# THE UNIVERSITY OF ZAMBIA/ZIMBABWE OPEN UNIVERSITY

IMPACTS OF FREE PRIMARY HEALTH SERVICES IN MPIKA DISTRICT FOR THE LAST 10 YEARS

BY

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## APPROVAL FORM

The undersigned certifies that they have read and recommended to the University of Zambia/Zimbabwe Open University for acceptance; a project entitled “Impacts of free primary health services in Mpika district for the last 10 years” submitted by Tamani Phiri in partial fulfillment of the requirement of Masters of Business Administration (MBA)

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# DEDICATION

This work is dedicated to the almighty God for the numerous moments I have received his grace and mercy well knowing that I don't deserve it.

Because of Him, I continue to look forward to soaring even with my imperfections.

# ABSTRACT

This study sought to determine the impact of free primary health care in Mpika district for the last 10 years that Zambia as a nation has provided free health services. Its target respondents were the health sector staff and the clients (patients). Its objectives were to determine the impact of free health care on utilization of the health facilities by means of responses obtained from patients at the facilities. It also investigated the meaning of quality of health care among the clients and sought to determine if, in the opinion of the clients, the removal of User Fees improved the quality of health care in the district. The last specific objective of this study was to determine the effects on health system management brought about by free health services.

The research selected health centres in the district from which in-charges were interviewed. Clients were also interviewed along with conveniently selected long serving employees and health system administrators. Interview guides and data extraction tools were used as data collection tools.

The study's main findings where that utilization of health centres increased and that the client's perspective of the impact on quality of health care was that it improved upon revocation of User Fees. The health system lost a source of income, accountability to the community was reduced and there was a reduction in the amounts of unaccounted for finances. Another thing that resulted from the removal of User Fees was the reduction in the perceived value of health care and medical supplies by the community.

The study recommends that other options of financing, especially those that pool up resources and don't demand direct cost from the clients on access of health care should be adopted to ease the financial burden on individual patients. It also recommends that resources should be channeled to reducing patient waiting time, cleaning the environment and availing drugs for use as these are the

elements that constitute quality health care in Mpika district from the clients' perspective. The community should be deliberately involved in the process of delivering health care and that financial regulations should be applied to all financing options so as to increase the level of accountability and reduce the amount of unaccounted for resources.

For further research, this study recommends that future researchers focus on determination of the extent of the increase of health facility utilization that resulted from the revocation of the User Fees in the district. This would help the health financers to determine what health financing levels will optimize health care while maintaining a reasonable health facility utilization rate.

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# CHAPTER I

## INTRODUCTION

The Republic of Zambia is a developing nation. As it strives to achieve the best possible development, it adopts and implements policies that it perceives will maximize utility for its citizens. Different guiding documents such as the National Development Plans and other policy guiding documents have been effected and revised owing to changing circumstances and time.

The Ministry of Health (MoH) has crafted the National Health Strategic Plan (NHSP) in synchrony with the National Development Plans (NDPs), regional and international regulations and protocols on health. As a guiding document, the Ministry has instituted the National Health Policy which acts as a guide on implementation of the National Health Strategic Plan by stating how aspects of the health sector such as Financing, Provision of Health Care, Human Resource for Health, Equity of health care provision and other aspects of similar nature will be governed.

Health financing as an area of specific concern affects not only the quality and quantity of the health services being provided, but the quality and quantity of the medical supplies with which the health services are provided. It further affects the affordability of the health care services and consequently accessibility of the health services. It subsequently affects the distribution of health service provision and access to health care services on social economic lines.

Mpika district is one of the seven districts in the newly created Muchinga Province in the north-eastern parts of Zambia. Mpika is among the two thirds of Zambian districts classified as rural in the country. It has an estimated extrapolated population of 260, 000 with an area of 40,935 square kilometers, (CSO census, 2010).

## 1.1 Background

In the early 1990's, the Zambian Economy was undergoing reforms under the Structural Adjustment Programs (SAPs) aimed at improving sustainability of the economy and the sub-sectors in it. The health sector, among other measures, introduced the User Fees as a means of improving financing to the sector. It was believed that the services that are publicly offered will best be financed privately and vice versa. This was going to be achieved through the introduction of User Fees. The user fee was a fee that was born by the health seeker that was meant to contribute directly to the financing of the health services that they consumed. According to the National Health Care Financing Policy of 1998, these fees also applied to primary health services and would help to sustain the provision of quality health care in the face of an ailing economy.

In the year 2006, the government of the Republic of Zambia through the Ministry of Health decided to provide primary health care services without charging User Fees to health service seekers. The reasoning behind this was that the poor population mainly from the rural areas, were being hindered from accessing health services as they were unable to pay the fees. The removal of User Fees, driven by the goal of increasing health care accessibility especially by the rural population was announced by the President in April, 2006. The revenue losses to the health service providing facilities owing to this policy decision were to be recovered by other means of financing of services delivery by the central government in form of grants.

This year (2016) marks ten years of health service delivery without any revenues realized from User Fees charged on primary health services. During these ten years, the health sector has had to look to the central government and other sources of health financing other than User Fees to sustain the financial requirements of delivering the services.

Mpika is a district with a populace that was intended to benefit from this policy shift. The District Health Office provided health care to its residents in compliance with the National Health Policy under the supervision of the Ministry of Health through the Provincial Medical Offices; Northern Provincial Medical Office from 2016 to 2013 and Muchinga Provincial Medical Office from 2013 to 2016.

It is therefore expected that the free primary health service policy, after 10 years of being in effect has yielded the anticipated results. Mpika district is expected to have experienced some changes in the health sector that is due to the removal of the User Fees over that last ten years. This study is meant to investigate the effects of the removal of this policy within the last 10 years on quality, quantity and management of the health system.

## 1.2 Statement of the problem

Zambia, in its long term development course of transforming the nation into a Middle in-come prosperous nation by the year 2030 has prioritized health. It is in the interest of the nation to keep healthy people healthy and to provide diagnostic and curative services to the sick within the nation. "A nation of Healthy and Productive people" is the vision that the Ministry of Health is driven by in providing health care to the populace of Zambia. Alongside this vision is the mission of "equity of access to cost effective quality health care as close to the family as possible". With these two guiding statements, the government is committed to providing Zambians with health care regardless of their economic status or ability to pay for it right in the area where they live or as close as possible to where they live. In attaining this objective, the nation is signatory to many supra national organizational agreements and treaties. The nation is also signatory to a good number of the international treaties that are health related. One such health related treaty is the Ouagadougou Declaration which is the basis of the Public Health Care approach that Zambia has

adopted (MOH, 2013). This treaty requires a country to spend at least $33 per capital on health expenses per annum.

