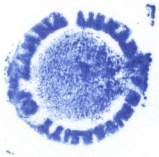
USER FEES: DETERMINING PEOPLE'S ABILITY AND WILLINGNESS TO PAY FOR HEALTH CARE - A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HEALTH SECTORS IN LUSAKA URBAN

by

MARGARET. M. MUTATI

(ZRN, ZRM, BScN)

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF ZAMBIA IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER IN PUBLIC HEALTH.



SCHOOL OF MEDICINE

DEPARTMENT OF COMMUNITY MEDICINE

UNIVERSITY OF ZAMBIA.

LUSAKA, 1996/97

DECLARATION

I here by declare that this dissertation represents my own work, and that it has not previously been submitted for a degree at this or another university.

SIGNED

_____(Student)

_____(Supervisor)

23/03/98

APPROVAL PAGE

This dissertation of Margaret Mwila Mutati is approved in partial fulfilment of the requirements for the award of masters degree in Public Health by the university of Zambia.

Signed

_____ Examiner 1

_____ Examiner 2

ABSTRACT

User fees in Lusaka, Zambia, were introduced in government health care facilities, in August 1993, with the overall aim of providing Zambians with equity of access to cost effective quality health care as close to the family as possible. The introduction of user fees was based on the assumption that households are able and willing to pay for health care.

This study aims to determine households' willingness and ability to pay for health services in public and private health care sectors in Lusaka urban. Once determining factors are identified measures intended to provide policy makers with data for enhancing the design of the scheme can then be recommended.

A cross-sectional study was conducted in Lusaka, during the months of October to November 1996. Using a three stage sampling procedure for identifying participants in the study, a total of 252 patients were interviewed.

The study revealed the following : 72.2%(n=252) of the households had the ability to pay based on the pre-set criteria, with 76.6% indicating that the current fees being charged in the public sector were affordable. About 60% indicated that with their current incomes they were able to access health services in the public sector. Of the 252, 64.7% were members of the University Teaching Hospital medical scheme, an insurance scheme for households.

In order of importance, the main determinants of health care choices were distance (57.9%), quality of service (42.9%), and cost (16.7%). The findings suggest that in the population studied, cost was not a critical determinant. However, comparing various treatment outlets,

findings are that 86.5% attended government health services because they were nearest to their homes as compared to 1 (1.9%) of those attending traditional healers.

The study population defined good care in public and private sectors in terms of availability of drugs (78.6%), staff attitude (52.8%) and technical competence (40.1%). However, among the traditional healers patients did not consider technical competence as being important. Although the majority of households were able to pay, there remained about 29.5% of the households who were unable to pay for health care, which raises an equity problem.

A majority of the patients had come to accept user fees (60.7%) in public health facilities on condition that the government improved the drug situation and health staff attitudes. The medical scheme which would have provided a safety net for the poor is not known among the majority of people.

In conclusion, the study revealed that more than two thirds of the population interviewed were able and willing to pay, and that good quality health services, as perceived by patients, is drug availability and good staff attitudes. With these in place many more would be willing and able to pay for health services.

Based on the findings of the study, it is recommended that:-

(a) The Government identifies the factors contributing to the shortage of drugs in health facilities, with the view of introducing measures to improve the situation.

(b) Care should be taken to focus on improving staff attitudes, through various incentives and training.

(c) Attempts should made to provide adequate information on the operations of medical scheme.

(d) There is an urgent need to spell out exemption policy and maintenance of equity.

ACKNOWLEDGEMENTS

I sincerely thank everybody who in one way or the other contributed to the successful completion of this study.

Special thanks go to Professor P. Sims, for his tireless efforts, dedication, guidance, constructive criticisms and indeed his moral support from beginning to end of this study. To Dr. N. Ngandu, for his valuable contribution on the methodology, Dr. R. Msiska, (Geneva) for the professional guidance and advice on various aspects of the study, and Mr. O. Chinganya, (Central statistics),for his expert advice on the various statistics used in this study.

To Eve for her numerous help in every way, to Alfy, Fred, Christer, Kats, for their expert computer work at all stages of the study, Xtine for her dedicated help especially in qualitative analysis. The study would not have been possible without patients, health care providers and all authorities who gave permission to let the study be carried out in their health care facilities, to all these people I say thank you.

I further acknowledge the tremendous moral support from Irene, my niece and mentor, and indeed my entire family. My list will not be complete without saying a big thank you to my dearest husband UMM and our little boy Chanda-(Mr.C), for giving up so much of their time to enable me complete the study and above all for financing the program and this study, well done and God bless!

Last but nevertheless not the least, to Dr. Baboo, for proof-reading the final draft and making constructive criticisms.

TABLE OF CONTENTS

CHAPTER 3.0

CHAPTER 4.0

CHAPTER 5.0

LIST OF TABLES

APPENDICES

LIST OF FIGURES

CHAPTER 1.0

INTRODUCTION

1.1 OVERVIEW ZAMBIA

Politics and administration

Zambia was a British colony until 24th October, 1964 when she gained her political independence. Since then, the country has undergone three major phases of governance. Firstly, the post independence era of multiparty politics up to 1971. This era was followed by one party rule before reverting back to a multiparty system in 1991, through democratic elections won by the Movement for Multiparty Democracy (MMD).

Administratively, Zambia is divided into nine provinces and 63 districts. The government comprises the central and local governments. The local government is administered through 63 district councils. Lusaka is the capital of Zambia and is a provincial capital for Lusaka province.

Economy

Zambia has a mixed economy consisting of a modern and urban oriented sector confined to the line of rail. The modern sector is dominated by parastatal organizations, while the private sector has been predominant in construction and agriculture. Most of these parastatals are now being privatized by the government. Copper mining is the main economic activity, accounting for 95% of export earnings and contributing 45% to government revenue during the decade following attainment of political independence(1965-1975). This situation was sharply changed by the drastic decline in world copper prices in 1974 and 1975. There was some improvement in prices in 1978,

but in 1981-1982 prices dropped sharply again leading to short supply of essential commodities and services. Inflation rose well over 100%.

The decline in national economy had its impact on particularly social sectors, health, and education. The implication of this situation on the health sector resulted in shortages of drugs, erosion of infrastructure, declining access to health care and poor staff morale which resulted in many professionals leaving the country for 'greener pastures' in the nearby countries.

Education

Education has been provided by the government and church missions and some parastatal organizations notably Zambia Consolidated Copper Mines(ZCCM), which has over time provided education largely for their employees. Private schools have evolved in the recent past mostly in urban areas.

The formal educational system of Zambia comprises three levels. The first level consists of seven years of primary education divided into first four years of lower and three years of upper primary schooling. The second level is secondary education consisting of two years of junior and three years of senior education. The third level is post secondary education which comprises university programs and various technical and vocational programs.

Health system and general health situation in Zambia

Health care in Zambia is provided by the government, religious missions, industries particularly ZCCM, a number of parastatal companies, private practitioners, armed forces and traditional healers. Of these institutions the government has been the principal

provider of care through a wide network of health centers and hospitals, followed by religious missions which provide approximately 30% of total hospital beds, mainly in district and general hospitals. There are eighty three hospitals in Zambia which comprise three central (tertiary)hospitals, three specialist hospitals (pediatric, psychiatry, leprosy), nine provincial hospitals located in each provincial capital, and sixty eight district hospitals.

A remarkable demographic feature of the population of Zambia is its growth rate, which at 3.0% per year (CSO;1995), is one of the highest in the world. Life expectancy is 47 for male and 49 for female,(world population statistics, 1995). Between 1980 and 1992 the infant mortality rate (IMR) was estimated to be 108.9, and child mortality rate was 98.4 (Zambia Demographic Health Survey, 1996). Communicable diseases are the major causes of morbidity and mortality in Zambia. Although HIV/AIDS is rapidly increasing in Zambia, the commonest cause of morbidity and mortality in 0-5 age group, continue to be malnutrition, malaria, diarrhea and respiratory infections. However, among adults the pattern of cause of death in hospitals has changed in the last two years with AIDS related deaths taking first position, Msiska, et al. (1995). The increase in the number of AIDS sickness coupled with the high number of new orphans is likely to create further strain on the over burdened health care system, government and households.

1.2 BACKGROUND TO THE STUDY

Administration of the Health care system was highly centralized and oriented towards hospital care with health services being basically free until 1991, following general and

presidential elections, which brought the Movement for Multiparty Democracy (MMD) into power.

As part of a development to democratize the political system, the government initiated reform of the health care system, with the overall aim of providing Zambians with equity of access to cost effective, quality health care as close to the family as possible. The Primary Health Care Strategy has therefore been adopted with the focus on managing for quality under a decentralized system of health care delivery making districts autonomous with establishment of health boards.

Reform of the health care system was necessitated by high population growth and budget constraints in recent years, which was limiting the ability of the government to improve the services available to the population or even to maintain the current level of the health services.

In an attempt to address these constraints, the MMD government has looked to Cost-Sharing by users of health care services to generate additional revenue and improve quality and efficiency within the health sector.

Zambia, like many developing nations in the sub-Saharan region, has implemented user fees for services in government health care institutions. The government advocates that households should play a critical role in the production of health and as such, all able-bodied Zambians with the capacity to earn an income are, in principle, expected to contribute to the cost of health care.

Introduction of user fees came at a time of a worsening economic situation in Zambia. Employment levels and wages declined, poverty was estimated to affect approximately 69% of Zambians. People were reported to be living in households with expenditure per adult equivalent or below a level sufficient to cater for basic needs (Zambia Poverty Assessment Report, 1994). Although there is an increase in informal sector employment, the Urban Poverty Assessment(UPA) Survey (1994), Lusaka, reported that income ranged from K1091 to K30,000/day. Besides unemployment and drought in the recent years accounting for poverty in most Zambian households, the catastrophically costly consequences of the AIDS epidemic are slowly being felt by majority of the people , further threatening to create, new pockets of poverty. This is a viscious cycle which would have ernomous economic bearing, contributing to the already existing national debt, (Zambia Annual Budget, 1996).

Literature has shown that income and generally ability to mobilize resources are highly associated with the utilization patterns of health services, while ability to pay is related to income level and economic well being. Consumers' willingness to pay may be equally, if not more contingent on, perceived value for money.

1.3 STATEMENT OF THE PROBLEM

Following the introduction of user fees in Lusaka urban in August 1993, there has been a reported decline in the overall utilization pattern of health services, (Booth, et al. 1994).

Data from the Ministry of Health collected after implementation of fees and analyzed by Sally Lake, (UNICEF, Lusaka office, 1994), suggested massive abstention as an

immediate and possibly durable response to the introduction of fees in Lusaka. Both out patient and maternity delivery services were adversely affected with some urban clinics recording an average fall of 61-98% respectively. The situation had not recovered by February, 1994.

This has cast doubt on the frequent suggestion that after an initial fall in response to the introduction of fees, health service utilization always bounces back.

Kalyalya and Milimo,(1996), also report low utilization of health services in areas studied in other parts of the country, following introduction of fees.

Increased use of home remedies, self diagnosis, self prescription and procuring of drugs from make shift drug stores in community markets and homes emerged as the prevalent coping mechanisms resorted to, in the wake of user fees.

With this reported decline in the utilization of health services in government health institutions, there is a likelihood that the affected population may seek services of traditional healers or private practitioners since these form part of the health care system in Zambia and their services are known to be utilized by many people despite the fact that their fees appear higher than those charged by the public health sector, (Kaona, F.A.D.et al. 1994).

While people may have various choices of health care in the private sector, no data is available to show how accessible these services are, in terms of peoples' ability and willingness to pay.

The study is therefore an attempt to determine the extent to which people are able and willing to pay for health care in the public and private health sectors in Lusaka.

1.4 JUSTIFICATION

The introduction of user fees in government health care facilities is based on the assumption of households' ability and willingness to pay for such services. The ability to pay for health services has probably been compromised by the downward spiral of the economy over the past 10 years. The World Bank Poverty Assessment report revealed that nearly 50% of households are below the poverty datum line(World Bank, 1994). In the absence of a clear financing policy and poorly functioning exemption mechanisms, individuals could easily be denied access to health services.

Literature has shown that userfees, despite having the benefit of generating much needed revenue and discouraging frivolous use of services, have on the other hand a potential negative effect of excluding low income individuals from necessary access to medical care,(Gertler, et al.1987; Huber, 1993)

Gertler, et al. (1987), argue that since user fees increase the price of care, the poor respond by decreasing their consumption.

From a public health perspective, it is only logical that people have access to a health facility where they may receive proper consultation and diagnosis before consuming self prescribed drugs or indulging in practices that may be harmful to their health. Failure to pay for health care at any facility - public or private, may result in people dying at home

or being brought to hospital in the last stages of illness. The final consequences of the last resort is likely to be costly to both the government and households.

This study therefore aims to contribute to policy dialogue by systematically examining factors that influence households' ability and willingness to pay for health services in Lusaka urban. A study of this nature is therefore considered appropriate and timely.

1.5 OBJECTIVES

1.5.1 General Objective

To determine households' ability and willingness to pay for health services in public and private health care sectors in Lusaka urban.

1.5.2 Specific Objectives

1. To determine the proportion of people able and willing to pay for health care.
2. To identify factors that could influence households' ability and willingness to pay for health care.
3. To establish determinants of health care choice and the underlying factors that could influence choice.
4. To recommend measures intended to provide policy makers with data for informed policy choices and enhancing the design and implementation of health financing policy.

1.6 HYPOTHESES

1. The willingness to pay for health services by people depends on the quality of health services being provided.
2 The ability to pay for health services depends on mode of payment.
3 Cost is a barrier to health services

CHAPTER 2.0

LITERATURE REVIEW

Health services in Zambia were basically free from time of attaining political independence in 1964, until October 1991, when the Movement for Multiparty Democracy (MMD) came into power through democratic elections.

The MMD Government has developed a radical reforming policy for the future direction of health services. The ruling party manifesto amounts to a fundamental change towards improvements in Primary Health Care and in hospital services. The main thrust of the reforms is for better management and improvements in quality of service. The Government upholds the principle that all people should make a contribution for good quality health care and therefore, everyone in Zambia with an income shall contribute towards maintenance of his/her health.

The Government's health vision is to develop a health care system which will provide Zambians with equity of access to effective quality health care as close to the family as possible. This means provision of better management for quality health care for the individual, the family, and the community, (National Health Policies and Strategies, October, 1992).

Through out the developing world, user fees for health have become a common method for supplementing government budgets while discouraging unnecessary health care use. Zambia like many developing countries in the sub-Saharan region, has also implemented user fees for services in government health institutions.

Although user fees appear to place extra financial burden on households literature has shown that people are generally able and willing to pay for health care. Studies done in Zambia and elsewhere, have indicated extensive expenditure on traditional medicine, private practitioners and mission hospitals, (Kalumba, et al., 1994; Kanyata, 1995; Kara counseling, 1995; Shawl and Griffin, 1995). The Bamako initiative experience has also revealed that only 10-30% households have difficulty in paying minor fees, (McPake,et al,1993).

Economists have traditionally used the concept of 'demand' defined as willingness and ability to pay and suggest that evidence of existing payments and patterns of expenditure can be cited as evidence of affordability of user fees .

The idea of ability to pay is sometimes used regarding the consumption of other goods mostly luxuries such as alcohol. Gertler, et al. (1990), argue that as long as a person's expenditure on such luxuries exceed the expected costs of medical care, it is judged that an individual is able to pay for medical care. Household surveys in Ethiopia suggest that expenditures on traditional medicine constituted 20% of total household expenditure, 33% private and 47% "modern" medicine. Similar expenditures have been documented in Kenya and Tanzania's studies respectively, where in-kind payments such as livestock, are also common among patients of traditional healers,(Shawl and Griffin, 1995).

