03 Self-employed

04 Part-timer

05 Peasant

06 Unemployed

7. If you are the head of your household, on average how much money do you earn monthly?

01 5,000 to 30,000/=

02 30,000 to 55,000/=

03 55,000 to 80,000/=

04 Over 80,000/=

II. UTILIZATION OF OUTPATIENT SERVICES

8. How far is this hospital from your home?

01 kilometers

9. Which means of transport did you use?

01

10. Why did you decide to come to this hospital?

01

11. Were laboratory investigations carried out before you were written medicine(s)

01 Yes

02 No

12. Were you told by the services provider who attended you what disease you were suffering from?

01 Yes

02 No

13. Did you get all the drugs you were prescribed?

01 Yes

02 No

14. If Yes, how much money did you pay in total in order to get the care you were seeking for?

    01

15. If No, explain why you did not get the drugs?

    01

16. Were you satisfied with the care you received?

    01 Yes

    02 No

17. If no, explain why?

    01

18. In your opinion, how do you rate the amount you spent in getting the care you were seeking for?

    01 Affordable

    02 Unaffordable

    03 Uncertain

19. Which method did you use to raise the amount you spent?

    01

20. Are you still willing to seek for your care in this hospital?

    01 Yes

    02 No

21. If Yes, explain why?

    01 Price are affordable

    02 Delivered services are of good quality

    03 Other reason (specify)

22. If delivered services are of good quality, which indicator(s) do you use to measure the noted quality?

    01

    02

23. Have you ever postponed seeking for care because you were unable to pay?

    01 Yes

    02 No

24. If Yes, which alternative did you make instead?

    01

25. Did you pay for the sought care?

    01 Yes

    02 No

26. If you did not pay, explain why?

01

27. Following the introduction of cost sharing in public district hospitals, what is your perception on the following:

27.1 **Quality of** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

27.1.1 If the quality of deliver outpatient services has either remained constant or decreased, explain why?

01

27.1.2 In your opinion, what should be done to ensure an improved quality of delivered outpatient services

01

27.2 **Accessibility to** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

27.2.1 If accessing delivered outpatient services has either remained constant or decreased, explain why?

01

27.2.2 In your opinion, what should be done to maximize accessibility to delivered outpatient services?

01

27.3 **Equity of** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

27.3.1 If the equity of delivered outpatient services has either remained constant or decreased, explain why?

01

27.3.2 In your opinion, what should be done to ensure delivered outpatient services are equitable?

01

28. In case there is an increase on user fees, will you be willing to pay more fees?

01 Yes

02 No

THANK YOU FOR ANSWERING THESE QUESTIONS

Appendix J: **HOUSEHOLD HEAD QUESTIONNAIRE**

NOTE: **Dear household head, may you answer ALL APPLICABLE questions according to given instructions.**

Day/Month/Year

Questionnaire Number

Name of Hospital

Type of Hospital

CIRCLE OR FILL IN ANSWERS

1. BACKGROUND INFORMATION

1. Your sex
   - 01 Male
   - 12 Female
2. Your age (completed years)
   - 01
3. Your marital status
   - 01 Single
   - 02 Married
   - 03 Divorced
   - 04 Separated
   - 05 Widowed
   - 06 Cohabiting
4. Your highest educational qualification
   - 01 No formal education
   - 02 Primary education
   - 03 Secondary education
   - 04 Post secondary education - certified
5. Your occupational status
   - 01 Full time salaried employee
   - 02 Business
   - 03 Self-employed
   - 04 Part-timer

05 Peasant

06 Housewife

6. If you are married, state your spouse's occupational status

01 Full time salaried employee

02 Business

03 Self-employed

04 Part-timer

05 Peasant

06 Unemployed

7. On average, how much money does your household earn monthly?

01 5,00 to 30,000/=

02 30,000 to 55,000/=

03 55,000 to 80,000/=

04 Over 80,000/=

II. UTILIZATION OF OUTPATIENT SERVICES

8. How far is the nearest hospital from your home?

01 kilometres

9. Do you normally go there?

01

10. If yes, which means of transport do you normally use to go there?

01

11. Why do you normally go to this hospital?

01

12. When was your last visit to this hospital after the introduction of cost sharing in public district hospitals?

01 Day/Month/Year

13. Were laboratory investigations carried out before you were written medicine(s)?

01 Yes

02 NO

14. Were you told by the services provider who attended you what disease you were suffering from?

01 Yes

02 No

15. Did you get all the drugs you were prescribed?

01 Yes

02 No

16. If yes how much money did you pay in total in order to get the care you were seeking for?

01

17. If no, explain why you did not get the drugs?

01

18. Were you satisfied with the care you received?

01 Yes

02 No

19. If no, explain why?

01

20. In your opinion, how do you rate the amount you spent in getting the care you were seeking for?

01 Affordable

02 Unaffordable

21. Which method did you use to raise the amount you spent?

01

22. Are you still willing to seek for your care in that hospital?

01 Yes

02 No

23. If yes, explain why?

01 Prices are affordable

02 Delivered services are of good quality

03 Other reason (specify)

24. If delivered services are of good quality, which indicator(s) do you use to measure the quality?

01

02

25. Had you ever postponed seeking for care because you were unable to pay?

01 Yes

02 No

26. If yes, which alternative did you make instead?

01

27. Did you pay for the sought care?

01 Yes

02 No

28. If you did not pay, explain why?

01

29. Following the introduction of cost sharing in public district hospitals, what is your perception on the following:

29.1 **Quality of** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

29.1.1 If the quality of delivered outpatient services has either remained constant or decreased, explain why?

01

29.2 **Accessibility to** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

29.2.1 If accessing delivered outpatient services has either remained constant or decreased, explain why?

01

29.2.2 In your opinion, what should be done to maximise accessiblity to delivered outpatient services?

01

29.3 **Equity of** delivered outpatient services in these hospitals?

01 Improved

02 Remained constant

03 Decreased

29.3.1 If the equity of delivered outpatient services has either remained constant or decreased, explain why?

29.3.2 In your opinion, what should be done to ensure delivered outpatient services are equitable?

01

30. In case there is an increase on user fees, will you be willing to pay more fees?

01 Yes

02 No

THANK YOU FOR ANSWERING THESE QUESTIONS

Appendix K: **Public District Hospitals selected from Morogoro and Tanga regions by Amount collected through Cost Sharing during 1994 in US $**

REGION	H(1)	AMOUNT COLLECTED IN US $	H(2)	AMOUNT COLLECTED IN US $
Morogoro	Kilosa	1,807.5	Mahenge	1,720
Tanga	Handeni	5,015.48	Korogwe	4,454.22

SOURCE:
- Morogoro and Bombo Regional Medical Officers Offices
- National Bank of Commerce, City Branch

NOTE:
- H(1) and H(2) are code numbers used to stand for actual names of selected public district hospitals.
- Also it should be noted that the above public district hospitals were selected depending on data which was available at Regional level during data collection.
- The exchange rate used throughout this work was of the 10 August 1996 where 1 US $ = 580 Tshs.