The forerunner document to the currently used health provision guide, the National Health Policy bears witness to the fact that Zambia is signatory to the Abuja declaration. The Abuja declaration mandates the government of the Republic of Zambia to spend a minimum of 15% of the annual budgeted expenditures of discretionary funds to Health Care provision, (MoH, 1991).

Amid deteriorating economic conditions, the government was failing to raise the WHO projected $33 per capital health expenditure to sustain the required health care services, (ibid). In the year 1993, the government in an attempt to incorporate alternative forms of health financing decided to introduce User Fees in the Heath Financing Reforms of 1993. User fees are an out of pocket charge that was levied on the health care seeker at the point of health service delivery. The central Board of Health in its cost sharing brief of 2002 states that this form of financing was considered appropriate because it was going to allocate resources to the Health Care providing institutions according to the proportion of health seekers attended to at the institution. These funds were meant to be appropriated by the health care institutions that receive them and not remitted to central government for redistribution. As a supplementary funding form to the public expenditure on the health sector, the User Fees were assumed to give the health service providing institutions a level of cushioning from the possible failure to provide the necessary funding or delayed funding by central government.

While the realized funds from the User Fees charged were by far less than what the Health providing institutions required to run the centres, the supplementary form of funding was seen to have additional benefits. Some of the identified benefits included the continuity of service delivery

in the absence of the government funding, the promotion of efficient expenditure patterns of resources, the increased community involvement and a sense of ownership of the health service providing institution and its resources both by the staff and the community (MoH/ZHIP, 2002).

The User Fees were administered in Zambia as an alternative source of health financing for about 13 years from the year 1993 with exemptions for special groups of citizens. The exemptions were meant to improve equity of access and cost effectiveness against varied economic and social classes of the community. The groupings that enjoyed exemptions where based on age range, disease from which one suffered, social economic status and whether the health seeker was physically able or unable to pay. Under 5's and over 65's were exempted from the charges. Chronically ill patients (TB, AIDS, Cholera, STIs patients) were also exempt. The health workers also had the discretion to identify and exempt citizens that were living in absolute poverty. And finally the physically challenged were exempt from paying User Fees upon accessing health services (Masiye et'al, 2005)

In spite the provision of exemptions, equity of access to health care for all the people of Zambia regardless of their geographical location, gender, age, race, social, economic, cultural or political status was not attained. The Demographic Health Survey of 2001/2002 reviewed that 30% of rural patients were turned away from health centres due to inability to pay User Fees before accessing health care. Masiye et'al (2008) describes this observation in his study as "reluctance among providers to sacrifice revenue for exemptions". Hjortsberg C (2003) observes in his study "Why do the sick not utilize health care? The case of Zambia" that the populace that is less affluent stay away from utilizing health care facilities when there are fees attached to the health services being provided that they perceive to be beyond their means.

It follows therefore that while User Fees as a means of health financing allows the facility to have resources at hand to provide necessary and quality health care to the citizens, it also significantly reduces utilization of health facilities especially among the poor and mostly in rural areas. It was in an attempt to address the reduced utilization and increase the equity of access to health care that the Government of the Republic of Zambia through the Ministry of Health removed User Fees in the year 2006. Masiye et'al (2008), documents that there was a 55% increase in utilization of health services in the rural areas in less than 3 years following the removal of the User Fees.

As a means of cushioning the loss of revenue that the districts will suffer from by removal of the User Fees, the Ministry of Health saw it fit to establish a User Fees replacement grant. An additional financing provided to the health providing institutions through the District Health Offices that was aimed at leaving the health providing institutions in the same financial position as they were before the removal of the fees, (Masiye, 2008). Unfortunately, some district received a replacement grants that was less than what they used to realize from User Fees. Districts such as Mpika, Monze and Nakonde had percent differences of replacement grant of -23%, -40% and -6% respectively, (ibid).

The delivery of good quality health care with a good degree of equity to access as a guiding principle requires abundant resources to be available to the health service providers. On the other hand, User Fees as a form of health financing that has the potential to complement government's efforts in providing adequate resources for provision of quality health care also has the potential of reducing access to health services among the poor hence reducing equity of access to health care.

In summary, User Fees are a form of health financing. For a nation such as Zambia that has its per capita expenditure on health that is lower than the WHO recommended, User Fees are a possible remedy that can contribute to attainment of the much desired heightened and sustained health financing. However, User Fees in the health sector have proven to reduce the accessibility of health care among the rural poor. It is for this reason that utilization of health facilities that charge User Fees is lower than would be without it. It follows therefore, that the effects of revocation of User Fees among the 54 rural districts in the country is worth researching. Of specific interest might be the effects of revocation of User Fees in the rural districts that received less replacement grant compared to the revenues realized from User Fees. Mpika district is one such district and the effects over the last ten years of revoking the User Fees policy is the concern of this study.

## 1.3 Purpose of the study

This study came at a time when many studies have been done in the area of health financing with a fair share of researchers focusing on the subject of Removal of User Fees. The introduction and removal of User Fees in Zambia has attracted a lot of attention which has resulted in a lot of findings and recommendations being made. A few researchers have concentrated on district catchment areas with one having taken the case of Chongwe district. This study will make recognition that districts have varied conditions prevailing and as such will opt to focus on a single district with specific conditions of deprivation, population, social economic status of populace (rural poor) as well as health seeking behavior.

The research recognizes that some studies have been done to explore the effects of revocation of the User Fees in terms of utilization and health seekers perception of the quality of the health service being provided. None of these studies has taken the context of Mpika district or another district with similar features such as deprivation, population economic status and ratio of

replacement grant to User Fees revenues. The study has also added an aspect that has not been researched on before; the effects of User Fees revocation on health system management.

All these aspects being explored were in Mpika district of Muchinga province of Zambia. Mpika district is peculiar for its unique nature in hardships associated with health system management due to constrained resources and vast catchment area and population.

Another unique thing about this study is that, unlike other studies that have been done shortly after the revocation of User Fees policy, this study aimed at covering the last decade of free primary health care in Zambia. It is hoped that this wider time range will allow for an even better understanding of aspects that might have not been easy to capture in the shorter time frame.

The government of the republic of Zambia is constantly looking for more ways of efficiently financing the health sector. This is because the per capita expenditure on health is below the WHO recommendations and as such further financing is required. On the contrary, the Ministry is upholding equity to access as a guiding principle which then is compromised by charging of User Fees. In addition, the health system managers are also faced with constant resource constrains in their attempts to achieve provision of equitable health care for all and as close to the people as possible.