In short, households typically pay substantial amounts of money for health care. From these comparisons, Kalumba, et al.(1994), argue that similar charges could be made for government services. Literature has also shown that utilization of services is likely to be

reduced in situations where fees are introduced with little improvements in quality, (De Bethune, et al. 1989; Waddington, et al, 1989), and that people even the poor will pay for services perceived to be of high quality with drugs available (Haddad and Fournier, 1995). Quality of care has been recognized as a significant factor influencing demand. Litvack and Bodart, (1993), pointed out that perceived quality of service is one of the most important determinants of patients' choice of provider and willingness to pay. Policy analysts have also echoed the importance of improving quality of service in addition to introduction of user fees, so as to encourage willingness to pay. The World Bank (1987), suggests that improvement in the quality of services provided by the public system would compensate for the negative effects of prices, knowing that the relatively long standing practices of the church mission facilities who charge, gives fairly conclusive evidence, that people will pay for quality health care.

Although people advocate quality service it is in most cases very difficult to measure because the concept of quality in health care is understood differently by different people. For instance, Vuori,(1982), defines quality in health care as containing different aspects such as consumer participation , consumer and provider satisfaction, continuity, affordability, adequacy, accessibility, effectiveness, efficiency, scientific technical quality and contribution to overall socio-economic development.

Participants in a seminar on quality assurance organized by the Ministry of Health (MOH), Livingstone-Zambia, (1993) agreed that the definition of quality of care in Zambia should include the provision of compassionate, safe, timely, and affordable services in a suitable environment. Particular attention should be given to the vulnerable

groups and should guarantee maintenance of professional competence of health care providers with acceptable working conditions. Quality of care should also ensure patient satisfaction and make effective and efficient use of available resources, (MOH and WHO, 1993).

While some studies have indicated that generally people are able and willing to pay for health care , they fail to address adequately implications of fees on the households. Baum, and Strenski (1989), reported results of a survey which indicated that 60% Thai farmers were forced to sell land in order to pay for medical expenses. Studies in Haiti (Coreil, 1983), and in Ghana (Waddington and Enyimayew, 1989), found that high payments for traditional medicine undermined the capacity of households to meet minimum food expenditures, agricultural development, and education.

Cobbert, (1988), cautioned researchers and policy makers not to overlook the possibility that poor people were likely to be sick. The causation between poverty and ill health run both ways . On the one hand , ill health increases the possibility of poverty through reduced earning ability and high health care costs, on the other hand poverty contributes to ill health because of poor living conditions, lower nutrition and less access to health care.

As much as many governments would like to exempt some vulnerable groups on social economic grounds it is usually difficult to reach a consensus on what constitutes perfect indicators for ability to pay for health care. Huber, (1993), cites a frequently used benchmark for ability to pay and suggests that a typical household should not have to pay more than 5% of their annual income on health care. Information available from other

middle income African countries based on Huber's study (1993), indicates that the average percentage of household annual income spent on health care is in the range of 2.2-4.3%. In Zambia, the household budget survey report (1993/94) estimated that Zambian households spend 0.8% of their total annual income on health care .

Huber, (1993), further argues that user fees should not require households to finance their health care out of sale of assets, and suggests that the goal of user fees should be to generate revenue, without discouraging utilization of necessary services or placing an excessive burden on low income households.

Although many studies including this one have used 'household' as a unit of analysis, the term is fraught with many difficulties, (Adams and Castle, 1994). Demographers generally employ their definitions centered on the provision of food from a common granary, the use of common hearth or cooking pot, or the enumeration of all who look to the same household head. Overlooked are complex intra household relationships, functions and important networks of support and obligations that extend beyond household boundaries. Anthropologists on the other hand prefer the term 'domestic domain' which relates not only to the preparation of food but also to processes such as the socialization of children, transference of property and maintenance, and reproduction of household values and influence, (Adams and Castle, 1994); Kendall and Bhattacharyya, 1994), further define household as a dynamic behavioral process through which household members combine their (internal) knowledge, resources, and behavioral norms and patterns with (external) technologies, services, information, and skills to restore, maintain and promote the health of their members.

This last approach encourages us to consider a household as a critical determinant in the provision of quality of care within the given social and economic environment.

CHAPTER 3.0

METHODOLOGY

3.1 Identification of Variables and Their Definitions.

Ability to pay

Cost of medical care equivalent to/or exceeding 1%* of total annual household income.

Willingness to pay

Paying for medical care perceived to be value for money and considered a quality care/service by the individual.

Good service

One or more of the following indicators:

- Availability of drugs
- Technical competence of personnel
- Staff attitudes considered by the individual as positive
- Privacy/confidentiality of illness
- Cleanliness of infrastructure.

Quality of service

Will include good service and/or other services perceived by respondent as satisfactory.

Staff Attitude

Behavior of staff towards a patient perceived as positive or negative by the patient

*** NOTE:** Computation based on household budget survey report 1993/94, Zambia, states that Zambians spend 0.80% of total annual household income on medical care. In this study 1% annual household expenditure on medical care has been used to determine the number of households who are able to pay for health care.

Cost of Medical care

Total Cost of all medical related services i.e. consultation, prepayment fees, drugs, admission and other services e.g. X-ray, Laboratory, etc., and transport to and from health care service outlet .

Determinants of health care choices

- Cost of medical care
- Distance of health facility
- Quality of health care offered
- Mode of payment.

Household

A group of persons living permanently together, or visiting for a period of 1- 4 weeks before the interview date, regardless of blood relations and usually headed by one person considered head of household.

Head of Household

A person entrusted with the responsibility of looking after the affairs of the household, e.g. Mother, Father, Owner of house.

Health Service Outlet

Public, private, health care facilities and traditional healers points of health delivery.

Private Health sector

- Private Hospital
- Company Owned Hospital
- Traditional Healers.

Public Health Sector

Government Owned hospital/Urban health centers.

User fees/user charges

Will be interchangeably used to mean all medical related expenses

3.2 Design

The study was a cross-sectional comparative study and involved interviewing patients using public and private health sector facilities.

Unstructured interviews were also held with health care providers in charge of all health service outlets that took part in the study . Two focus group discussions were held with traditional healers. Qualitative as well as quantitative methods were therefore applied for data collection.

3.3 Study Setting

The study took place in Lusaka the capital city of Zambia. Lusaka is the fastest growing city in Zambia and is one of the most highly urbanized in the Sub-Saharan Africa south of the equator(DHMT Civic Center , Lusaka ,1993). The projected population for 1994, based on the 1990 census is 1,243,087 and its annual growth rate is 6.19% (more than the national average of 2.7% as per 1990 census). The city is densely populated with 3,255 persons per square kilometer.

Lusaka, like most urban areas in Zambia is surrounded by shanty compounds on the outskirts of the city. Most of these compounds are heavily populated and lack adequate provisions of public services such as water and as a result people have resorted to shallow wells. There are 93 residential areas, 30% of these are shanty compounds. About 75% of Lusaka's population live in the peri urban areas.

The city is the commercial center of Zambia with some light industry, textiles, mechanical, trading and engineering being the major fields of formal employment. The government leads in employment figures.

Health care in Lusaka is provided by the Government, Private Sector, Parastatal and Private Companies and Traditional healers. Under the government sector, there are three hospitals namely the University Teaching Hospital (UTH) (1835 beds), Chainama Hospital (500 beds) and Maina Soko Military Hospital (66 beds). The UTH is the national reference hospital and is accessible to the majority of people in Lusaka while Maina Soko is a military hospital with some limited accessibility to civilians, and Chainama was until recently, a mental hospital but now has plans to open its doors to general patients.

There are 22 government health centers and four first aid posts (the 22nd health center within Chainama has been handed over to Chainama as its teaching outpost). The health centers have been divided into eight administrative zones. Ten of the centers have maternity facilities and the remaining 12 do not have. The ten maternity centers operate 24 hours per day and are linked by radio communication and have an ambulance service. The catchment population of the health centers ranges from 20,000-128,994 (Lusaka DHMT, 1993). Under the private sector there are 200 private surgeries and two hospitals, there is one parastatal hospital belonging to ZCCM and there are approximately 28 known Non-Governmental Organizations (NGO'S), engaged in preventive and rehabilitative Primary Health Care activities. Estimates suggest that there are more than 1000 traditional healers in Lusaka and approximately 100 private doctors in Lusaka alone (Simukoko, et al. 1995).

The study samples were drawn from zones 5 and 7 (see appendix ix). These zones comprise of low and medium cost housing areas. Low cost areas are those with mainly shanty/squatter type of housing with crowded plots where as medium cost areas are those areas with higher quality housing of medium size and medium plots. Zones 5 and 7 comprise of the following health centers:

ZONE 5: Chawama, and Lilayi

ZONE 7: Chilenje, Kabwata, Bauleni, State lodge, and Prisons

Chawama and Bauleni were conveniently selected to represent low cost housing areas, while Chilenje and Kabwata were selected to represent medium cost housing areas.

According to Poverty Assessment Report (1994) a 1/4 of the entire Zambian population live in low income urban areas where the majority are below the poverty datum line, it is these people who are therefore likely to be negatively affected by user fees, hence the justification to sample from these areas rather than the high cost areas. Another reason for choosing zones 5 and 7 for the study is based on an assumption that the urban population in Lusaka is homogeneous and geographical locations may not have any influence on social economic status of households and therefore not likely to produce bias.

3.4 STUDY POPULATION

The population included patients using services at urban health centers, private clinics, and traditional healers or those accompanying them.

Inclusion criteria:

- Patient of any sex or accompanying relative, if patient is a minor or is too ill to be interviewed
- 18 years and above. At 18 years, an individual is eligible to vote in Zambia and as such considered mature enough to make an independent decision. Therefore, this age appeared appropriate for participating in the study
- Using services for which they are supposed to pay for, this means that patients attending ante natal or children's clinics for immunizations or other services were not eligible to participate in the study except in circumstances were these services were being paid for as the case was in some private clinics.
- Able to converse in English or any local language the interviewer was fluent with.
- Health care providers in charge of all health service outlets in the study areas including traditional healers.

3.5.0 SAMPLING PROCEDURES

A three stage multistage sampling procedure was applied in selecting patients from urban clinics. The first stage constituted primary sampling units (PSUs), which in this case were the zones.

Simple random sampling was applied to select the two zones. The urban clinics in those zones formed the secondary sampling units (SSUs), which were conveniently selected and included two low cost and two medium cost housing areas respectively. The elementary sampling units (ESUs), i.e. patients were then drawn from the selected urban

clinics using systematic sampling procedures to get the desired sample size and were used as a unit of analysis.

Samples for patients attending private clinics and traditional healers were conveniently drawn from all available practitioners in the areas of selected urban clinics. Near by areas outside the two zones were also used to draw a few patients until the required sample size was obtained. In both cases, that is, patients of traditional healers and private practitioners, quota sampling was applied for the period of data collection in those areas (i.e. 5 weeks - October/November), 1996).

Purposive sampling was applied to choose Health care providers from service outlets in study areas.

3.5.1 SELECTION OF PATIENTS AND SAMPLE DESIGN

3.5.1(a) Selection of patients at urban clinics:

Patients were selected from urban clinics in study areas representing low and medium cost housing areas. Based on clinic records, daily attendance was estimated at approximately 200-500, giving a daily average attendance of 350. 10% of daily average attendance (35), was considered the required sample per clinic.

Systematic sampling procedures were applied to get the sample at each health center. The sampling interval was ten, therefore every tenth patient seen was eligible to take part in the study until the desired number was reached. Patients were interviewed at exit polls. Interviews took place during the day and lasted between two to three days at each center.

3.5.1(b) Selection of Patients at Private Clinics and Traditional Healers.

All patients attending Private clinics/traditional healers on the day of interview were automatically eligible to participate in the study if they met the inclusion criteria.
In the absence of appropriate data for estimating sample size for these two groups and also due to time and other resource constraints, sample size was conveniently estimated to allow for comparison. A total sample of 100 patients was therefore drawn, i.e. 50 patients from traditional healers and 50 patients from private practitioners respectively. Patients were drawn from private clinics and traditional healers within study areas and in some cases near by areas, outside zones five and seven. Quota sampling procedures were applied in all cases until desired sample sizes were reached. Interviews were conducted at exit polls. Data from these service outlets were collected over a period of one to two weeks at each service outlet because of the limited number of patients at some private surgeries and traditional healers. This meant that data had to be collected even at weekends, whenever it became necessary.

3.5.2 Sample Size

Based on sampling procedures applied for selecting patients at urban clinics, private clinics and traditional healers, the actual study sample size including a 5% attrition rate therefore comprised of:

148 patients from urban clinics

52 patients from private clinics

52 patients from traditional healers

Total = 252

3.5.3 Health care provider Interviews and Focus group discussions

Interviews were held with health care providers in charge of all service outlets in the study areas and traditional healers that provided us with patients for interview. In addition, focus group discussions were held with both traditional healers who provided patients and those who did not. Interviews were held at respective service outlets and this was done after interviewing their patients.

3.6 DATA COLLECTION TECHNIQUES AND TOOLS

3.6.1 Structured Interview Schedule

A Structured interview schedule with open and closed ended questions was used to collect data from patients seeking care from urban clinics, private clinics and traditional healers. Factors likely to influence households' ability and willingness to pay were systematically examined.

3.6.2 Checklist for health care provider Interviews and focus group discussions

Unstructured interviews and focus group discussions as mentioned above were held with health care providers. The idea was to get their opinion on user fees in the health sector. A checklist was used to guide the interviews and focus group discussions. Topics for interview and discussion included:

1.Current utilization pattern of health services

2.Criteria for arriving at user fees

3. Patient purchasing power

4. Advantages of user fees

5. Disadvantages of user fees

6. Future of user fees in Zambia

7.Comments/suggestions for the future

3.6.3 Health Care Facility Checklist

Finally, a checklist was used to obtain and reinforce data on the quality of service offered. Information was obtained on basic facilities and equipment as follows:

1. Transport
2. Telephone/Radio Communication
3. Laboratory for basic Laboratory tests (Blood slides for malaria parasites, Urine, Stool etc.)
4. Availability of essential drugs
5. Infrastructure:
   - Cleanliness
   - Availability of toilets
6. Equipment and other facilities

3.7 ETHICAL CONSIDERATIONS

Permission to conduct the study was obtained from the Research and Ethics Committee of the University of Zambia, Lusaka City Council, Private Practitioners Association, Traditional Healers Association and Ministry of Health, Traditional medicine unit.

Participation in the study was purely voluntary for those patients who met the inclusion criteria. The purpose of the study was clearly explained to the patients who were also allowed to ask questions. If there was no objection the patient was made to sign or thumbprint an informed consent form and participated in the study. There were no problems experienced in this area.

3.8 PILOT STUDY

A Pilot study was done a week before the main study. Patients were interviewed from urban clinics, private clinics and traditional healers, in low and medium cost housing areas of zones not included in the study. Six patients from one urban clinic, three from one private clinic and three from one traditional healer were interviewed. One health care provider was interviewed from each of the service outlets. Based on the results of the pilot study, the instruments were adjusted accordingly.

3.9 DATA ANALYSIS

Data was analyzed using the EPI-INFO6 software to generate frequencies. Graphs and cross tabulations were done using SPSS software. Chi-square calculations were the main statistics used to determine relationships between main variables and this allowed for comparison between health service outlets.

3.10 LIMITATIONS OF THE STUDY

1. Sample size may be considered small, this has been due to resource constraints. However it is the view of the researcher that results of the study could contribute to a body of knowledge that could be utilized in future studies.

2. Non availability of current registers for both private practice and traditional healers created limitations in sampling procedures involving these sectors of health care, hence convenience sampling procedures were applied, this could affect the representativeness of the sample at city level. However, the researcher is of the view that data obtained could

possibly be compared with other low income compounds of similar size and legal status in Lusaka.

