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# Financing and Delivery of Health Services in Eastern and Southern Africa

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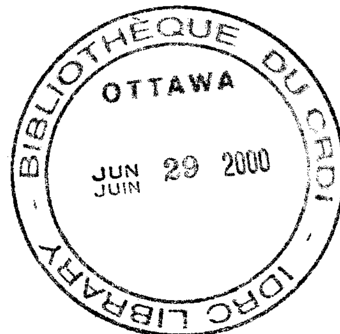

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# COST-SHARING AND LOCAL ACCOUNTABILITY: ALTERNATIVES TO THE FINANCING OF HEALTH SERVICES IN UGANDA.

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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 sêrvice 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

- (i) reducing the spread of HIV infection through increased public awareness of the 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 1980's.

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.

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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 |
| --- | --- | --- | --- | --- |
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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? ----------------------------------------

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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? |
|---|---|
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| | |

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?------------------------------------------------

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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?

______________________________________________________________

______________________________________________________________

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______________________________________________________________

______________________________________________________________

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

______________________________________________________________

______________________________________________________________

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______________________________________________________________

______________________________________________________________

**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]

______________________________________________________________________

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

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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?

______________________________________________________________________

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______________________________________________________________________

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

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______________________________________________________________________

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

______________________________________________________________________

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______________________________________________________________________

______________________________________________________________________

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?

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______________________________________________________________

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

______________________________________________________________

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______________________________________________________________

______________________________________________________________