The purpose of this study is therefore to determine the right mixes of health financing that can be ideal to achieve the vision of the Ministry of providing equitable access to health care as close to the people as possible in rural poor districts such as Mpika.

## 1.4 Objectives of the study

### General Objectives

This study was aimed at determining the effects that the removal of User Fees from primary health services has had in Mpika district for the past 10 years. It strove to determine the extent to which the policy step to remove User Fees has attained its intended objective of increasing the utilization of health facilities. It went further to determine any effects on the quality of health care as perceived by the health seeker and finally investigate effects on health system management.

### Specific Objectives

The research was aimed at achieving the following specific objectives:

I. Determine the effect on utilization of health facilities from the removal of User Fees
II. Investigate the perception of health seekers on the quality of health services after the removal of User Fees
III. Find out how health system management has been affected by the removal of the User Fees

## 1.5 Research questions

- What was the average change in utilization of health centres in Mpika district after the revocation of User Fees?
- What attributes constitute quality health care according to the health seeker in Mpika district?
- What is the order of importance of the attributes that constitute quality of health care according to the health seeker in Mpika district?

- What are the effects of removal of User Fees on health system management in Mpika district?

## 1.6 Significance of the research

This research was done with the intent to inform policy decision on matters of health financing that concern rural districts such as Mpika district. It is also hoped that the information realized at the successful completion of this study should point to possible health financing mixes that can yield better combination of equity to access and utilization of health services.

The findings of this study will further provide information on the perceived quality of health care being provided by the institution to the catchment population in the district. The Health system managers can use this information to shape their priority areas to meet and adequately satisfy the health seekers.

The study will lastly provide information upon which determination of which financing options are efficient for effective health system management can be based.

## 1.7 Delimitations of the study

The study focused on the effects of revocation of User Fees in Mpika district of Muchinga province over the last ten years. To achieve this, information was solicited from as far as the 13 years before the abolition (from the time of introduction of User Fees, 23 years ago). It compared the two time dichotomies both in facts and perceived elements such as the quality of the service being provided.

It endeavored to constitute quality health care from the health seekers vantage point. It also attempts to find out how health system management has been affected by the removal of User Fees.

The study sampled Health Facilities in Mpika district from which information was collected and analyzed. Mpika district has 30 health facilities (operational at the moment), the first level hospital inclusive and most centres far flung, making it hard and costly to reach all the centres. Information was collected from the District Health Office as well especially on matters that were cross cutting and common to all health centres in the district.

## 1.8 Limitations of the study

Due to financial constraints, the study conveniently sampled and collected primary data from representative health facilities. Secondary aggregate district data was also accessed from the district office in an attempt to have appreciation of the holistic district picture on aspects being researched on.

Due to staff turnover, the study had challenges in finding respondents in the sampled health facilities who had worked for at least 23 years; the period in which there was the introduction and revocation of User Fees. As a result, the study relied more on official records which in some cases were not available.

## 1.9 Operational definitions

Health Facility or Health Centre: this is an institution under the Ministry of Health that provides health services to the populace. It can be a Hospital, an Urban Health Centre, A Rural Health Centre or a Health Post.

Health financing: a form of providing financial resources meant to aid the provision of health resources at current and in the future.

Ministry: generally, will refer to the Ministry of Health in the Republic of Zambia unless otherwise stated.

Guiding Principles: these are tenets that the Ministry of Health has recognized and pledged to abide by in the provision of health services to the Zambian populace.

Research: refers to an organized, deliberate effort to go out and collect information, organize it and derive inferences from it concerning some phenomenon. In this document, it is used interchangeably with study.

Frivolous demand: refers to demand for health that is not necessary. It arises when people seek health services even when they are not really sick. It can be to collect drugs which they think will be needed later or due to ignorance.

Allocative efficiency: is an economic concept that refers to sharing of resources by allocating them to cost centres according to level of importance or strategic relations. Resources allocation is only considered allocatively efficient if the manner in which they are allocated reflects the strategic priorities of management among the cost centres.

Health service delivery: refers to the provision of heath care to the people by the government/private institutions through the institutions established for health provision and health system management.

Health Care: is the collection of services that are provided both for preventive and curative purposes by the health specialist. This package is a collection of consultancy, diagnostic services, rehabilitative and drug supply to mention but a few.

Quality: this is the ranking of what is considered of superior nature or better preferred. Quality of health therefore refers to attributes of health that makes heath service with those attributes superior or better preferred.

Facility utilization: the number of people who seek health care from a health facility for the first attendance in a year. This variable measures the demand of health services in the catchment area of a particular health centre. It can also be used to assess the levels of disease burden by measuring utilization due to a particular disease.

By-Pass surcharge is a fee paid to a health facility for skipping other lower level hospitals. This charge is meant to discourage people from attending higher level hospitals on first attendance. It is recommended that cases are escalated from lower levels to higher levels as need be.

# CHAPTER II

# LITERITURE REVIEW

## 2.1 Introduction

This chapter focuses on reviewing the body of knowledge for literature both normative and positive that has relevance to the topic being researched on. It will pick out thematic areas of theories that concern the research topic under the following headings; What are User Fees?, arguments for charging User Fees, Arguments for revocation of User Fees, Equity to access of health care, Quality health care, Continuity and sustenance of health care, User Fees in African health and User Fees in a Zambian health. A brief summation of theories will be made to conclude this chapter.

## 2.2 What are User Fees?

User Fees are charges that are levied on the user of publicly provided services on access to a service. This charge is meant to pay for the provision of the service being consumed. As a means of health financing, User Fees have two prominent features which should be considered every time health financing is being made. These factors include; firstly, the lack of cost sharing as the person who is seeking health care is the one that will bear the cost directly proportional to the services demanded. Secondly the User Fee is charged at every attendance to the facility. This therefore means that cost sharing is not possible and that the more one visits the health facility, the more one gets to pay for the services being sought (Lagarde and Palmer, 2008).

In Zambia, User Fees were charged on access to health care from public health facilities between the years 1992 and 2006. During this period, the cost associated with the provision of health care was assumed to be partly covered by resources realized from the User Fees. A charge was set on consultation, diagnostic tests, on drugs and any other health related service that was being provided at the public health facility.

## 2.3 Arguments for charging User Fees

The early 1990's were hard economic times for Zambia. It was during these times that Zambia sought assistance from the World Band for the possible financing for revival of the economy. The world bank recommended that the Zambia reconfigures its economic system and puts in place policies that will promote self-sustenance. Among these self-sustaining policies recommended by the World Bank was charging of User Fees. This saw the introduction of User Fees in the health sector, (World Bank, 1987).