3. Problems were encountered in getting access to traditional healers in the initial stages. Traditional healers were sometimes identified by posters on the streets or their houses or from passers-by. This caused problems until a traditional healer who belonged to THPAZ was identified. She helped recruit other traditional healers in the study. Some problems were further encountered with private patients because of the limited daily attendance in most surgeries. Some study areas had very few surgeries, and at some surgeries practitioners operated only on part time basis and sometimes only at specific times or days. In some cases it became necessary to make appointments to suit practitioners and their clients. This meant that data had to be collected even at weekends whenever it was necessary. This stretched the data collection period over a longer period.

4. There was a possibility of excluding potential users of health services in this study because household financial situation varies according to the period of the month. Depending on the level of income, the household at the time of the interview may or may not have the required resources to access the health services.

5. The use of a health facility as an interview site, while able to provide accurate information on quality of service may not be able to reveal those patients who are going to other service providers at the same time. Household interview in addition to this approach would probably provide information on patterns of resort and their influence on access to health services. Time and resource constraints limited this study to the design.

6. Income estimates may not be reliable, because people usually regard their incomes as 'confidential' and therefore may not tell the truth. Also, depending on their opinion of user fees they may give information to either reflect ability to pay or otherwise.

7. A four week recall period for medical expenditure could have been a problem for some individuals, but the design of the question was such that it allowed for probing on various medical costs.

CHAPTER 4.0

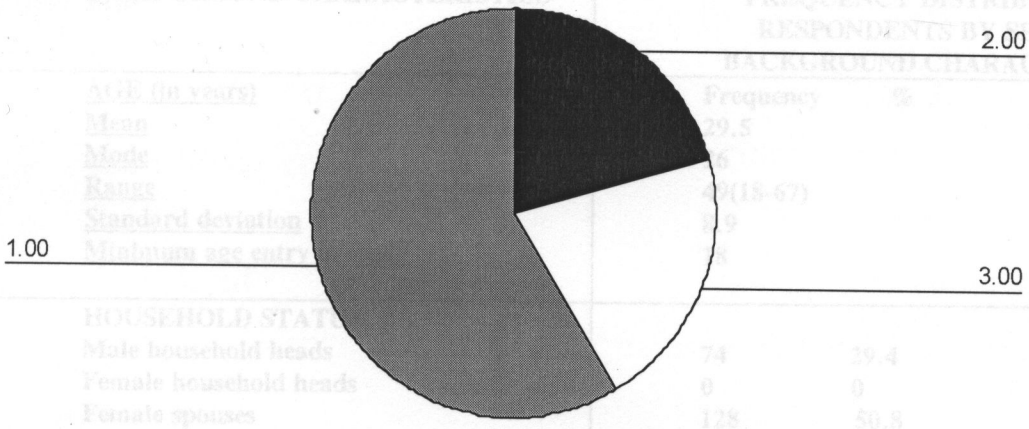
RESULTS

I. PRELIMINARY INFORMATION

The study was conducted between the months of October and November, 1996. The data collection period was approximately 5 weeks , morning and afternoons including some weekends. Two research assistants helped the principal investigator collect data. Three sets of data were collected from patients, health care providers and assessment of health care facilities.

Study areas were in zones 5 and 7 of Lusaka urban (Chawama, Bauleni, Chilenje, Kabwata and nearby areas such as Kamwala and Libala).

FIG 1: SAMPLE SIZE ACCORDING TO HEALTH SERVICE OUTLET



1 = Public outlet (58.7%)
2 = Private outlet (20.6%)
3 = Traditional (20.6%)

A total of 252 patients participated in the study, giving a response rate of 100%. 148(58.7%) were drawn from 4 public health service outlets, (appendix IX)52(20.6%) from 8 private service outlets, (appendix VIII) and another 52(20.6%)from 14 traditional healers points of health delivery, which were mostly dwelling places,(appendix XII).

An interview schedule with both open and closed ended questions was used to interview patients. A total of 25 health care providers were also interviewed, and two focus group discussions were conducted using a checklist with open ended questions. Assessment of basic facilities and equipment was done at public and private service outlets.

II. PATIENTS

TABLES:1a),b),c): BACKGROUND CHARACTERISTICS OF RESPONDENTS
Table 1 a) AGE, HOUSEHOLD STATUS AND SIZE

BACK GROUND CHARACTERISTICS	FREQUENCY DISTRIBUTION OF RESPONDENTS BY SELECTED BACKGROUND CHARACTERISTICS	
AGE (in years)	Frequency	%
Mean	29.5	
Mode	26	
Range	49(18-67)	
Standard deviation	8.9	
Minimum age entry in study	18	
HOUSEHOLD STATUS		
Male household heads	74	29.4
Female household heads	0	0
Female spouses	128	50.8
Dependents of either sex	50	19.8
HOUSEHOLD SIZE		
1-5	133	52.8
>5	119	47.2
Mean	5.9 Persons per household	

Tables 1(a),(b),(c) give an overview of selected background characteristics of respondents. Table 1(a) shows that minimum age entry in the study was 18 years. Other measures of central tendency are as shown in the table. Of the total sample interviewed, 74(29.4%) were male heads of households, 128(50.8%) female spouses, 50(19.8%)dependents of either sex and no female headed household was recorded. Mean household size was 5.9 people per household, 133(52.8%) households comprised 1-5 people and 119(47.2%) households were more than 5.

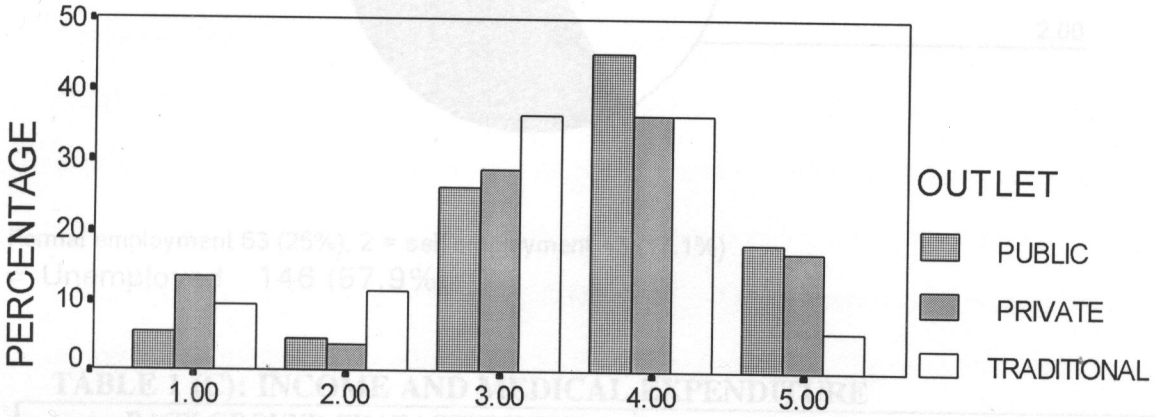
Table 1 b): EDUCATION AND EMPLOYMENT

BACK GROUND CHARACTERISTICS	FREQUENCY DISTRIBUTION OF RESPONDENTS BY SELECTED BACKGROUND CHARACTERISTICS	
EDUCATION	**Frequency**	**%**
None	**20**	**7.9**
Primary	**88**	**34.9**
Secondary	**105**	**41.7**
College/university	**39**	**15.5**
EMPLOYMENT		
Formal	**63**	**25.0**
Self	**43**	**17.1**
Unemployed	**146**	**57.9**

Table 1(b) shows educational level of respondents and their employment status. Majority of the respondents, 232(92.1%) had some form of education ranging from primary to college against only 20(7.9%) who had none. (For distribution among health service outlets see fig.2).

Employment status data revealed that majority, 146(57.9%) were unemployed, 63(25%) had formal employment, and 43(17.1%)self employment mainly vending and marketing,(see also fig.3).

FIG 2: EDUCATION LEVEL BY HEALTH SERVICE OUTLET

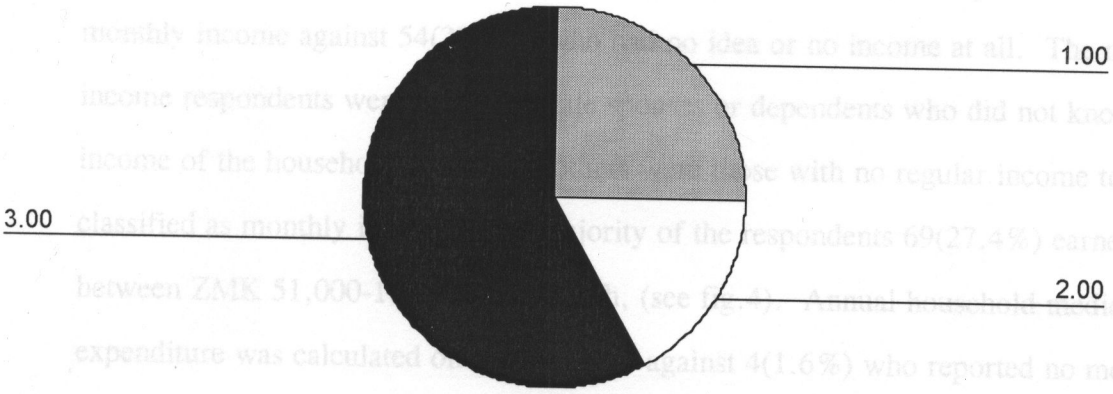


EDUCATION LEVEL

1 = NONE 2 = LOWER PRIMARY 3 = UPPER PRIMARY

4 = SECONDARY 5 = COLLEGE / UNIVERSITY

FIG 3: EMPLOYMENT STATUS



1 = Formal employment 63 (25%), 2 = self-employment 43 (17.1%)
3 = Unemployed 146 (57.9%)

TABLE 1 (C): INCOME AND MEDICAL EXPENDITURE

BACK GROUND CHARACTERISTICS	FREQUENCY DISTRIBUTION OF RESPONDENTS BY SELECTED BACKGROUND CHARACTERISTICS
HOUSEHOLD INCOME PER MONTH (ZMK)	Frequency %
No idea	54 21.4
< 50,000	47 18.7
51,000 - 100,000	69 27.4
101,000 - 150,000	11 11.9
151,000 - 200,000	20 7.9
> 200,000	32 12.7
ANNUAL HOUSEHOLD MEDICAL EXPENDITURE (ZMK)	
Minimum	2,4OO
Mean	209,373.17
Median	90,000
Mode	12,000
Maximum	4,363,200
Range	4,360,800 (2400-4,363,200)

Table 1(C) gives an overview of approximate monthly household income and annual average medical expenditure. A total of 198(78.6%) were able to report their household monthly income against 54(21.4%) who had no idea or no income at all. The no idea/no income respondents were mostly female spouses or dependents who did not know the income of the household heads, and others were those with no regular income to be classified as monthly income. The majority of the respondents 69(27.4%) earned between ZMK 51,000-100,000 per month, (see fig.4). Annual household medical expenditure was calculated on 248(98.4%) against 4(1.6%) who reported no medical expenditure for various reasons such as review, and in some cases some respondents could not recall expenditure for the past 4 weeks preceding interview. Mean medical expenditure per household was ZMK 209373.17, Other measures of central tendency representing medical expenditure are as shown in the table. Proportions of medical expenditure to income are presented in table 2.

FIG 4: HOUSEHOLD INCOME PER MONTH

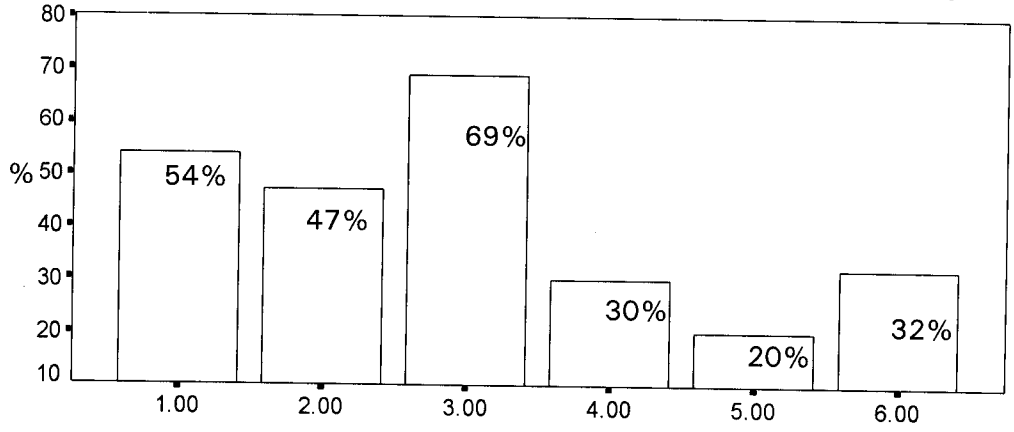


FIG 5: REASONS FOR SEEKING CARE

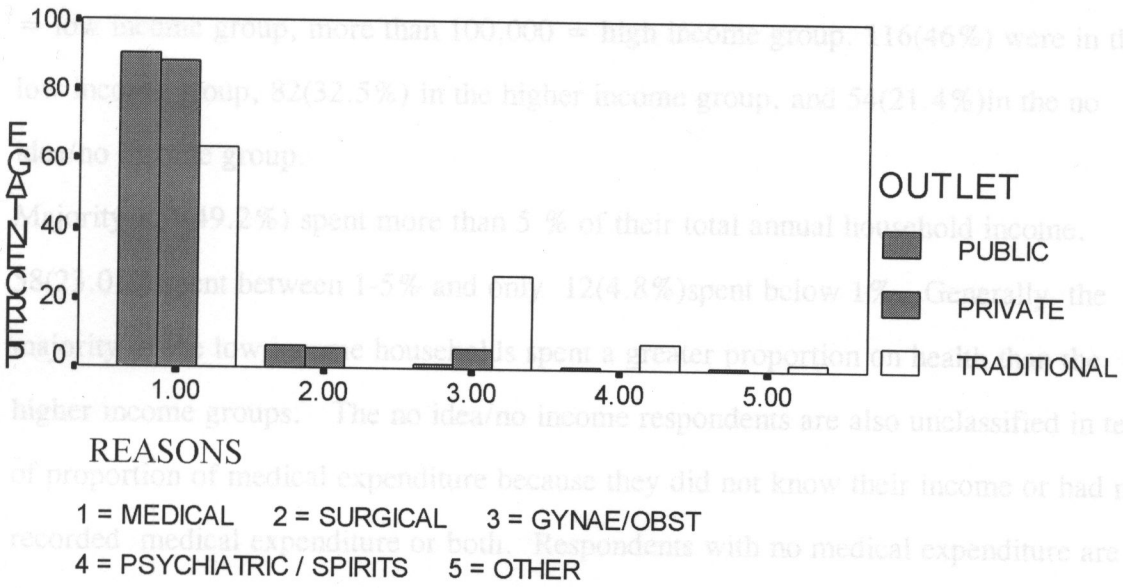


Figure 5 shows patients' presenting symptoms at the three service outlets they visited. The majority of the respondents had medical problems, 213(84.5%), followed by gynecological/obstetrical symptoms 19(7.5%), surgical 13(5.2%), psychiatry evil spirits 5(2.0%) and other unclassified ill-defined problems 2(0.8%). Medical problems were the most common between all the outlets distributed as follows: Public 134(90.5%), Private 46(80.5%), Traditional 33(63.5%).

