Financing and Delivery of Health Services in Zambia

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

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List of Abbreviations and Acronyms

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

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EXECUTIVE SUMMARY

Background

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

Community Involvement

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

User Charges and Outcomes

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

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

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

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

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

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

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

Recommendations:

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

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

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

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

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

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

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

Background Information

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

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

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

Economic decline and health expenditure

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

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

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

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

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

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

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

Changes in Health and Welfare Indicators

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

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

Bamako initiative

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

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

Health reforms

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

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

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

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

Health Financing

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

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

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

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

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

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

Objectives of the study:

Determine trends in the financing and delivery of Health Services.

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

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

Examine Community Willingness and ability to pay.

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

Determine the relationship between the public and private health providers.

Statement of the Problem

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

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

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

Methodology

Data collection methods and Research tools

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

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

Sampling process

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

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

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

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

Data analysis

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

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

Study Findings

Respondents Characteristics

Socio-demographic characteristics

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

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

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

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

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

Water and Sanitation characteristics

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

Morbidity and perceived causes

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

Community Needs

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

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

Community Involvement

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

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

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

User Charges and Outcomes

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

Levels of user charges by providers

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

Table 2:

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

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

Capacity and affordability to pay

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

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

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

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

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

Box 1

Views about community capacity to pay for their needs

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

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

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

Willingness to pay

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

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

Table 4

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

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

Table 5:

Reasons given for and against the continuation of user fees

(Expressed in percentages)

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

Social Welfare Scheme for Exemptions

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

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

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

Table 6

Knowledge about the social welfare scheme for those unable to pay

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

Utilization of health services

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

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

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

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

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

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

Box 2

Views against and for the continuation of user charges

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

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

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

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

For charges:

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

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

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

Quality of health care

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

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

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

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

Table 8

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

(Expressed in percentage of respondents)

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

Key:

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

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

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

Private / Public Sector Collaboration and Utilization

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

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

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

issue.

Table 9:

Pro and cons of public/ private sector collaboration

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

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

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

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

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

Table 7

First and second actions taken for an illness episode

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

Note

"-": Less than 1 %

(n): Total

Discussion

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

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

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

Community Participation

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

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

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

Willingness and capacity to pay

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

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

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

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

Social Welfare Scheme

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

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

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

publicisation of the scheme.

Quality of Care

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

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

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

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

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

Recommendations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 2

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

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

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

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

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

Source: CSO, Country Profile reports