Willingness to pay was inferred from the high household expenditure on private health service care noticed in many countries, Zambia inclusive. And according to Shepard and Benjamin (1988), this implies that people have within them the ability and willingness to spend on health care for the purpose of getting quality services.

Following the weakening economic conditions and the willingness that citizens showed to pay for health care, charging User Fees before access to health services at public health institutions became rational as the provision of these services was becoming financially unsustainable for the government.

According to the Central Board of Health and the Zambia Integrated Health Project (2002), User Fees were going to not only serve as a source for additional income for the health providing facilities, but also provide a source of financial incentives for the health workers as most of the activity based allowances will be paid from the same funds. As facilities were charging, they were not expected to remit the User Fees to the central government but rather identify health related expenditures that they could take care of to improve health services. Besides purchase of drugs, tools and furniture to enable facilities provide the services better, paying of staff allowances was also catered for from the same fund. This improved motivation among staff greatly.

The introduction of User Fees also came with regulations and accountability protocols to follow. One of them was that the health centre in-charge should be accountable to the community through the Health Centre Advisory Committee which was a collection of Neighborhood Health Committees. This was done through regular meetings and random book checks that the community representatives were entitled to. In cases when the Health Centre Management failed to account for the funds, the community had the right to request intervention from higher levels of government. This move was looked at as a great step in getting the community involved in providing health care that they deemed befitting (ibid).

ETC Crystal (2004) advances the thought that financial and systems stability can be attained through the charging of User Fees. User Fees as a health financing alternative can yield enough financing that can be used to supplement central government heath financing. In some cases where User Fees collections are adequate, they can replace or at least be able to cover most costs that otherwise would have to wait for funding from central government. He is of the view that the additional funds realized will enable the facility execute extra programs that otherwise would be constrained by limited or non-availability of resources.

Ridde (2003) is a proponent of the thought that User Fees can result in equity to access of health services as payments will be made upon accessing health services regardless of one's capability to pay. He however adds that equity in this case is best achieved when management is flexible enough to exercise exemptions especially for the poor and the economically incapable sections of society. Bonus et'al (2003) in expressing the same thought stresses the fact that User Fees can actually achieve what he calls "disproportionate" benefits for the poor as the demand for health services would increase while that of other sections of society will be assumed constant. All this is possible if the resources generated by charging of User Fees are used to improve the quality of health services and the number of people that can access the health services at each given time.

Another argument for the implementation of the User Fees policy is that it brings about efficiency. Efficiency of health care services in this case refers to the utilization of health care only when appropriate and the usage of resources in a way that can yield the best health results possible. ETC Crystal (2004) argues that User Fees in the health sector can restrain consumers of health services from unreasonable demand of health. He argues that unless the consumers of the service deem the health need to be worth the User Fee or better shall they demand for the health service. It follows therefore that what he calls "frivolous demand" of health services will be curbed. Another way in which efficiency is promoted by the User Fees policy in the health sector is by using the fee charged for individual health services as a signal. Variations in fees charged can be a source of a good understanding of the costs associated with providing each service and as such clients will demand for the services only when necessary (ibid).

## 2.4 Arguments for revocation of User Fees

Unlike what some theorists have said, there is empirical evidence towards reduced utilization of health services upon introduction of User Fees. Some of the clients would be in need of health services but end up staying away from the health facilities because they cannot manage to pay the demanded User Fees before being attended to (Masiye et'al, 2005). Some scholars have further reviewed that non-health service related costs such as the cost of travel, the cost of upkeep when at the health facility and possibly the loss of income during the period of seeking health services are good enough barriers to frivolous demand for health services. User Fees are an additional cost which not only limits or curbs frivolous demand but reduces utilization of the health facilities as well. Liu and Mills (2002) further argue for deteriorating allocative efficiency as User Fees prompted health facilities to provide more of the services that were earning more fees than the ones that were really needed by society. The health institutions, unlike business houses don't necessarily allocate resources to the most profitable or most yielding services but rather the most socially required services. User Fees, according (ibid) failed in this area too.

Witter (2005) identifies and calls one of the effects of usage of User Fees as a means of financing health care as consumption inefficiency. According to him, people who are sick and in need of health services are kept away from health service access by the costs. Major among the costs associated with seeking health services is the user fee which is incurred at the point of health access and therefore is compulsory to all (except for exempt classes). In the Zambian scenario, Hjortsberg (2003) state that User Fees were a hindrance to access to health services in most of the areas in the country. Among other factors investigated as to why people don't access health services, the User Fees factor came out prominent among the rural populace. Masiye et'al (2008) clams that the

revocation of the User Fees by the government in the year 2006 resulted in an increase in health facility utilization of 55 percent in the (then) 52 rural districts of the country. It can be concluded therefore that the presence of the User Fees hindered 55% of the rural populace from attending health facilities for health care when they were sick.

## 2.5 Equity of access to health care

Equity of access to health care is one of the guiding principles of health service delivery in Zambia according to the National Health Policy, (MoH, 2013). According to MoH, equity to access is a state of affairs in which all can access health care regardless of their social economic status, ability to pay for the service or geographical location according to their respective health needs. This therefore translates in access to health services that does not discriminate on social, economic or geographical lines.

Equity to health care access is a phenomenon that is opposed by the charging User Fees especially in the rural areas of developing countries. Like other obstacles to health access, User Fees are being looked at from the perspective of James (2006) as a reason why equity to health cannot be met. While the obstacles to health access might be non-financial, User Fees are financial costs to the health seekers and hence considered as financial barriers. As such, User Fees are affordable to some while to others they are not affordable depending on respective economic standings.

## 2.6 Quality health care

Quality of health care, like quality of any other thing is a subjective matter. Different groupings in society can have different aspects and attributes that they will consider to be quality. According to

Masiye (2008), Quality of Health Care constitutes patient waiting time (the shorter the waiting time, the better the health service), consultancy being provided by duly qualified and certified health staff, availability of appropriate drugs as prescribed by qualified health personnel, staff courtesy, and cleanliness of the surrounding environment in which the health service is being provided. This combination of these attributes, according to Masiye, is the patient's perception of what quality health care should constitute. According to his findings, the patients perceive these elements in order of importance as follows; availability of drugs, cleanliness of the surrounding environment and waiting time. In his findings, consultancy of health provision by a duly qualified person and staff courtesy have the same ranking.

According to the MOH (2013), quality of health care constitutes among others, sustainability, equity to access, qualified consultancy, consistence of standards, cost effectiveness, delivering the health care package as close to the family as possible (access to a primary health service facility in less than five kilometers radius of your residence).