Table 2: INCOME BY PROPORTION OF ANNUAL HOUSEHOLD MEDICAL EXPENDITURE (Proportion of household budget spent on health per annum)

PROPORTION OF ANNUAL HOUSEHOLD INCOME SPENT ON HEALTH CARE					
INCOME (ZMK)	BELOW 1%	1-5%	ABOVE 5%	UNCLASSIFIED	TOTAL
NO IDEA/ NO INCOME	0	0	0	54 (21.4%)	54 (2 1.4%)
< 100,000	5 (2%)	30 11.9%)	77 (30.6%)	4 (1.6%)	116 (46.0%)
> 100,000	7 (2.8%)	28 (11.1%)	47 (18.6%)	0	82 (32.5%)
TOTAL	12 (4.8%)	58 (23.0%)	124 (49.2%)	58 (23.0%)	252 (100%)

Chi-square = 234, DF= 6, p = 0.00

Table 2 shows proportion of household budget spent on health per annum. Income is categorized into low income group and high income groups i.e. less than ZMK 100,000 = low income group, more than 100,000 = high income group. 116(46%) were in the low income group, 82(32.5%) in the higher income group, and 54(21.4%)in the no idea/no income group.

Majority 124(49.2%) spent more than 5 % of their total annual household income, 58(23.0%) spent between 1-5% and only 12(4.8%)spent below 1%. Generally the majority of the low income households spent a greater proportion on health than the higher income groups. The no idea/no income respondents are also unclassified in terms of proportion of medical expenditure because they did not know their income or had no recorded medical expenditure or both. Respondents with no medical expenditure are those who had incurred no medical costs on the day of interview nor at any time during the last four weeks prior to interview, for themselves or any member of the household. Most of these were children who had been brought for review at public service outlets.

NB. income and medical expenditure were critical variables for estimating proportion of medical expenditure. Statistically there was a significant association between income and proportion of medical expenditure (chi-square = 234.2,df = 6, p = 0.00).

TABLE 3: OPINION ON FEES BY SERVICE OUTLET
(Does health service outlet influence affordability?) chi = 11.2, df = 4, p = 0.02

	HEALTH SERVICE OUTLET			
OPINION ON FEES	PUBLIC n=148	PRIVATE n=52	TRADITIONAL n=52	TOTAL
AFFORDABLE	104 (70.3%)	41(78.8%)	48(92.3%)	193(76.6%)
NOT AFFORDABLE	34(23%)	9(17.3%)	4(7.7%)	47(18.7%)
NOT SURE	10(6.8%)	2(4%)	0	12(4.8%)
TOTAL	148	52	52	252(100%

Table 3 shows 193(76.6%) of the respondents whose opinion was that fees were affordable, against 47(18.7%) and 12(4.8%) who were not sure. Among those who said fees were affordable the majority 48(92.3%) were traditional healer patients, 41(78.8%) were private and 104(70.3%)public. The opposite is true for those respondents whose opinions were that fees were not affordable. Most of the not sure respondents were those who had visited the service outlets for the first time and therefore could not comment because they were mainly referred by relatives or friends. In this study, 75(29.9%) visited their service outlet of choice for the first time, 117(46.6%) had always done so, and 58(23.5%), sometimes did so.

Statistically, there was a significant association between health service outlet and respondents' opinion of fees at the three service outlets, (chi-square = 11.2, df = 4, p = 0.02).

TABLE 4: FACTORS THAT INFLUENCE CHOICE OF HEALTH SERVICE PROVISION (what factors influence choice of health service provision?)

	HEALTH SERVICE OUTLET			
UTILIZATION FACTOR	PUBLIC	PRIVATE	TRADITIONAL	TOTAL
COST	31 (20.9%)	7 (13.5%)	4 (7.7%)	42 (16.7%)
DISTANCE	128 (86.5%)	17 (32.7%)	1 (1.9%)	146 (57.9%)
QUALITY OF SERVICE	59 (39.7%)	34 (65.4%)	15 (28.8%)	108 (42.9%)
PAYMENT MODE	4 (2.7%)	9 (17.3%)	4 (7.7%)	17 (6.7%)
OTHER	22 (14.9%)	18 (34.6%)	36 (69.2%)	76 (30.2%)

Table 4 summarizes results of factors that respondents believed influenced their choice of health service provision. Distance emerged the most determining factor with 146(57.9%) responses which were mostly from public patients. This was followed by Quality of service 108(42.9%), Cost 42(16.7%), and mode of payment 17(6.7%) took third, and fourth, positions respectively. 76(30.2%) gave other unclassified responses such as " 24 hour service", "availability of doctors all the time especially at weekends", "UTH OPD is closed so no where to go", "referred by friend/relative", "tried elsewhere and failed", " heard on the radio" etc.

Statistical relationships between utilization factor and health service outlet are shown below:

Utilization factor	chi-square	df	p	relationship
Cost	5.4	2	0.07	No
Distance	130	2	0.00	Yes
Quality	15.5	2	0.00	Yes
Mode of payment	13.1	2	0.00	Yes
Other factors	6.3	2	0.04	Yes

TABLE 5(a): INCOME BY REGISTRATION ON MEDICAL SCHEME
(Is income a critical factor for registration?)

	REGISTRATION ON MEDICAL SCHEME			
INCOME (ZMK)	YES	NO	NOT SURE	TOTAL
IDEA/NO INCOME	27(10.7%)	27(10.7%)	0	54(21.4%)
< 100,000	77(30.6%)	39(15.5%)	0	116(46%)
> 100,000	57(22.6%)	23(9.1%)	2(.8%)	82(32.5%)
TOTAL	161(63.9%)	89(35.3%)	2(.8%)	252(100%)

chi = 10.9, df = 4, p = 0.03

Table 5a gives the registration status of respondents on the medical scheme. Majority 61(63.9%) were registered against 89(35.3%) who were not. The majority of the registered, 77(30%), and non registered, 39(15.5%), were low income households. Statistically there is a significant relationship between income and being registered on the medical scheme, (chi-square =10.9, df = 4, p = 0.03).

TABLE 5(b): INCOME BY REASONS FOR NON REGISTRATION ON MEDICAL SCHEME (Is income a critical factor for registration?)

	REASONS FOR NON REGISTRATION (N = 89)			
LEVEL OF NCOME (ZMK)	NO MONEY	WOULD PAY AS AND WHEN	OTHER	TOTAL
NO IDEA/NO INCOME	15 (39.5%)	3 (15.8%)	8 (25%)	26 (29.2%)
< 100,000	20 (52.6%)	8 (42.1%)	11 (35.5%)	39 (43.8%)
> 100,000	3 (7.9%)	8 (42.1%)	13 (41.9%)	24 (27.0%)
TOTAL	38(42.7%)	19 (21.3%)	32 (36%)	89 (100%)

Table (5b) shows that 89(35.3%) of the total sample were not registered with any medical scheme, 38(42.7%) of this number said they had no money to pay , 19(21.3%) would pay as and when necessary and 32(36%) gave other responses. Majority of those who had no money to pay 20(52.6%) belonged to the low income group and only 3(7.9%) to the higher income group. Other unclassified responses, 32(36%), reflected lack of knowledge and procedural constraints in registering with the scheme. Some of the responses were 'lost card' , 'rarely gets sick', 'no idea about renewing scheme', 'no drugs', 'erratic cards', 'congestion', 'no idea on procedure of registration', etc. Statistically there was a significant relationship between income and non registration on medical scheme, (chi-square = 15.9, df = 6, p = 0.01).

TABLE 6: INCOME AS A BARRIER TO HEALTH SERVICES (Does income influence access to health services?)

BARRIER TO HEALTH SERVICES				
INCOME (ZMK)	BARRIER	NO BARRIER	NOT SURE	TOTAL
NO IDEA/NO INCOME	20 (7.9%)	32(12.7)	2 (0.8%)	54 (21.4%)
< 100,000	49(19.4%)	65(27.8)	2 (0.8%)	116 (46.0%)
> 100,000	27(10.7%)	55(21.8)	0	82 (32.5%)
TOTAL	96 (38.1%)	152(60.3%)	4 (1.6%)	252 (100%)

Table 6 shows that 96(38.1%) did not seek medical care because they had no money to pay against 152(60.3%) and 4(1.6%) who were not sure if any of the household members had the experience or not. 49(19.4%) of the households who did not seek medical care were from the low income group against 27(10.7%) from the higher income group. The 20(7.9%) who did not also seek care from the No idea/No income group could probably constitute the majority who had no income at all.

It was also noted that the majority 65(27.8%) who said income was not a barrier, were from the low income group against 55(21.8%)from the higher income group, and 32(12.7%) from the no idea/no income group. While 96(38.1%) respondents failed to seek medical care because of financial constraints, 86(34.1%) had to borrow money or sell assets such as radios, clothes and in some cases cows, in order to raise money for medical care. Statistically there was no relationship between income and access to health care, (chi-square (pearson) = 4.9, df = 4, p =0.29).

TABLE 7: FACTORS THAT DETERMINE GOOD SERVICE BY SERVICE OUTLET (what do people perceive as good service?)

	HEALTH SERVICE OUTLET			
FACTOR PERCEIVED AS GOOD SERVICE	PUBLIC	PRIVATE	TRADITIONAL	TOTAL
TECHNICAL COMPETENCE	54 (36.5%)	24 (46.2%)	23 (44.2%)	101 (40.1%)
STAFF ATTITUDE	80 (54.1%)	33 (63.5%)	20 (38.5%)	133 (52.8%)
CLEANLINESS	20 (13.5%)	13 (25%)	1 (1.9%)	34 (13.5%)
PRIVACY	4 (2.7%)	4 (7.7%)	3 (5.8%)	11 (4.4%)
DRUGS	119 (80.4%)	47 (90.4%)	32 (61.5%)	198 (78.6%)
OTHER	22 (14.9%)	10 (19.2%)	16 (30.8%)	48 (19.0%)

Table 7 summarizes results of the factors perceived by respondents as good service. Generally availability of drugs 198(78.6%) was the most determining factor of what was considered as good service and is also the prominent factor in all the 3 outlets. Staff attitudes 133(52.8%) was the 2nd factor and being more prominent among private patients. Technical competence 101(40.1%) was the 3rd factor, and the majority 24(46.2%), were private patients, followed by traditional healer patients 23(44.2%) and 54(36.5%) public patients. Cleanliness was considered part of good service by only 34(13.5%). Again, this was appreciated more by private patients, 13(25%). Privacy, 11(4.4%) was the least factor considered as a factor in good service and represented minority percentages at all the three outlets. However, private patients were still the majority who advocated privacy, followed by traditional healer and lastly public patients. 48(19.0%) gave other factors as determinants of good service such as 'credit facilities', 'good food', 'availability of equipment and other facilities'.

Statistical associations between factors perceived as good service by service outlet are as shown below:

Factor	Chi-square	df	p	Relationship significant
Competence	1.9	2	0.37	No
Attitude	6.8	2	0.03	Yes
Cleanliness	11.9	2	0.00	Yes
Privacy	2.6	2	0.27	No
Drugs	16.1	2	0.00	Yes
Other	54.6	2	0.00	Yes

TABLE 8: QUALITY OF SERVICE BY PROPORTION OF MEDICAL EXPENDITURE(Is quality of service a critical determinant for willingness to pay)

AFFORDABILITY				
IS QUALITY OF SERVICE CRITICAL?	**CAN,T AFFORD (not able to pay)**	**CAN AFFORD (able to pay)**	**NOT SURE (unclassified)**	**TOTAL**
NO	9(3.6%)	103(40.9%)	32(12.7)%	144(57.1%)
YES	3(1.2%)	79(31.3%)	26(10.3%)	108(42.9%)
TOTAL	12(4.8%)	182(72.2%)	58(23%)	252(100%)

Table 8 shows that 182(72.2%) spent well over 1% of their total annual income on health, (able to pay); 12(4.8%) spent less than 1% (not able to pay); and 58(23%) were unclassified because they neither knew their income nor their medical expenditure for various reasons, (see table 1 and 2). Table 8 further shows that only 108(42.9%) said quality of service was a critical determinant for willingness to pay, 144(57.1%) said it was not, and majority were from those respondents who had the ability to pay, 103(40.9%) against 79(31.3%). Of the unsure responses 32(12.7%) said no to quality against 26(10.3%).

Statistically there was no relationship between quality of service and willingness to pay for health care, (chi-square = 2.7, df = 3, p = 0.44)

TABLE 9: MODE OF PAYMENT BY PROPORTION OF MEDICAL EXPENDITURE (Is mode of payment a critical determinant for household's ability to pay?)

PROPORTION OF MEDICAL EXPENDITURE			
MODE OF PAYMENT AS A DETERMINING FACTOR FOR ABILITY TO PAY	< 1% (not able to pay)	> 1% (able to pay)	UNCLASSIFIED
DETERMINANT	0	16(6.3%)	1(0.4%)
NOT A DETERMINANT	12(4.8)	166(65.9%)	57 (22.6%)
TOTAL	12(4.8%)	182(72.2%)	252 (100.0%

Table 9 shows that only 17(6.7%), indicated that mode of payment was a determinant for ability to pay. 235(93.3%) said it was not a determinant, with majority 166(65.9%), able to pay.

Statistically there was no association between mode of payment and ability to pay for health care, (chi-square = 4.9, df = 3, p = 0.18)

TABLES 10 (a), (b), (C):COMMENTS AND SUGGESTIONS ON USER FEES FROM ALL THE THREE HEALTH SERVICE OUTLETS.

10 a) PUBLIC OUTLET

COMMENTS / SUGGESTIONS	TOTAL
Fees to continue but improve on drugs and other services	153 (60.7%)
Abolish fees , money hard to come by and there are no drugs	55(21.8%)
other	44 (17.1%)
TOTAL	252 (100.0%)

Respondents attending all the 3 service outlets gave above comments / suggestions on user fees in the public sector.

The majority 153(60.7%) agreed that fees continue and cautioned government on improvement on drugs and other services. Some respondents called for the abolition of fees, 55(21.8%) and gave various reasons as stated in the table. 44(17%) gave various suggestions and comments such as "consider increasing fees to improve services", "improve staff attitudes", government not to increase the current fees etc.

Some respondents also urged the government to discourage the 'policy' in health centers and hospitals that does not enable an individual to utilize the medical scheme before a 24 hour period of registration elapses. Other miscellaneous responses reflected lack of knowledge of the policy on user fees by such responses as 'continue fees but not for the poor and old people', 'scheme expensive and is no good , since you even pay when you are not sick', 'it is not fair to charge sick people '.

10 (b) PRIVATE

COMMENTS / SUGGESTIONS	TOTAL
Continue it is business and drugs and other services are available	78(32%)
Fees too expensive	72 (29.5%)
Other	94 (38.5%)
TOTAL	244 (100.0%)

Table 10 (b) shows comments and suggestions on user fees as it applies to the private health sector. 244(96.8%) of the total samples gave various suggestions, 8(3.2%) had no comments. 94(38.5%) of those who responded to the question gave other unclassified responses such as; 'reduce fees', 'difficult to comment, fees vary from one extreme to the other and from surgery to surgery. A few advocated closure of some surgeries because they believe private practitioners just want money , others said private practitioners employ unqualified staff and sometimes use over diluted medicines, especially in injection form to cater for many clients.

10(c) TRADITIONAL

COMMENTS / SUGGESTIONS	TOTAL
Fees to continue its a means to earn a living and they are negotiable	60(24.7%)
Fees exorbitant. Some traditional healers are fake and just swindle you	48 (19.8%)
Other	135(55.6%)
TOTAL	243 (100.0%)

A total of 243(96.4%) gave comments suggestions on user fees as they apply to traditional healers, 9(3.6%) gave no comments. 135(55.6%) were unclassified responses such as 'fees to continue because some diseases can only be treated by traditional healers' , ' continue fees, they assist them with transport for fetching roots in the bush and their medicine is effective'. Other responses called for traditional healers to reduce fees because people are poor and others said they get roots from the bush which are all God's creations. Other comments were just non committal expressing their disbelief in

traditional healers' practices. Such responses were common among patients from public and private service outlets and not from traditional healers' patients.