Quality of health care is affected by the existence of User Fees. In many cases the extent of the User Fees charge determines the cost of access to health and eventually affects the utilization. On the other hand, User Fees are perceived to raise funds which can allow for the financing of health care and hence result in sustenance. Bijilmaker (2003) is among the scholars who have supported the notion that User Fees have a positive correlation with the quality of health being delivered. According to him, sustenance, efficiency and equity of service delivery is enhanced by the User Fees policy. It is argued that the funds realized might be used to access medical supplies, to clean up the environment, access new and better medical equipment, or even to incentivize staff who are involved in the delivery of the services. Gilson (1997) and Liu and Mills (2008) are cited to have advocated that negative correlation between User Fees and quality of services. They purport that

the existence of User Fees, even though it improves the resources available for health service delivery, might not allow for the socially justifiable allocation of health resources. This might lead to socially inefficient allocation of resources.

## 2.7 Continuity and sustenance of health care

Sustenance or sustainability of health care is an approach to health care provision that ensures maximum usage of resources for health (all resources including financial and human resources) for the provision of health to all health seekers for the present and the foreseeable future. Sustenance blends efficiency at present and availability of the same efficient service to all health seekers in the future. In plane expression, it is having the best health care today that we are sure will be available tomorrow (Gilson, 1997)

The main objective of the World Bank in suggesting the introduction of User Fees in the health sector in Zambia was to create extra source of financing for the provision of health care which was solely funded from the central government and in some instance by Non-governmental organizations working with the central government. The government saw it fit to easily embrace the suggestion because health financing capacity was dwindling with the ailing economy of the late 1980s and the early 1990s (World Bank, 1998). The born of contention is on the sustainability of health care provision.

The Zambian government through the Ministry of Health, in the health provision guiding document, the National Health Policy acknowledges sustainability of health service provision as one of the guiding principles in the provision of health care, (MOH, 2013).

The World Bank maintains that the introduction of User Fees contributes directly towards the improvement of health financing at current and in the future. This, according to World Bank translates into a direct improvement of health service delivery sustenance. The increased funding will allow that in the present and in the future health needs are taken care of at the same standards and the standards are sustained (World Bank, 1987).

A contrasting thought is expressed by Gilson (1997) who purports that the resources realized from User Fees are significantly low to a point where their contribution towards sustenance of quality health care is not recognizable. His research discloses that User Fees realization in most African countries averaged 5 percent of the health care budget. He further argues that an additional 5% income to the health financing does little to guarantee sustained delivery of health care.

Interestingly, James et'al (2006), qualifies the benefits of User Fees to be more than just the financial receipts. He argues that the charging of User Fees at point of service delivery has a multifaceted effect on the quality and sustenance of health service delivery that cannot be limited to financial gains only. According to him, the fact that funds are collected at service delivery point makes it easy to appropriate. This makes it possible to have a supplementary reserve of resources in cases of delayed or not receiving Recurring Departmental Charges from the central government. Nyonator and Kutzim (1999) argued that since its existence doesn't necessarily mean that the funding from central government ceases, its presence as a supplementary fund will add greatly to the sustenance of health service delivery.

## 2.8 User Fees in African health

Most African countries have experienced debates on whether to evoke or revoke the User Fees policy in their respective health sectors. Most of these debates, like in the case of Zambia were fueled with some form of instability or turbulence in financing of the health sector. Gilson accredits his findings in his work to a research that covered over 15 African countries on the matter of User Fees in the health sector. This suggests that a good number of countries in Africa have engaged User Fees as a means of financing their respective health sectors. Some still use them while others have revoked the policy and others have not even adopted the User Fees policy in the first place for varied reasons.

## 2.8 User Fees in Zambian health

In Zambia, the User Fees were the most talked about issue at the times of introduction and revocation of the same. In the early years of the 1990's with influence from external stakeholders, the debates led to the introduction of the charges. In the mid 2000's the debate took a different turn, whether to continue the User Fees charges or to discontinue them. A good number of researches have been done to ascertain the effect; both negative and positive that might have arisen from the policy. A fair amount of debate into the effects of removal of the policy was observed in the years leading to 2006. Scholars such as Masiye F, et'al 2005, Masiye F, et'al 2008, Seshamane V, et'al (selected papers from 1995-2000), Situmbeko L.C and Zulu J.J 2004 to mention but a few focused on the subject in the Zambian context. This is not to mention the many papers written by and for the Ministry of Health on various occasions.

Of close similarity to this research is a research done at national level by Masiye F, Chitah B.M, Chada P, Simion F in 2008 titled the Removal of User Fees at primary Health Care facilities in Zambia; a study of the effects on utilization and quality of care. The study was done on behalf of Equity in Health in East and Southern Africa (EQUINET). This study was done two years after the implementation of the free health service policy. One might argue that it was necessary at that time while others might think certain effects of the policy couldn't be picked at such a short time from revocation. but later when they become more evident in the long run.

Another similar study on the Removal of User Fees in Zambia was done in Chongwe district by Royd Onde, in pursuit of his Masters of Business Administration from the Copperbelt University. This research was done in 2009 and its concentration was on the Impact of the abolition of User Fees in the health centres in Chongwe district.

## 2.9 Summary

A User Fee, which is a charge that is levied on the seeker of health services at the point of access is arguably effected for one or more of the following reasons. To increase the funding base for the provision of health services, to reduce frivolous demand of health services, to increase the accountability of health facilities on health financing to the community, improve sustainability of the provision of health services and to improve equity to access. However, charging of User Fees is not short of criticism. Some of the arguments against the User Fees policy are that; they pose a financial barrier to accessing health services and they can also lead to misinterpretation of economic efficiency and not social efficiency. It is also perceived that User Fees are closely related to matters of continuity and sustenance of the provision of the health services. In Zambia, like

many countries in Africa, the debate on whether to implement or not to implement the User Fees policy has been rife and mainly fueled by the ailing economic status in the country. External stakeholders have taken no second thought recommending that User Fees can be a solution to the nations need for sustainable health financing.

# CHAPTER III

# METHODOLOGY

## 3.1 Introduction

In this chapter, focus is placed on the design of the research. It will tabulate the research design used, research population covered, the sample and sampling procedures used, data collection procedures used, data collection instruments and the data analysis procedures that were made use of. These steps will sum up the approaches that guided the execution of the research.

## 3.2 Research design

The study used a mix of both cross sectional and longitudinal study in that it looks at some different areas in the same time period and it also compared the same variables over the period of time that isolates the effects of the policy of interest. The research looked at the effect on utilization of health facilities, perception of health seekers on the quality of health services and how health management has been affected by the removal of the User Fees in 2006. The approach used was to look at what each of the variables was from as far as twenty-three years ago (13 years before 2006) and then compare to what is obtaining now. The study did not endeavor to follow trends of the variables but rather to compare the current status to the status the variables were at before the removal of the User Fees.

## 3.3 Research population

The study was undertaken in Mpika district. The definition of Mpika district taken here is as recognized by the Government of the Republic of Zambia as at the date of writing the research proposal (October, 2016). (Intentions of subdividing the district have been announced). Mpika is one of the seven districts of Muchinga Province and is situated at the southern end of the province.

The district as at current has a total surface area of over 40,000 $km^2$ and has an estimate extrapolated population of approximately 260,000 (based on the 2010 National Housing and Population Census). Within it are 34 health facilities (health posts, Rural Health Centres, Urban Health centre and Hospitals).

The research gathered data from the District Health Office, The District Hospital and Rural Health centres. Health seekers were also interviewed in the quest to obtain their opinion on the quality of services that they are accessing. Documents pertaining to financing and User Fees that might be accessed were collected for analysis and employees that had been working for over ten years in the health sector were specially (purposively) sampled and interviewed.

## 3.4 Sample and sampling procedures

Out of the 34 health facilities, the research purposively picked on centres that were in existence for over ten years and that have a reasonably high population to increase representativeness of the population. The research collected data from 10 facilities the District Hospital included and the District health office.

The proposed selection of centres to be visited for data collection based on the population is as indicated below:

Table 1; Health facilities visited in the district, their catchment populations and distances from District Health Office

| No. | Centre Name | Distance from District Health Office in Km |
|---|---|---|
| 1 | Michael Chilufya Sata | 12 |
| 2 | Luchembe RHC | 65 |
| 3 | Chikakala RHC | 20 |
| 4 | Chalabesa RHC | 105 |
| 5 | Mpika Urban | 4 |
| 6 | Chibansa RHC | 15 |
| 7 | Chilonga HCH | 27 |
| 8 | ZCA RHC | 18 |
| 9 | Nabwalya RHC | 150 |
| 10 | Mpepo | 110 |
| | | |

The target respondents at the District Health Office (DHO) were the District Medical Officer (DMO), Planner, Accountant and other officers that have been working there for over ten years. At the hospital, the Medical Officer In-charge and other senior staff involved in Financial and Administrative Management Systems (FAMS) were targeted. At the rural health centres, the key respondents targeted were the Health Centre In-charge, the Community (Neighborhood Health Committees and the health seekers). For health care seekers, preference was given to residents who had resided in the same area for the last ten years.

## 2.5 Data collection procedures

It was intended that the data collection for this research takes place in a space of a month and one week. This period being between first week of November and second week of December, 2016. However, the collection of data took place from second week of December, 2016 to first week of January, 2017. Immediately following the data collection, analysis and documentation of the findings started.

The data of interest in the collection process was the Financial and Administrative Management Systems (FAMS) data from before the abolition of User Fees (before 2006) and the data variables for the period ten years after the abolition of the User Fees (to present - 2016).

The research made use of the following data collection procedures; document reviews (the documents found did not have sufficient information to draw conclusions for how much utilization increased) and interviews.

## 2.6 Data collection instruments

The data collection instruments that were engaged in this process included:

**Data extraction/capture;** the tool was used to extract specific data from documents and records that have relevance to the research topic. This was also used to capture and analyze data that might be provided but not on a single document or on a sheet that doesn't expressly give out the information needed.

**The interview guide;** was used to give direction to interviews with senior officers from whom qualitative information was obtained. Follow up questions that were not included in the interview

guide but were brought in where needed and clarity was sought over matters as the discussions went on.

## 2.7 Data analysis procedure

The data collected through the research process was sorted out into the three thematic areas of the research's specific objective i.e. utilization of health facility, perceived quality of health care and the effects on health system management.

The data was then analyzed for any changes or patterns of significant note that might be due to policy change. This was done mainly by comparing the data to the period before the removal of User Fees (i.e. before 2006 and after).

### Utilization of facilities

The utilization of facilities took into considerations all first attendants at each facility that was selected for data capture. The trend on attendances across the last 20 years was analyzed for any significant changes in utilization that might be explained by the removal of User Fees. Unfortunately, the health facilities did not keep records of utilization for the health services for the period the research was interested in. This made the research fail to determine by how much (to what extent) utilization changed. However, it was established that utilization of the health facilities increased with the introduction of the free health service policy.

### Quality of health care

Under quality of care, the first four attributes that respondents identified as most affecting quality of health care were adopted as the most contributing to quality of health care. The respondents were requested to do the ranking of attributes that affect their perception of quality health care

from a predetermined list on a given scale. The aggregate ranking was thereafter used to determine whether reduction of costs affected the quality of the health care provided.

**Effects on health system management**

The health systems management data is by nature highly qualitative and as such the obtained interview recordings and narratives were analyzed collectively. Significant and common aspects were teased out and financial figures that arose were controlled for inflation and time value for money. Trends within the financial figures were isolated for any correlation to the removal of User Fees.

It was also expected that health systems management respondents might identify effects that might not be quantifiable. Such data was reported as given provided that there is strong evidence that they are as a result of the removal of User Fees.