III. HEALTH CARE PROVIDERS

A total of 25 health care providers in charge of health care facilities and traditional healers who provided us with patients were interviewed using a checklist with open ended questions . Interviews were conducted at respective health care facilities after a session of interviews with their patients. At public service outlets 4 in-charges were interviewed i.e. 2 sisters in charge and 2 clinical officers. At private service outlets, 8 private practitioners were interviewed and comprised 3 medical officers , 4 clinical officers and 1 registered nurse in charge of one of the clinics . A total of 14 traditional healers (6 males and 8 females), provided us with patients for interview. 13 gave us permission to interview them. One had a busy schedule and therefore could not be interviewed. Two focus group discussions were also held with traditional healers , each group comprised 5 and 6 traditional healers respectively.

The same checklist used with the other health care providers was used. What came out from interviews and focus group discussions was that generally people's purchasing power is poor due to economic constraints and massive poverty among households. While health care providers cited some advantages of user fees such as improvement of services, they also blamed the government for failure to provide adequate drugs and introducing the medical scheme too quickly before the people were sensitized. Policy makers were urged to address these issues if implementation of fees was going to be a success. Private practitioners and traditional healers had other specific concerns (see table 15 appendix IV(v)).

IV. HEALTH CARE FACILITIES AND EQUIPMENT

An assessment of basic facilities and equipment was done at 4 public and 8 private health care facilities. The exercise deliberately excluded traditional healers points of health delivery because their basic facilities and equipment differ in many aspects. A checklist was used to assess the facilities with the help of the one person-in-charge of the health facility or who ever was delegated to the researcher. Results show that some facilities were not available or adequate at some health service outlets such as transport for patients, laboratory facilities, etc. Most basic equipment is however available in almost all outlets, (see table 16, appendix IV(vi)).

CHAPTER 5.0

DISCUSSION

The research aimed at establishing whether people are able and willing pay for health services. Those assumed to have the ability to pay have been defined as those who spend over one percent of their annual income on medical expenses. Those with willingness to pay have been defined as those who perceive quality as the main justification for paying for medical services.

The research will therefore show whether the ability and willingness to pay is a function of quality of health care. In addition, it will also establish if the ability to pay for health services depends on the mode of payment, whether cost is a barrier to health services or not.

Tables 1, a, b, & c do summarize the demographic characteristics of the respondents. Variables of focus are on what may be considered as variables of interest for the study, like education, employment, income and expenditure patterns. One would expect that the more people are educated the more likely they are to be employed, earn a salary and therefore, be able to pay for medical care. Education therefore is a major factor for employment and for payment.

The study has shown that despite the majority 232 (92.1%) having some form of education, 146 (57.9%) were unemployed,(see table1b and figures, 2&3). It can also be noted that as much as 69 (27%) households in Zambia today were earning between K51,000.00 - K100,000.00 per month, which from observation appears to be average

income for most households. Expenditure on medical care, per year, on average was K 90,000. Income levels may therefore give an insight into households' ability to pay for medical care.

Ability to pay for health care

Results presented in table 2 show that 182(72.2%) of the households in the sample can afford to pay for medical services. This may suggest that probably the fees are affordable at the prevailing income levels of the households in the population.

Table 3 shows that the opinion of the different households attending the various health outlets was that the fees were affordable. Of the three outlets, 48(92.3%) of those attending traditional outlets thought fees were affordable followed by those attending private outlets 41(78%) and finally those attending public outlets 104(70%). These are fairly high figures suggesting that most households could easily, by price, access any of the outlets.

The main thing coming out of this is that cost is not a major factor in having access to health services. This observation is further supported in Table 4 where it comes out clearly that cost is not the main determinant of choice of health care outlet and is more evident in those attending traditional healer services where only 4(7%) thought cost was factor. This may explain why 48(92%) of these households thought the fees charged were affordable. With respect to all the service outlets, only 42(16.7%) thought cost was a factor compared to 146(57.9%) who instead thought distance was the main factor

income for most households. Expenditure on medical care, per year, on average was K 90,000. Income levels may therefore give an insight into households' ability to pay for medical care.

Ability to pay for health care

Results presented in table 2 show that 182(72.2%) of the households in the sample can afford to pay for medical services. This may suggest that probably the fees are affordable at the prevailing income levels of the households in the population.

Table 3 shows that the opinion of the different households attending the various health outlets was that the fees were affordable. Of the three outlets, 48(92.3%) of those attending traditional outlets thought fees were affordable followed by those attending private outlets 41(78%) and finally those attending public outlets 104(70%). These are fairly high figures suggesting that most households could easily, by price, access any of the outlets.

The main thing coming out of this is that cost is not a major factor in having access to health services. This observation is further supported in Table 4 where it comes out clearly that cost is not the main determinant of choice of health care outlet and is more evident in those attending traditional healer services where only 4(7%) thought cost was factor. This may explain why 48(92%) of these households thought the fees charged were affordable. With respect to all the service outlets, only 42(16.7%) thought cost was a factor compared to 146(57.9%) who instead thought distance was the main factor

influencing choice. Implicitly, this finding may support the established notion that cost is not a barrier to having access to health care outlets.

Table 5a shows the households registered with the public medical schemes. The table shows that the majority of those registered earn incomes below K100,000. So essentially, those earning less than K100,000, the majority attend public outlets and are registered with the scheme. This finding may support the perception that, poorer people are more likely to be sick and as such seek health care more often, Huber, (1993). Those with relatively lower incomes seem to look at public outlets as the major alternative whilst those in higher income levels seem to stay away from public outlets and instead seek private or traditional care.

As table 11 (appendix IV(0)1) shows, the majority in this group prefer public outlets. There is an apparent difference in preferences between the two income groups. Since there is enough evidence to suggest that the fees are affordable, there should be other factors other than cost that determines choice of health care.

To support the notion of affordability, there is evidence from table 5b to suggest that as much as 8 (42.1%) of the households in the lower income group, are not registered for other reasons other than the lack of money. Overall, households who said they would afford to pay but only when in immediate need were 19(21%).

The results have established enough evidence that despite one's income level, the fees charged at these outlets are affordable. Table 6 shows that 152(60.3%) of the households

did not consider income levels as a barrier to accessibility to health services. Coincidentally, the majority 65(27.8%) of these are in the lower income group. In addition, table 12 (appendix IV(ii)) shows that the majority 193(76.6%) of the households were of the opinion that fees were affordable. The size of the household does not seem to influence affordability. As table 12 (appendix IV(ii)) shows, there was almost the same number of households in the household categories less than 5 and over five expressing affordability.

It can, therefore , be categorically stated that because incomes are "adequate", most households have the ability to pay for health services. As such, there is a relationship between " adequate income " and ability to pay. The chi square statistic in table 2 shows a very high level of significance (00%), implying that, one can confidently reject the null hypothesis that there is no statistical relationship between income and ability to pay. Therefore, as long as incomes are not a barrier or constraint, people will have the ability to pay for health services.
These findings are supported by Waddington and Enyimayew (1989); McPacke, et al (1993); and Shawl and Griffin, (1995).

Incomes are adequate because probably the cost of health services is relatively cheap. A typical Zambian household spends only 0.8% of their income on health care as quoted in the Household Budget Survey Report of 1993/1994 and the minimum registration on the medical scheme is ZMK 500 / person per month (presently equivalent to about USD 0.5). However, this same report did not take in consideration transport costs to and from health care facilities.

The research has shown that the cost of health care is affordable with the prevailing levels of income. Whilst, the households can afford to pay for services, their willingness to choose and pay for a particular outlet is determined by a number of factors.

Implications

Although there is enough evidence from this study to suggest that userfees are affordable by the majority, there is still a possibility that a minority in the population may still be denied access to health care for failing to pay. Booth, et al. (1994), in their cost recovery study reported that there still exists among Zambians, the core poor or ultra-poor whose income generating capacity is minimal. They concluded that sizable numbers of people who require medical attention, are now staying at home and in some cases dying because they are unable to pay the fees.

Although the Government has made some arrangement for such a category of people, it is clear from this study that some people are still being denied access to health services as shown in table 6 where 96 (38.1%)of the total sample indicated that they failed to seek health care at one time or the other because of financial problems.

This finding is further supported by Table 5b) which shows that 38(42.7%) of the sample failed to register on the medical scheme because of lack of money, again the majority, 20(52.2%), coming from the lower income group. Some respondents in the sample indicated that they usually sell assets to raise income for medical care, (see table 6). Huber, (1993) argues that households do not need to sale assets in order to purchase health care. Studies elsewhere have also shown that people do sale substantial amounts of

farm land to raise money for health care, (Coreil, 1983; Waddington and Enyimayew, 1989).

In addition, it was discovered that, as much as, 20(71%) of those who were given prescriptions at public health centers had no money to buy medicines. In this study 139(55.2%) were given follow up appointments and an unrecorded number referred elsewhere for other services (see table 13 in appendix IV (iii). It is also important to note that some service outlets lacked basic facilities and equipment as shown in tables 16a&b (appendix IV (vi). The implication is that the affected population will be required to pay for services elsewhere. Transport services in the public sector for instance is very erratic and most patients referred to higher levels of care have to find their own transport to and from health centers.

The implication for the above short comings when health centres are confronted with constant drug stock outs is that people are likely to incur substantial travel and time costs. In addition there will be a high mark-up on drugs. A study by Litvack, et al (1993) has shown that the wealthier ones are more able to meet these expenses than the poor whose time is spent on other vital daily life saving activities such as food preparation, field cultivation, etc.

Medical care can only be sought after the basic necessities are met. In Litvacks' study, travel and time costs associated with seeking distance care served as prohibitive barriers to the poorer people and as a result many would end up purchasing drugs in partial dosages from local drug peddlers in market places despite the common perception of poor quality.

The figures of the affected population may appear small, but the impact on the affected households can not be overlooked.Therefore , the policy regarding exemption from paying medical userfees by a category of people in the population, should be fully and clearly explained to both health personnel and consumers of the service at the grassroot level, if the policy is to benefit the affected population.

Factors affecting choice of health care outlet

Table 4 shows that the majority 146(57.9%) of households chose service outlets because of distance. This is followed by quality of service 108(42.9%), cost 42(16.7%) and mode of payment 17 (6.7%). All these factors of choice (have chi-square values which) are highly significant implying a highly significant relationship with choice, (see table 4). The prominence of distance shows that most households seek health services close to their locations. There are several reasons why distance could be prominent. Though these are merely speculative, one of the reasons could be cost of transportation. Of those who consider distance as the major determinant of choice, the majority (86.5%) attend public health service outlets. This is possible since most public centers are centrally located. This is in sharp contrast to those who attend traditional healer services, where only (1.9%) thought distance was a major factor. This may indicate the confidence people have in traditional healers. The study has established that they seek health care despite the distances involved. Some respondents traveled long distances, including outside Lusaka. Probably as more public outlets are located within the communities, the question of distance will have less prominence.

Leeson and Frankenberg (1977), stated other factors that influenced the patients' choice of agency. They found out that it was not only the 'traditional' or 'modern' outlooks of

an agency that predominates ones' choice but other factors such as social group, past experience, the stage of illness, circumstances surrounding the agency and issues of non response to treatment.

Their main finding was that convenience, defined as distance, short queues and privacy, was one of the core factors that influenced choice. Their findings agree with this study on the question of distance but not on privacy. In this study privacy ranks among the least factors considered as a determinant of choice, (see table 7).

The quality of service is another major determinant of choice of service outlet. As table 4 shows, there is a relationship between service outlet and quality which is highly significant($p<0.001$).

This aspect of quality is perceived more in those seeking services from the private sector. Here, 34(65.4%) of the households seeking private health services demanded good quality. This is expected because private outlets are perceived to be privately run and relatively small to enable good quality services being provided.

Most patients attending private outlets are attended to promptly and outlets are less congested. On the other hand, 59(39.7%) of households attending public demand good quality. The main reason could be that most do not expect relatively good services from public outlets because they are government funded and deal with relatively more patients. As such, the irregular funding and the associated problems do not encourage people to look forward to good quality. The poor quality of services provided by the public system

has been acknowledged by various sources, including the World bank, (Shawl and Griffin ,1995).

The least concerned about quality are those who attend traditional outlets. Here, only 15(28.8%) perceive quality as critical. This is expected because most traditional outlets are individually run, usually from a house, and as such, the clients do not look forward to most attributes of quality such as cleanliness and promptness, etc.

Most traditional healers do not have the resources to make their centers comform to expected standards, but despite this, their services are still appreciated by many. A similar finding was found by Kaona, et al .(1990) on the Copperbelt. In this study traditional healers requested for financial assistance from government to enable them acquire plots to build bigger houses to accommodate their patients who need observation at times, (see appendix IV(v)).

Among the attributes of quality, most people consider the availability of drugs as the most important. Table 7 shows that 198(78.6%) associate drug availability to good quality service. This is followed by staff attitude, technical competence, cleanliness and lastly, privacy. Drug availability has been acknowledged to have a significant impact on the utilization of public health resources, (MOH Report, 1991; Haddad and Fournier, 1995).

There is a statistically significant relationship between drug availability and choice of service outlet,(Table 7). Again, the majority 47(90%) are those attending private outlets. Most private health outlets seem to stock relatively more drugs than public and traditional

outlets. This finding is supported by table 16c (appendix IV (vi)) which shows that basic drugs are always available in private outlets. The findings also seem to suggest that people seeking care from traditional healers are less bothered by drug availability probably because they know that medicines there are almost always available. Generally, most households will seek a particular outlet as long as drugs are available.

Information from table 7 further seems to suggest that private outlets provide quality service. Those attending private outlets have shown consistency in terms of demand for staff attitude, technical competence, cleanliness and privacy.

There is a statistically significant relationship between staff attitude and choice of service outlet, (chi-square, pearsons', sig level 0.03%). The private outlets seem to have better staff attitudes followed by public and lastly, traditional. This result is expected considering the characteristics of these outlets. Staff in most private outlets are well paid and deal with less clients and have reasonable work loads which is not the case in the public and traditional outlets. This can greatly affect staff attitude. Haddad and Fournier, (1995) are of the opinion that rejection of public health facilities is sometimes associated with a negative perception of health care workers. The workers are sometimes blamed for lacking compassion, or being inattentive, dishonest or disrespectful.

There is no statistical relationship between choice of outlet and technical competence. Despite this, the private sector again seems to show more concern. This, again, has to do with the perception that private outlets have attracted more competent staff. The demands from the public and the traditional seekers seems to be almost the same.

Cleanliness, though not ranking highly, has a significant relationship with choice of outlet. Those attending private outlets were the majority in considering cleanliness as a major attribute. Generally, private outlets seem to be cleaner than public outlets, again the reasons are obvious.

Privacy was the least considered attribute for quality, only 11(4.4%) expressed concern. The private seekers, again, showed prominence. In addition, there was no significant statistical relationship between privacy and choice of service outlets. One possible reason is that most medical problems may not require as much privacy as gynecological or sexually transmitted diseases. Figure 4 shows that medical problems were the most common across all the service outlets.

It has been established that quality has a significant relationship with the choice of outlet chi-square (pearson's) significance level = 00%

Quality as a determinant of willingness to pay

Meanwhile, it has also been established that the majority of those who have ability to pay do not consider quality as a critical determinant, (Table 8).the main determinant.
As can be seen in table 8, 103(40.9%) of the households who have ability to pay thought quality was not critical versus 79(31.3%) who thought otherwise. For those who are unable to pay only 1% thought quality was critical. The statistics show that there is no relationship between willingness to pay and quality of service. The null hypothesis is thus not rejected.

This result brings out two things; firstly, that the low income bracket households do not mind a lot about quality, in terms of paying for it, secondly, the higher income group does show some concern on quality but not to an extent that it is significant to influence their decisions.