# CHAPTER IV

# DATA PRESENTAION AND DISCUSSION

## 4.0 Introduction

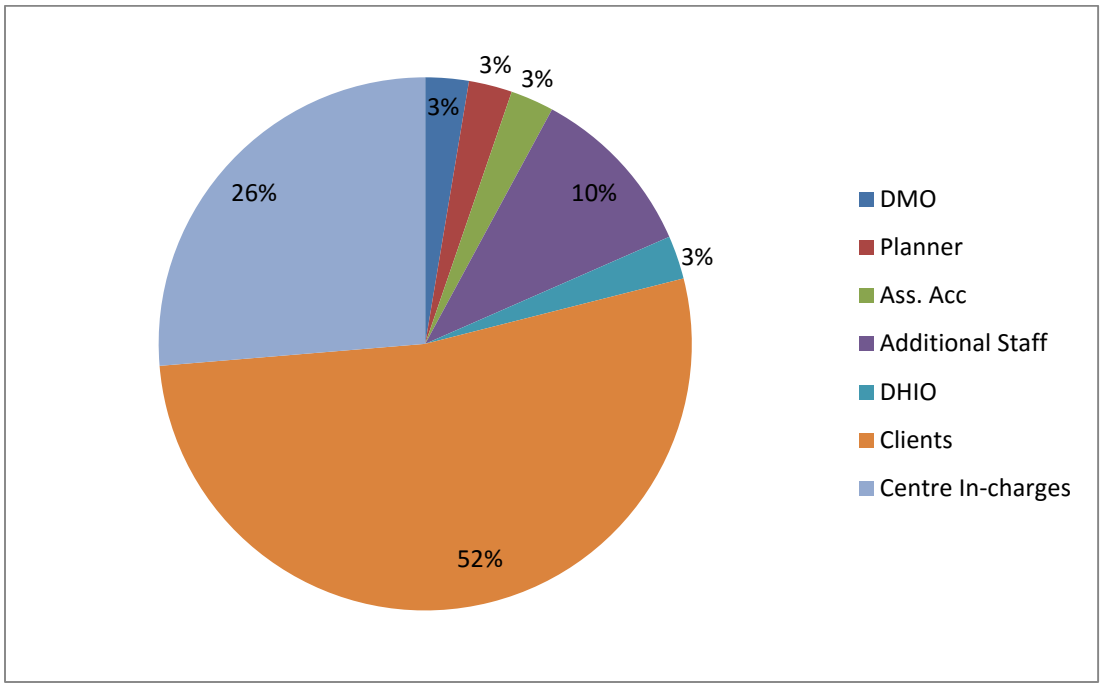
In this section, summary statistics of the data captured during the research process and discussions on observed patterns are done. The data presented here are abstracts and not really a representation of all the data as it was captured and analyzed. The section starts with statistical summary of the respondents and their selected features tabulated in 5.1. It goes on to analyze Health Centre utilization in section 5.2, Quality of care is the focus in 5.3 and in 5.4 the effects of revocation of User Fees on Health System Management. Discussion of findings is done in the respective subsections. A summary of the key findings is given in 5.5.

## 4.1 Statistical summary

The interviewed respondents included the District Medical Officer, the Planner, the District Health Information Officer, the Assistant Accountant, and some selected staff from those who served long enough to bear witness to effects of removal of User Fees. Further, ten center in-charges were interviewed and some patients from the Rural Health Centres (RHCs) and the hospital were also interviewed to obtain perceptions of quality of service from the client's perspective.

Respondent tabulation by cadre and Office

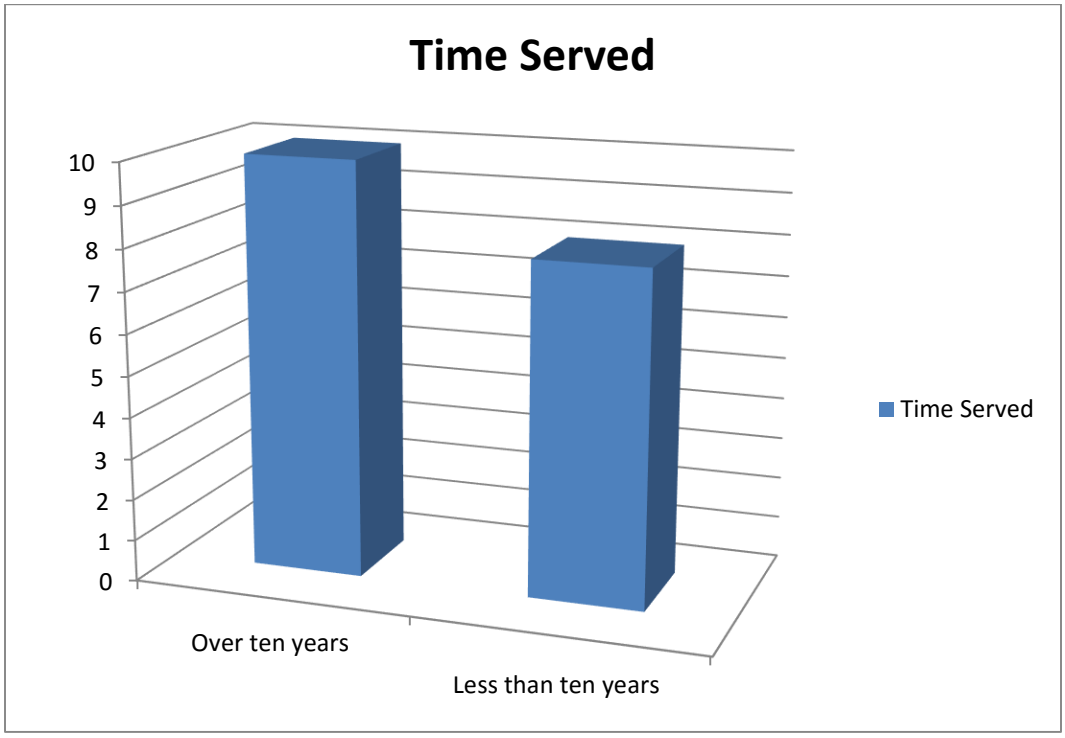
Figure 1: Composition of respondents by cadre, office and title.




The greater portion of the set of respondents was made of people external to the health system i.e. clients constitute 52% while Centre In-charges constituted 26%. The additional staff made up 10% of the respondents. The others categories of respondents make up the rest of the set of respondents.

Respondents by years in public service

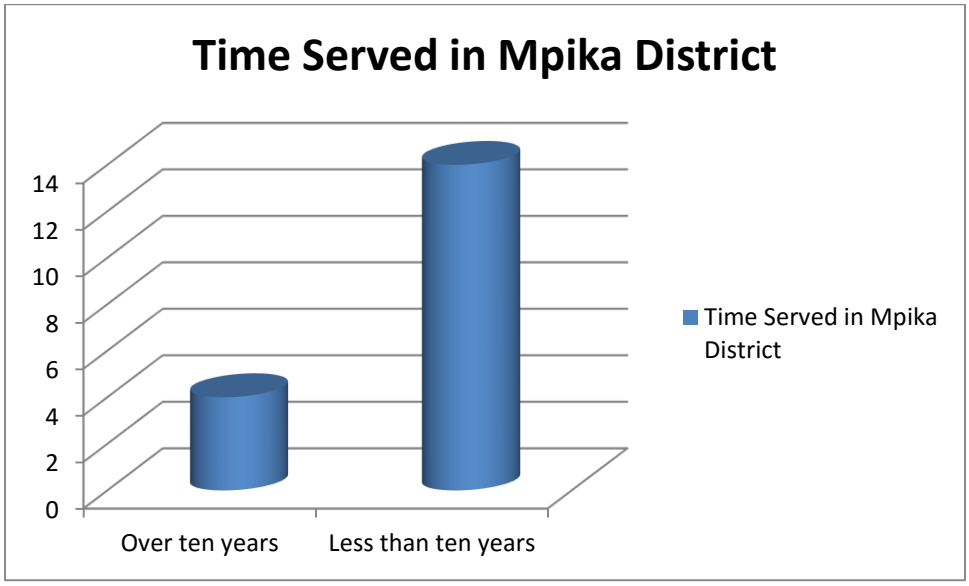
Figure 2: Distribution of respondents by time spent in service (Less than ten years/Over ten years)




According to the figure above, among the respondents internal to the health system, more respondents served more than ten years while a smaller fraction of them served less than ten years.