With respect to the low income group, this result is expected as they have no choice anyway. Whatever services they get may be considered good enough. As for the higher income group, the results show that the income they earn has nothing to do with where they seek health services from. It is not necessary that the higher income groups will seek services whose prices portray some form of quality, like private outlets. This finding is supported by table 11a (appendix IV (o)), which shows that as much as 25(48%) of the higher income group visited traditional healer outlets which are of probably a lower cost and perceived to be of lower quality.

So the relationship between quality and willingness to pay, is indeed, not clear and thus the failure to reject the null hypothesis with no statistical relationship between the two.

Since it has been established that almost everybody has ability to pay for health services across all the possible outlets, the challenge to policy makers is to understand the factors that make the clients willing to pay. As stated above, the main attributes to consider under quality of service are drug availability, staff attitude, technical competence and cleanliness.

Policy analysts have echoed the importance of improving quality of services in addition to introduction of userfees so as to encourage willingness to pay. The MOH has acknowledged this concern hence the introduction of quality assurance teams.

The concept of quality is subject to many interpretations. By Zambian standards, it could appear quality of care should include provision of compassionate, safe, timely and affordable services in a suitable environment and should guarantee maintenance of professional competence of health care providers.
Quality of care should also ensure patient satisfaction and effective and efficient use of available resources, (MOH, WHO, 1993). A study of quality of urban health services in Lusaka in 1995 identified availability of medicine as one of the leading problems for health care quality.

Patient satisfaction is an important consideration in today's health care environment for several reasons. Firstly, in a democracy, patients should have the right to influence decisions and activities influencing them, Vuori,(1991). Secondly, patients' satisfaction might determine whether a person complies with treatment regimes, (Larsen and Rootman, 1976).Thirdly, failing to meet the customers' expectations of care might result in dissatisfaction, ultimately resulting in poor utilization of health services, (Faxelid, 1994). Fourthly, patient satisfaction may reflect the quality of care actually given. poor quality of service can lead to under-utilization which could be mis-interpreted for inability to pay,(Litvack, et al 1993; De Bethune,et al 1993; Waddington, et al 1989).

Mode of payment as a critical determinant for ability to pay

Another factor which the study addressed was the question of mode of payment. Mode of payment and choice of service outlet had a significant relationship. As shown in table 4, 17(6.7%) of the respondents thought it was a critical factor, and most of these patients were attending private and traditional healers'service outlets respectively. However, the mode of payment was not as critical as the other factors like quality and distance. This result is expected considering that among the three outlets, the public outlet is never negotiable. This result is consistent with qualitative data from health care providers in the private sector and traditional healers who said that most people preferred them because they allowed flexible payment terms, such as credit, installments etc.

The results of this study, regarding mode of payment, are consistent with other studies done elsewhere. From most findings, payment in kind is the most commonly used by traditional healers, (Deferranti, 1985; Akin, et al 1987; Vogel, 1988).

Although traditional healers and private practitioners allow credit payments they also indicated that they are being discouraged because of non payment by some patients. Consequently, they are contemplating changing this mode of payment. One implication is that the lower income group will have little or no choices of health care outlets.

As table 3 shows, 48(92%) and 41(78%) of those attending traditional and private outlets respectively thought the fees were affordable. The payment terms in these two outlets may explain why they emerge as major factors in the choice of outlet. Relatively fewer

households are of the view that fees in the public outlets are affordable. This could be due to the stringent modes of payments and the scarcity of drugs.

In most cases modes of payment to private and traditional outlets are flexible. Overall, mode of payment does not seem to be a very critical factor. Table 9 supports this observation ,where it is shown that, 165(65.9%) of those who had the ability to pay did not find it critical compared to only 16(6.3%) who thought otherwise. For the entire sample, as much as 235(93.3%) thought it was not critical. Therefore, although it has a statistical relationship with ability to pay, there is no evidence that it is very critical.

CONCLUSION AND IMPLICATIONS

The study has established that most people have the ability to pay for health care. Implied in the finding is the expectation that medical care is within reach.Therefore, the Government should for now, address issues that affect the willingness to pay , and not issues of pricing and ability to pay.

Health Reforms have dwelt much on cost sharing but not much on mode of payment which is flexible in private health service outlets. People are likely to benefit more from the relatively cheap medical care being offered in the public health service outlets if mode of payment is flexible and drugs are available. Flexible mode of payment seem to attract people and makes them willing to pay. Perhaps more people may find this a helpful option.

Distance was one of the most important factors influencing choice of outlet. This would call for further decentralization of health services up to the community level. As long as the outlet has the attributes the people want and is within reach people will use it. If problems of distance and other factors are addressed properly, the majority of the people will have first preference for public health service outlets.

This study is in agreement with the study of Choongo, and Limbambala, (1994), on distance.Recommendations from the study were that construction of more health centers be done especially in catchment areas with populations over 50,000 in order to improve the service, minimize distance and decongest the University Teaching Hospital.

Quality is the other major issue. As long as drugs are available, people will attach a high quality status to the outlet. So , as health centers are being taken to the communities, the issue of drug availability should be addressed simultaneously. Another aspect of quality is that people will seek services from any outlet which exhibits the attributes of quality irrespective of their income status. So, if a policy to enhance these attributes is encouraged in all the service outlets, there is a likelihood of de-congesting the already congested outlets, like public service outlets. Suggestions from respondents and health care providers in this study are that the government should seriously address the drug situation. Similar studies have highlighted on this matter, (Limbambala, M and Choongo, D; Atkinson, et al. (1995).

Policies should also be designed to improve staff attitude and technical competence. These factors were also identified as critical. This may call for continuous in-service

training of staff, provision of incentives and improvement of working conditions to motivate them.

Some People also identified cleanliness as a critical factor. This may call for added efforts in this area. Most people did not think privacy is a critical factor.

RECOMMENDATIONS

1. Policy makers should address the problem of drug availability in public health care outlets with urgency and seriousness. Attempts should be made to identify factors contributing to drug shortages and address them accordingly.

2. The issue of staff attitude should also be examined. Intensive in-service training and improvement in conditions of service of health personnel and also improvement in the infrastructure will boost morale of workers and perhaps encourage them to provide quality care.

3. Dissemination of more information on the concept of medical schemes is critical to enable people appreciate it more. Health personnel should be empowered with adequate knowledge concerning new policies in the health sector so that they can interpret correctly to consumers of health services. More seminars should therefore be held at all levels.

4. The study seems to suggest that most people are capable of paying for health care. If this is the case then, public outlets, should consider reviewing the fees, up to a reasonable level which could make the scheme self sustaining.

5. Privatization of public health service outlets should be considered in view of the fact that people are willing to pay for quality service regardless of cost.
6. The exemption policy should be fully and clearly explained and information disseminated to the beneficiaries and health personnel.

7. Future research must consider a larger sample and should include views from those who are not ill at time of study for comparison purposes of views of the well and ill population. In addition, a time-series analysis could be done to capture variability over time.

REFERENCES

1. Akin J.S, Birdsall N, and De Ferranti D (1987). Financing Health services in developing Countries: An agenda for Reform. World Bank, Wash D.C.

2. Atkinson S, Machwan'gi M, Ngenda L, and Douglas H (1995), Quality of Urban Health Services in Lusaka, Zambia.

3. Balm B.H, and strenski T. (1989) Short communication, Thailand: current Public Health Perspectives. *Inter. J. Health Planning and Management* 4: 194-98

4. Booth D, Milimo J, Bond J, Chimuka G, Nabanda S, Liywalii M, Mwaulusi K, Mwanamwalye M, Mwanza M, Peme E and Zulu L (1994). "Coping with Cost Recovery" A study of the social impact of and responses to Cost recovery in Basic services (Health and Education) in poor communities in Zambia.

5. Corbett, J. (1988) Famine and Household Coping Strategies. World Development 16: 1099-1122.

6. Corbett, J. (1989) Poverty and Sickness: The High Cost of ill Health. *IDS Bull* 2:58-62.

7. Coreil. (1983) Allocation of Family Resources for Health Care in Rural Haiti. *soc. Sci Med,* Vol 17: 709-719

8. DeBethune X, Alfani S and Lahaye J. (1989) The Influence of an abrupt Price increase on Health service Utilization: Evidence from Zaire. *Hlth POL.Plann* 4: 76.

9. De Ferranti, D. (1985) Paying for Health Services in Developing Countries: An Overview. World Bank Working papers: 12 & 111.

10. District Health Management Team Report (1993), Lusaka, Zambia.

11. Gertler P, Locay L and Sanderson W. (1987) Are User Fees Regressive? Welfare Implications of Health Care: Financing Proposals in Peru . *J. Economet* 36.

12. Faxelid, E. (1994) Patients' experiences of STD care in Sweden and Zambia" Thesis for LicMedSc, Dept of Inter Hlth and Soc Med, Karolinska Institute, Stockholm.

13. Haddad, S & Fournier, P. (1995) " Quality, Cost and Utilization of Health Services in Developing Countries - A Longitudinal study in Zaire. *Soc. Sci Med. vol : 40* No 6: 743-753.

14. Health Reforms News, (1995). April / June, vol 2(1). MOH, Lusaka

15. Huber, J. (1993) Ensuring Access to Health Care with the introduction of User Fees: A Kenyan Example. *Social Science Medicine vol 36*: No 4: 485-494.

16. Kalumba, K. Nangawe. E, Muuka-Kalumba, E. and Musowe, L. (1994) Looking Forward: Zambia's Health System Reform Agenda into the next century, " Experiences with Primary Health care in Zambia". WHO Report.

17. Kalyalya K, and Milimo, J. (1996), User Fees in the Health Sector: Policy Practice and Perceptions. Study Fund Report.

18. Kanji, N. (1989) Charging for Drugs in Africa: UNICEF's Bamako Initiative. *Health Planning and Management 4*(2): 110 - 120

19. Kanyata, C. (1995) A Study of Factors Contributing to Community Utilization of Traditional Medicine in Lusaka Urban. Unpublished report.

20. Kaona F, Mushanga M, Sukwa M, (1994) Research Results on the Impact of Introduction of Fee Buying in Health Care and Utilization of the Traditional Healing System on the Copperbelt Province of Zambia.

21. Kara Counseling Unit. (1995) Traditional Healers Knowledge on HIV / AIDS Transmission: A case of Lusaka Urban. Un-published report.

22. Kendall, P. & Bhattacharyya, K. (1994) The Household Production of Health : Integrating Social Science Perspectives on Micro-level Health Determinants. *Soc. Sci. Med. Vol 38* No 2: 205-215.

23. Larson, D & Rootman, I. (1976) Physician role performance and patient satisfaction. *Soc. Sci. Med. 10: 29-32*

24. Leeson, J & Franlanberg, R. (1977) The Patients of Traditional Doctors in Lusaka. African Social Research: 217-233

25. Limbambala, M. & Choongo, D. (1994) Assessment of Current Government Health Care Delivery Services in Lusaka Urban. Study Fund Social Recovery Report.

26. to Litivack, J & Bodart, C. (1993) User Fees Plus Quality equals Improved Access Health Care: Results of a Field Experiment in Cameroon. *Soc Sci Med Vol 37*, No 3.

27. McPake, B. (1993) User Fees for Health Services in Developing Countries: A Review of the Economic Literature. *Social Science & Med vol 36*, No 11: 1397-1405

28. McPake ,B. Hanson, K. and Mills, A. (1993) Community Financing of Health Care in Africa - An Evaluation of the Bamako Initiative. *Soc. Sci & Med vol 36*, No 11: 1383 - 95

29. Ministry of Health , and WHO. (1993) : Quality Assurance Seminar Report, Livingstone, Zambia.

30. - Msiska R, Nangawe, Mulenga E, Sichone D, Kamanga M, Kwapa J and Thuo K. (1995) Factors Determining Health Seeking Behavior Patterns in Lusaka, Zambia With particular Relevance to Sexually Transmitted Disease. Applied Health Research, Report No 1.

31. Myers C, Dow M and Banyanne C. (1985) Financing Health Services and Medical Care in Thailand. USAID report, Bangkok Harvard Institute for International Development, Cambridge, MA.

32. National Health Policies and Strategies (October , 1992)

33. Shawl, R. & Griffin, C. (1995) Financing Health Care in Sub-Saharan Africa Through User Fees and Insurance. World Bank Report, Wash D.C: 1-53

34. Simukoko, J. Sikasote, J. Sims, P. & Kalenge, G. (1995) Report on Urban General Practice in Lusaka.

35. Urban Poverty assessment Report (1994) Lusaka, Zambia.

36. Vogel, R. (1988) Cost Recovery in the Health Care Sector: Selected Country Studies in West Africa. *World Bank Tech paper No 82.*

37. Waddington. C and Enyimayew K. (1989) A price to Pay: The Impact of User Charges in Ashanti -Akin District Ghana. *Int. J. Health Plan & Management vol 4*, No 14.

38. World Bank. (1987) Financing Health services in Developing Countries : An Agenda for Reform. Wash D.C.

39. Zambia Annual Budget (1996)

40. Zambia Beneficiary Assessment Study, (1993)

41. Zambia CSO, 1995, 1990 Census of Pop, Hse and Agric, Vol 10, CSO, Lusaka

42. Zambia Demographic Health survey, (1996)

43. Zambia Household Budget Survey Report, (1993/94).

44. Zambia Poverty Assessment Report. (1994) vol 1 and 4 No 12985 ZA

45. Zambia Priority Survey Report. Vol 1 (1991)

APPENDICES

APPENDIX I: PATIENT INTERVIEW SCHEDULE

USER FEES: DETERMINING PEOPLE'S ABILITY AND WILLINGNESS TO PAY FOR HEALTH CARE: A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HEALTH SECTORS IN LUSAKA URBAN.

INTRODUCTIONS
1. Introduce yourself to respondent
2. Establish rapport
3. Explain purpose of Interview
4. Assure respondent of confidentiality of any information given

Respondent Identification No. _____

Study Site and Location
1. Urban Clinic_____ Residential Area;
2. Private Clinic_____
3. Traditional Healer_____

1. Chawama
2. Chilenje
3. Kabwata
4. Bauleni

Interview Date _____ Interviewer_____(Initials only)

Person being Interviewed
1. Patient
2. Accompanying relative/Parent/Friend

1. Age _____
2. Sex
   1. Male
   2. Female
3. Status in household
   1. Head of Household
   2. Dependent
   3. Spouse
4. Education
   1. None
   2. Lower primary
   3. Upper primary
   4. Secondary
   5. College/University
5. Employment status
   1. Formal employment
   2. Self employed
   3. Unemployed

6. What is the range of household income per month
    1. No idea
    2. Below K50,000
    3. K51,000 -100,000
    4. K101,000 - 150,000
    5. K151,000 - 200,000
    6. Above K200,000
7. Household size _____
8. How many members of the household are school going?
    _____
9. Any Chronic illness in the household{i.e. on and of or continuously for 6 months or more}
    1. Yes _____(Specify)
    2. No
10. Is any rent paid for the house where you are staying?
    1. Yes
    2. No
11. What is your source of water
    1. Council
    2. Well
    3. Borehole/council
    4. Other _____(Specify)
12. Do you pay for electricity?
    1. Yes
    2. No
    3. N/A (No electricity)
13. What is the main complaint that has made you seek care from here?
    1. Medical problem (Fever, cough, rash, diarrhea, STD, HIV/AIDS, PTB)
    2. Surgical problem (injuries, burns, operational wounds etc.)
    3. Gynae/obstetric problem (Female related conditions)
    4. Psychiatric illness/evil spirits
    5. Other _____(Specify)
14. How often do you seek care from here?
    1. First time
    2. Sometimes
    3. Always
15. What factor(s) have you considered for deciding to seek care from here {tick all responses considered applicable}
    1. Cost
    2. Distance

3. Quality of service _____(Specify)
4. System of payment (i.e. negotiable, credit or in Kind)
5. Drug availability
6, Other _____{specify}

16. What does good service mean to you? (Tick all applicable responses)
    1. Drug availability
    2. Technical competence of staff
    3. Positive staff attitudes
    4. Clean infrastructure
    5. Privacy
    6. Other_____(Specify)

17. Have you or any member of the household registered with any medical scheme?
    1. Yes
    2. No
    3. Not sure

18. If the answer to question 17 is No, What are your reasons?
    1. No money to pay
    2. Would rather pay as and when need arises
    3. No idea such schemes exist
    4. Other_____(Specify)

19. Have you or any member of the household been ill at one time but stayed home because you had no money to pay for health care at any facility?
    1. Yes
    2. No
    3. Not sure

20. Have you or any member of the household sold any asset or borrowed money in order to meet medical costs?
    1. Yes
    2. No
    3. Not sure

21. Household medical expenditure during the month.

MEDICAL COSTS	ADMISSION	TRANSPORT TO AND FROM HEALTH FACILITY OR ELSEWHERE FOR CARE/SERVICE	PREPAYMENT SCHEME (1 MONTH)	CONSULTATION	MEDICINE	OTHER SPECIFY	TOTAL
COSTS TODAY	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	
COSTS HERE OR ELSEWHERE FOR SAME OR OTHER ILLNESS DURING THE LAST 4 WEEKS (EXCLUDING TODAY)	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	
COSTS WITHIN THE LAST 4 WEEKS FOR OTHER HOUSEHOLD MEMBERS, HERE OR ELSEWHERE	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	K_____ N/A_____	
TOTAL							

22. What is your opinion of fees at this facility?
    1. Affordable
    2. Not affordable
    3. Not sure
23. Have you been given a prescription to buy medicines and /or referred elsewhere for further care?
    1. Yes
    2. No
24. If the answer is Yes, do you have money to pay for the prescribed medicines/care?
    1. Yes
    2. No
25. Have you been told to come back for review or any follow-up care?
    1. Yes
    2. No
26. From your observation, has anything improved in government health facilities since introduction of fees?
    1. Yes _____(Specify)
    2. No
    3. Not sure
27. What comments/suggestions/advice do you have concerning user fees in both the public and private health sectors?
    1. Public Health Sector _____
    2. Private Health Sector _____
    3. Traditional Healers _____

THANK YOU FOR PARTICIPATING IN THE STUDY!!!

APPENDIX II: HEALTH CARE PROVIDER INTERVIEW CHECKLIST

TITLE OF STUDY: USER FEES: DETERMINING PEOPLE'S ABILITY AND WILLINGNESS TO PAY FOR HEALTH CARE: A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HEALTH SECTORS IN LUSAKA URBAN.

Place of Interview _____

Person being Interviewed:

1. Sister in charge/Clinical officer in charge
2. Private practitioner{Medical Officer/Clinical Officer}
3. Traditional Healer

Topics for discussion:

1. Current utilization patterns

   _____

   _____

   _____

2. Criteria for fixing User fees

   _____

   _____

   _____

3. Patient purchasing power

   _____

   _____

4. Advantages of user fees.

   _____

   _____

   _____

   _____

5. Disadvantages of user fees.

   _____

   _____

6. User fees: What is the future in Zambia?

   _____

7. Comments/suggestions

   _____

THANK YOU FOR PARTICIPATING IN THE STUDY.

APPENDIX III: HEALTH CARE FACILITY CHECKLIST

1. Availability to Transport for referral of cases
    1. Yes
    2. No
    3. Not in working order
2. Communication - Radio/Telephone
    1. Yes
    2. No
    3. Not working
3. Laboratory facilities for basic tests
    1. Yes
    2. No
4. X - ray facilities
    1. Yes
    2. No
5. Other facilities _____(Specify)
    1. No
    2. _____
    3. _____
6. Toilet facilities
    1. Yes
    2. No
7. Cleanliness of Infrastructure
    1. Very clean
    2. Clean
    3. Not clean
8. Availability of essential drugs (Analgesics, Anti malaria, Anti biotics)
    1. Always Available
    2. Sometimes
    3. Rarely available
    4. Other
9. Sphygmomanometer
    1. Number available _____
    2. Not available _____
    3. Available but not in working order
10. Stethoscope
    1. Number available _____
    2. Not available
    3. Available but out of order

11. Thermometers
    1. Available _____
    2. Not available

12. Weighing scale
    1. Available _____
    2. Not available

13. Auroscope
    1. Available
    2. Not available

14. Proctoscope
    1. Available
    2. Not available

15. Opthalmoscope
    1. Available
    2. Not available

16. Patellar hammer
    1. Available
    2. Not available

17. Steriliser
    1. available
    2. Not available

18. Suction apparatus
    1. Available
    2. Not available

19. E.C.G. machine
    1. Available
    2. Not available

20. Vaginal speculum
    1. Available
    2. Not available

21. Oxygen
    1. Available
    2. Not available

END OF CHECKLIST.

APPENDICES IV(0) - IV(vi)

APPENDIX IV(0)
INCOME DISTRIBUTION BY HEALTH SERVICE OUTLET
(Is income a determinant for the choice of health service)

	HEALTH SERVICE SITE			
INCOME (ZMK)	PUBLIC (N=148)	PRIVATE (N=52)	TRADITIONAL HEALER (N=52)	TOTAL (N =252)
NO IDEA/NO INCOME	32 (21.6%)	17 (32.7%)	5 (9.6%)	54 (21.4%)
less 100,000	79 (53.4%)	15 (28.8%)	22 (42.3%)	116 (46.0%)
over 100,000	37 (25%)	20 (38.5%)	25 (48.1%)	82 (32.5%)
TOTAL	148 (58.7%)	52 (20.6%)	52 (20.6%)	252 (100%)

The table above shows income distribution among the service outlets. The majority of patients in the lower income group are from the public sector. For other details on income see table 1(c).

APPENDIX IV(i)

TABLE 11: OPINION OF FEES BY INCOME (Is affordability dependent on income?)

	OPINION ON FEES			
INCOME (ZMK)	AFFORDABLE	NOT AFFORDABLE	NOT SURE	TOTAL
NO IDEA/NO INCOME	39(15.5%)	11 (4.4%)	4 (1.6%)	54 (21.4%)
< 100,000	85(32.7%)	25 (9.9%)	6 (2.3%)	116 (46.0%)
> 100,000	69(27.3%)	11 (4.4%)	2 (7.9%)	82 (32.5%)
TOTAL	193 (76.6%)	47 (18.7%)	12 (4.8%)	252 (100%)

From the table it is clear that majority of respondents 193(76.6%) had the opinion that fees were affordable at their respective service outlets , 47(18.7%) said they were not affordable and only 12(4.8%) were not sure.

It can also be seen that majority of those who said fees were affordable were from the low income group. Majority of those who said fees were not affordable were also from the low income group but there was no difference in distribution between the other two income groups. Majority of the not sure responses were from the higher income group.

APPENDIX IV(ii)

TABLE 12: OPINION ON FEES BY HOUSEHOLD SIZE
(Does household size influence affordability of fees)

OPINION ON FEES				
HOUSE HOLD SIZE	AFFORDABLE	NOT AFFORDABLE	NOT SURE	TOTAL
1-5	106 (42.1%)	21 (8.3%)	6(2%)	133(52%
> 5	87 (34.5%)	26 (10.3%)	6(2%)	119(47%
TOTAL	193 (76.6%)	47 (18.6%)	12 (4.8%)	252 100.0%)

Table 12 shows that fees were more affordable by smaller households 106(42.1%) as against the bigger households 84(34.5%). In this study mean household size was 5.9.

APPENDIX IV(iii)
TABLE 13: OTHER AREAS OF HOUSEHOLD EXPENDITURE

AREAS OF HOUSEHOLD EXPENDITURE	FREQUENCY DISTRIBUTION OF RESPONDENTS BY SELECTED AREAS OF HOUSEHOLD EXPENDITURE (%)		
	YES	NO	TOTAL
EDUCATION	179(71%)	73(29%)	252
CHRONIC ILLNESS	54(21.4)	198(78.6%)	"
HOUSE RENT	150(59.5%)	102(40.5%)	"
WATER	217(86.1%)	35(13.9%)	"
ELECTRICITY	155(61.5%)	97(38.5%)	"
FOLLOW UP APPOINTMENTS	139(55.2%)	113(44.8%)	"
MEDICINE PRESCRIPTIONS AND REFERRALS TO OTHER HIGHER LEVELS OF CARE	41(16.3%)	211(83.7%)	"

Table 13 gives an overview of selected areas of household expenditure without necessarily calculating the actual expenditure in financial terms. Majority of the respondents said they incurred costs on education 179(71%), house rent 150(59.5%), water 217(86.1%)and electricity 155(61.5%). Please note that those who did not pay for electricity did not have any, and those who did not pay for water had their own dug up wells. Follow up appointments were given to 139(55.2%), and 41(16.3%) were given prescriptions for medicines, from public service outlets. Among those who were given prescriptions, 58(71.4%) said they had no money to purchase the prescribed drugs, only 23(28.4%) were able to afford.

APPENDIX IV(iv)....
TABLE 14: IMPROVEMENT IN QUALITY OF CARE IN GOVERNMENT HEALTH CARE INSTITUTIONS FOLLOWING INTRODUCTION OF USERFEES(Has anything improved?)

INCREASE IN QUALITY OF CARE	FREQUENCY DISTRIBUTION	%
YES	131	52
NO	100	21
NOT SURE	21	8.3

As table 14 shows there is an indication by majority of the respondents 131(52%) that quality of care has to some extent improved in public health care facilities since introduction of fees. Improvements are noted in cleanliness, staff attitudes and drugs, though these were said to be erratic. Other respondents were of the opinion that there was no improvement 100(39.7), and others were just not sure 21(8.3%), because they do not use the facilities or were simply non committal.

APPENDIX IV(v)

TABLE 15: OPINION ON USERFEES BY HEALTH CARE PROVIDERS(continues on next page)

UTILIZATION	PURCHASING POWER	ADVANTAGES	DISADVANTAGES	FUTURE OF USERFEES	COMMENT/SUGGESTIONS
-Attendance increased -Peak at month ends nd 2 week of months (Closure of UTH OPD possible reason for increase) -Average 300 per day	-Poor, with more people registering at month ends and paying cash with difficulty when ill	-People more Responsible for own health - Community participation (neighborhood health committee) - Supplementing running costs and allowances	-Fees too low to enable provision of quality service -Social welfare scheme not viable -Fees not meaningfully utilized	-Bright if drug situation improves	-More drugs -Improve conditions of service to motivate staff for provision of quality care. -More education on scheme.
-Attendance increase but peak at month ends -Average seen 10 people per day	-Poor, paying by negotiating for credit, installments. -A few advance payments	-Improved services / drugs - Improved staff attitudes -Keeps business running	-Unaffordable especially by the poor -Government system introduced too quickly	-Bleak people have no money	-Improve drug situation -Liase with drug and equipment manufacturers to reduce prices of these commodities -Utilize fees at health centers -Avoid political interference -Increase staffing levels and improve other services in government health facilities -Educate people on fees

T L	-Increased peak at month ends -Varies greatly from healer to healer some seeing 1-5 patients per day others 10, and some healers as many as 200-300 per day	- Poor , most people who can not afford modern care come because of mode of payment i.e. Negotiable Credit Paying in kind installments free	-Improve cleanliness in hospitals -Supplement services ,drugs and allowances -Assist with transport for fetching roots from the bush	-Erratic supply of drugs despite fees paid -Unaffordable by many people are dying in homes -Credit payments delayed and some times don't finish	-Bleak and depends on government policy.	-Government subsidize user fees -Improve drug supply -Education on fees -Collaboration and referrals between traditional healers and modern practitioners -Financial assistance to enable traditional healers acquire plots to build bigger premises to give quality care to their patients.

Table 15 presents summarized data in a matrix form, from health care providers who were interviewed and those who participated in focus group discussions.

- Attendance was generally said to be increasing in all outlets with increased peak at month ends.
- Purchasing power was said to be poor at all outlets and can be evidenced by increased attendance at month ends and desired mode of payments especially at private clinics and traditional healers. (i.e. credit, installments, paying in kind, negotiating)
- It was generally agreed that fees supplement running costs and staff allowances. For the private practitioners and traditional healers fees keep the business running . Fees were also said to improve services and staff attitudes because of the motivation through allowances . Fees were also reported to enhance community participation especially with the formation of neighborhood health committees at government health centers, and this to some extent is believed to have made some people more responsible for their own health.
- Some of the disadvantages expressed by all outlets include lack of drugs and people's inability to pay because of the poor economic situation in the country. Some policy issues were also mentioned, as fees too low in government facilities to enable them provide quality care , introduction of the scheme too quickly before adequate education of the masses, the ambiguous social welfare scheme and what was referred to as improper use of user fees at central level.
- The future of user fees was said to be bleak because of poverty in most Zambian households.
- Main suggestions on userfees were directed to policy makers. The government was called upon to improve the drug situation ,educate the masses on user fees, and improve conditions of service to motivate the workers. Private practitioners urged the government to intervene and Liase with the drug and equipment manufacturers to ensure that these commodities are affordable because they are the ones that determine the fees unlike is the case with traditional healers whose fees are mainly determined by spirits and disease. While the traditional healers called for subsidy of fees by the government , the health care providers in the public sector said fees were too low to enable meaningful delivery of health care.

Traditional healers called for more collaboration with the Ministry of Health and 'Modern' Doctors i.e. encourage referral of patients to each other especially diseases peculiar to traditional beliefs and customs. Traditional healers further requested for financial assistance from the government in form of loans, to enable them acquire plots to build premises which will enable them provide a better working environment for them and their patients who sometimes need to be observed. Most of the traditional healers interviewed live in 1-2 roomed houses which are also used as 'clinics'.

APPENDIX IV(vi)

TABLES 16 (a),(b),(c) : BASIC HEALTH FACILITIES AND EQUIPMENT AT PUBLIC AND PRIVATE HEALTH SERVICE OUTLETS

16(a) AVAILABILITY OF FACILITIES

FACILITIES	PUBLIC n=4	PRIVATE n=8	TOTAL N=12
TRANSPORT (AMBULANCE ETC.)	4	1	5
COMMUNICATION (TELEPHONE, RADIO)	4	3	7
LABORATORY FACILITIES	2	5	7
X-RAY	0	0	0
TOILETS	4	8	12
OXYGEN	4	5	9
DENTAL FACILITIES	2	0	2
ULTRASOUND	0	1	1
MINOR THEATER	0	1	1

Table (16a) gives an overview of basic facilities at service outlets assessed. Five of the service outlets had means of transport for their patients. Although all the four public health service outlets reported to have transport, it was erratic and not stationed at respective centers. It was discovered that one ambulance caters for more than one health center and is used not only for transportation of patients but stores , stationery, etc. It was common at times for patients being referred to UTH to book public transport themselves especially if emergencies occurred.

Laboratory facilities for basic services were also available in at least 7 health service outlets but none were reported to have x-ray services. Toilets were available in all 12 outlets though most of them required maintenance and adequate supply of water. Dental facilities existed only in two government outlets, while ultra sound and minor theater were recorded only in private health service outlets..

Table (16b) AVAILABILITY OF EQUIPMENT

	HEALTH SERVICE OUTLET		
EQUIPMENT	PUBLIC n=4	PRIVATE n=8	TOTAL N=12
SYPHYGOMOMANOMET -ER	4	8	12
STETHOSCOPES	4	8	12
THERMOMETERS	4	8	12
WEIGHING SCALE	4	6	10
AUROSCOPE	4	7	11
PROCTOSCOPE	4	4	8
OPTHALMOSCOPE	4	6	10
PATELLAR HAMMER	4	7	11
STERILISER	4	7	11
SUCTION APPARATUS	4	3	7
ECG MACHINE	0	2	2
VAGINAL SPECULUM	4	5	9

Assessment of equipment for the health service outlets concerned, generally revealed that they all had nearly all basic equipment, although quantities were not assessed. E.C.G machines were recorded in only two private health service outlets.

Table (16c): OTHER OBSERVATIONS I

DRUG AVAILABILITY			
HEALTH OUTLET	ALWAYS	SOMETIMES	TOTAL
PUBLIC	0	4	4
PRIVATE	8	0	8

II

II	CLEANLINESS OF INFRASTRUCTURE			
HEALTH OUTLET	Very Clean	Clean	Not Clean	Total
PUBLIC	0	4	0	4
PRIVATE	1	7	0	8

Table 16c(I and II) give results of some other observations carried out at the service outlets. Drugs were found to be always available in all 8 private service outlets and only sometimes available in public health service outlets where drugs were also said to be available mostly during the first two weeks following arrival of drug kits, and this greatly influenced attendance. Generally all the 12 service outlets were clean . Cleanliness was mainly based on the floor, absence of odors organization of reception area ,and general appearance of the grounds.

APPENDIX V: CLINIC ZONES

LUSAKA CITY URBAN CLINIC ZONES

ZONE	URBAN CLINIC	CATCHMENT AREA POPULATION
1	Chelstone	43106
	Kaunda square	32128
	Chainda	36506
	Chainama	186620
2	Chipata	83058
	Mandevu	89621
3	George	130380
	Matero Ref centre	83058
	George	86492
4	Makeni	27231
	Kanyama	99572
5	Chawama	86492
	Lilayi	30373
6	Kamwala	59169
	Railway	58735
	Civic Centre	30247
7	Chilenji	67136
	Kabwata	81930
	Bauleni	46967
	State Lodge	5000
	Prisons	-
8	Kalingalinga	55747
	Mtendere	51337

APPENDIX VI:
INFORMED CONSENT TO PARTICIPATE IN THE USER FEES STUDY

Dear Sir/Madam,
My name is_____from Department of Community of Medicine, University Teaching Hospital Lusaka. I am here with two other friends conducting a research on user fees.
The purpose of the study is to find out how people feel about paying for health care and to what extent they are able to afford these fees in health facilities of their choice, i.e. government hospital/clinic, private clinic, or traditional healer.
This compound was selected to participate in the study by chance with the assumption that findings of the study can be used to compare to compounds of similar legal status in Lusaka.
Results of the study are intended to contribute to policy discussions between the Ministry of Health and other relevant ministries in the design of an appropriate health financing policy.
Your selection to participate in the study is by chance and purely voluntary. Confidentiality of all information given will be ensured. No name will appear on the questionnaire.

Would you like to participate in the study?

1. YES_____(Signature)

2. NO_____(signature)

APPENDIX VII: RECRUITMENT TO THE USER FEES STUDY.

INSTRUCTIONS TO THE RESEARCH ASSISTANTS:

1. At any study site ensure that you introduce your self to the person in charge or traditional healer before you start recruiting patients for the study.
2. Explain purpose of the study and the capacity in which you are collecting data.
3. Show any relevant documents i.e. letters giving you permission to conduct your study at that site.
4. Once permission has been granted start selecting patients for interview following outlined sampling procedures, and inclusion criteria. Do not include very ill patients for ethical reasons and also to avoid biased responses.
5. Introduce yourself to respondent and briefly but clearly explain the purpose of the study
6. Tell them that the study is voluntary and that the interview will take approximately 10-15 minutes.
7. If they agree to participate in the study let them sign the consent form.
8. Establish rapport.
9. Assure respondent of confidentiality of all information to be given and that no name will appear on the questionnaire.
10. Select a quiet place for interview and ensure privacy. Use a language you are both fluent with.
11. Be attentive, listen and allow respondent to ask questions where necessary.
12. Do not forget to thank the respondent for participating in the study at the end of interview.

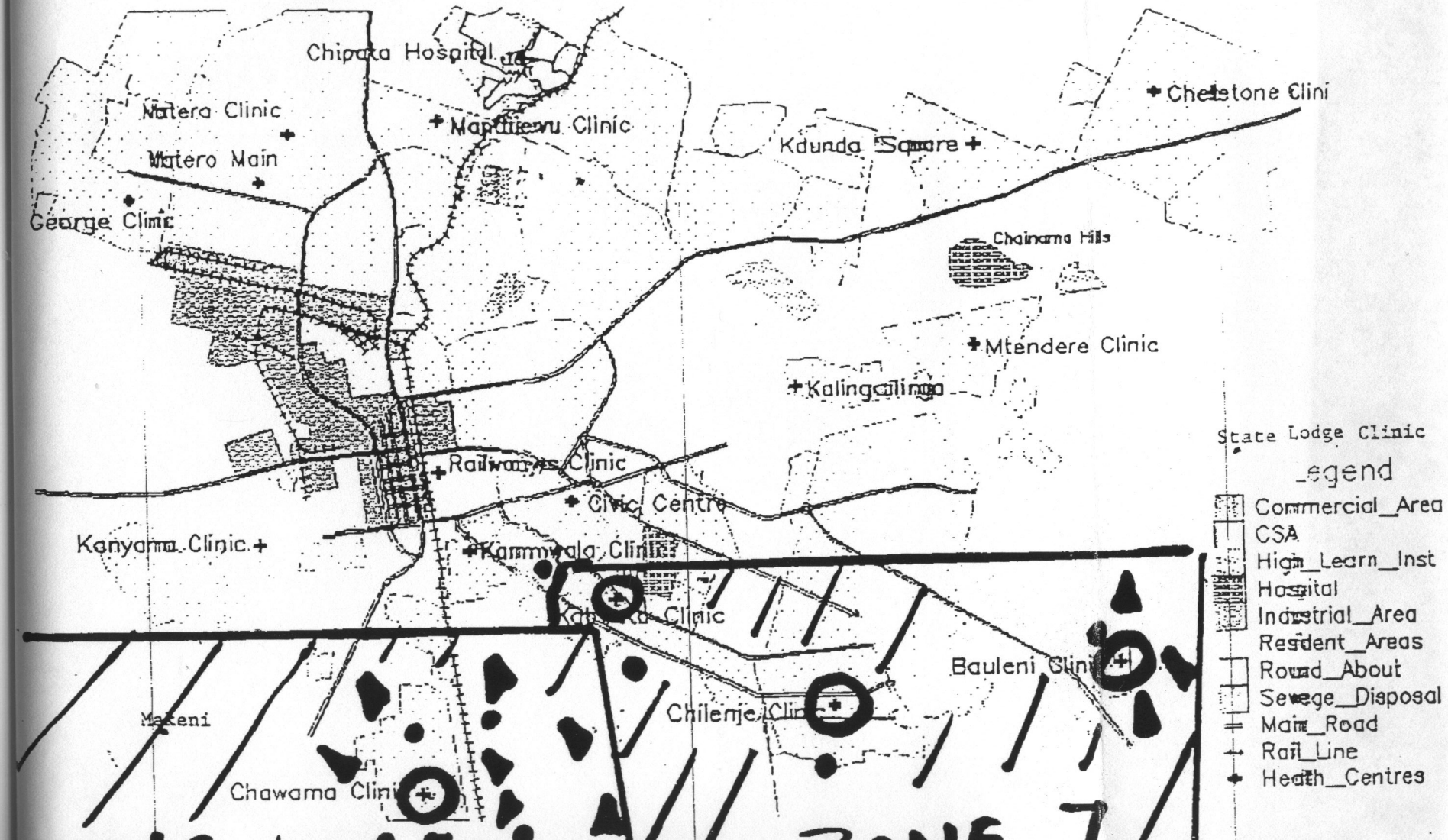
APPENDIX VIII
PRIVATE CLINICS WHICH PARTICIPATED IN THE STUDY

	Clinic	Study area
1	Munjile Surgery	Chawama
2	Chemlab Clinic	Chawama
3	Bell Hood Clinic	Chawama
4	Bethsida Surgery	Kabwata
5	Katungu Surgery	Chilenje
6	Kamwala medical center	Kamwala
7	Kuku Surgery	Chawama
8	Bronx	Bauleni

// URBAN HEALTH CENTERS
// ZONES 5 AND 7

APPENDIX IX

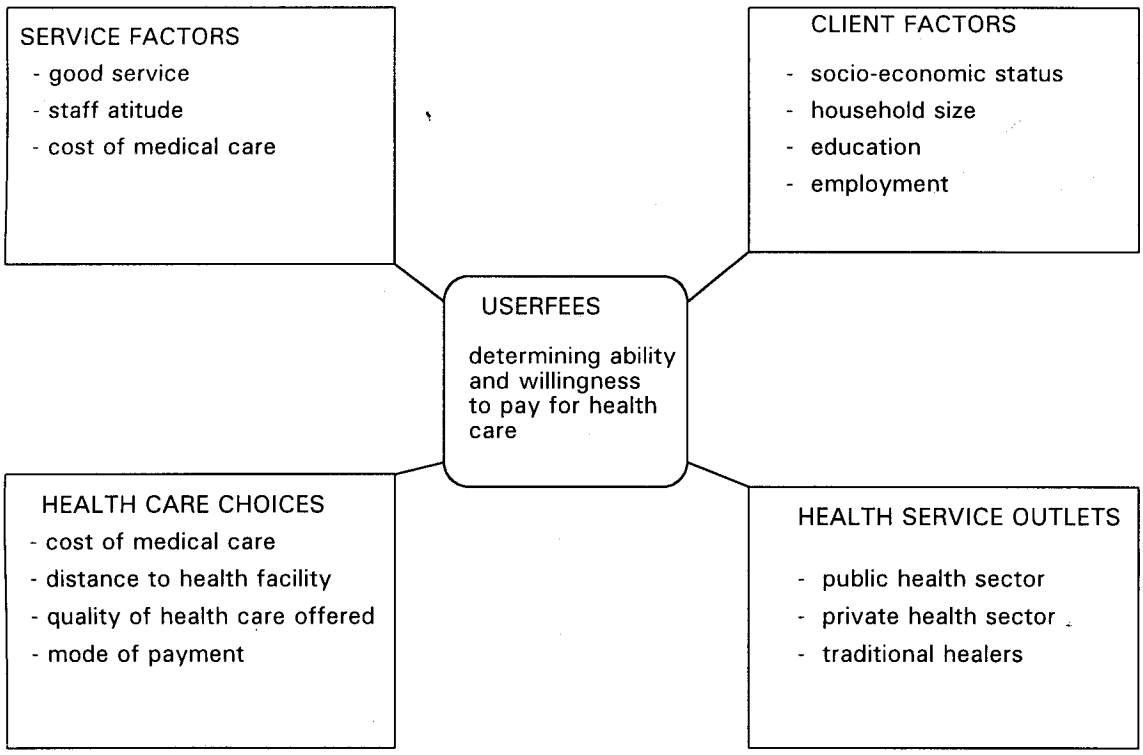
City Of Lusaka: Health Centres



APPENDIX IX
KEY FOR APPENDIX IX - STUDY AREAS

• PRIVATE SURGERIES
▲ TRADITIONAL HEALERS
⊕ URBAN HEALTH CENTERS
/// ZONES 5 AND 7

APPENDIX 10: DEPENDENT AND INDEPENDENT VARIABLES



APPENDIX XI: CORRESPONDENCE

THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE

Department of Community Medicine
P.O. Box 50110
Lusaka, Zambia

Telephone: 252641
211440 (UTH) 254824 (Pre-Clinical) Ridgeway Campus
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250763

Your Ref:

Our Ref:

OFFICE OF THE RESEARCH, ETHICS COMMITTEE

9th October, 1996

Mrs Margaret Mutati
c/o Dept. Community Medicine
Box 50110
LUSAKA.

Dear Mrs Mutati

RE: USER FEES: DETERMINING PEOPLE'S ABILITY AND WILLINGNESS TO PAY FOR HEALTH CARE: A COMPARATIVE STUDY BETWEEN PUBLIC AND PRIVATE HEALTH SECTORS IN LUSAKA URBAN.

This is to inform you that your Research Project titled as above was approved by the Research, Ethics Committee during the month of October, 1995.

You are hereby allowed to continue and finish your Research Project.

Yours Sincerely

Dr K S Baboo
CHAIRMAN/RESEARCH, ETHICS COMMITTEE

TRADITIONAL HEALTH PRACTITIONERS ASSOCIATION OF ZAMBIA

P.O. Box 32082
Lusaka
Telephone: 274114

17th August, 1996

Mrs. Margaret M. Mutati
P. O. Box 37716
Lusaka

Dear Mrs. Margaret M. Mutati,

Your letter dated 16th August, 1996 refers.

This serves to confirm that Traditional Health Practitioners Association of Zambia (THPAZ) National Executive Committee has no objectives in giving you permission to undertake a Research Study involving Traditional Healers in Lusaka urban.

We urge you to refrain from research studies which involves name of trees (patent), personal vendetta and individuals human rights.

Kindly keep my office informed of any irregularities or weak points you may come across during your research.

I wish you the best of luck during your research.

Yours Sincerely,

Dr. R. Vongo
THPAZ President.

cc. Director of Research - THPAZ

cc. The InCharge (THU) - Ministry of Health.

RV/mc

P.O. Box 30789
Lusaka
Tel: 252480 (Temporary)
Telex:.....

In reply please quote
No.....

REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

LUSAKA URBAN DISTRICT HEALTH MANAGEMENT TEAM

MCM/cmk
DHMT/33/10

18th September, 1996

Mrs Margaret M Mutati
P O Box 37716
LUSAKA

Dear Madam

Re: COMPARATIVE STUDY ON THE ABILITY AND WILLINGNESS TO PAY FOR HEALTH CARE IN PUBLIC AND PRIVATE HEALTH SECTORS IN LUSAKA URBAN

The above captioned subject matter refers.

Please be informed that permission has been granted for you to undertake a comparative study as mentioned above.

Kindly avail to us a copy of the results of your study.

Yours faithfully

DR R KUMWENDA PHIRI
DISTRICT DIRECTOR OF HEALTH

Zambia Faculty of General Practitioners

P.O. Box 30209
LUSAKA
ZAMBIA

28th October 1996

To Doctor in Charge

.....

.....

RESEARCH PERMIT

On behalf of The Faculty of General Practitioners, may I introduce, Mrs. Margaret Mutati, a Post-graduate student of Community Medicine, University of Zambia, doing Masters of Public Health, is currently doing a Research for her Thesis on " 'USER-FEE' Determining Peoples' Ability and Willingness to pay for Health care; A Comperative Study between Public and Private Health Sector in Lusaka Urban"
We have selected your Clinic because it serves the randomly selected community. Kindly assist her the best way you can.
Thank you.

Dr.Hilda Mutayabarwa
Chairperson, Faculty of General Practitioners

APPENDIX XII

Traditional Healers who Participated in the Study

	Name	Study Area
1.	'Dr' Mwanzabamba	Bauleni
2.	'Dr' A. L. Nyalugwe	Bauleni
3.	'Dr' Chabwera Phiri	Bauleni
4.	'Dr' Chimutengo	Chawama
5.	'Dr' Namushili	Chawama
6.	'Dr' Kafauitamvwa (Justine Nyirenda)	Chawama
7.	'Dr' Nyakaseya	Chawama
8.	'Dr' Kilimanjaro (Damsel Nambela)	Chawama
9.	'Dr' Mathew Matibini	Chawama
10.	'Dr' Lumwengo Kanyama	Chawama
11.	'Dr' Lute Nyama	Chawama
12.	'Dr' Mangalawila	Chawama
13.	'Dr' Musunga	Chawama
14.	'Dr' Kilimanjaro (John Musonda)	Chawama