Respondents by service in Mpika

Figure 3: Distribution of respondents by years spent in service in Mpika District (Less than ten/Over ten)



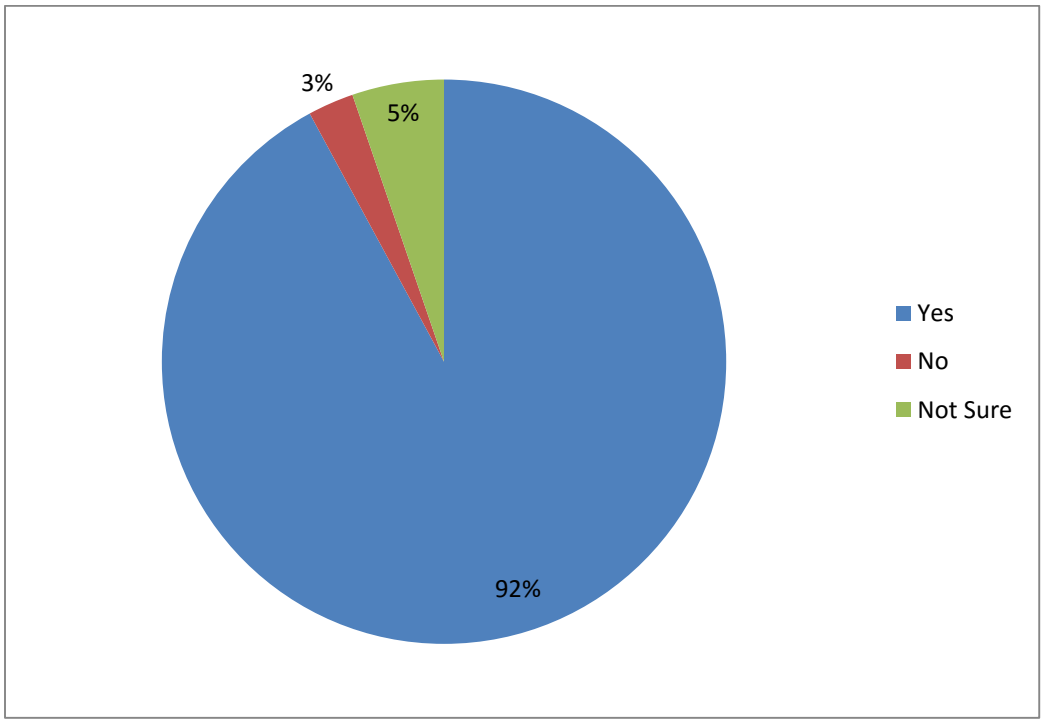

Of the respondents, few serviced over ten years in Mpika as compared to those whom served less than ten years in Mpika.

### 5.2 Utilization of Health Facilities

The utilization of health facilities in the district is a feature that the Ministry is interested in monitoring constantly for system management and system strengthening purposes. However, it turned out that there was no reliable information available on utilization of health facilities in the district for the last 10 years or greater that could give a definite measure of change of utilization due to removal of User Fees over the last 10 years.

On respondent's subjective thoughts as to whether the utilization had increased or reduced due to the removal of User Fees, the following were the findings (figure 5).

Figure 4: Respondents opinion on whether the utilization had increased or reduced as a result of abolition of User Fees

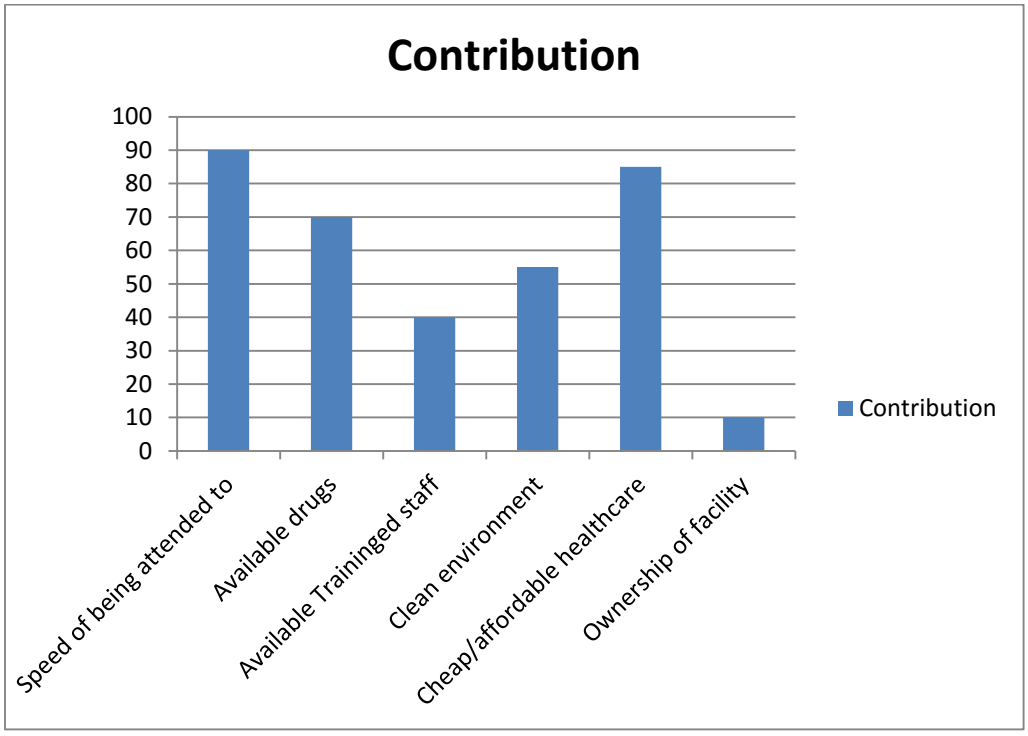



Ninety-two percent (92%) of the respondents thought that the removal of User Fees increased the chances of them attending a health facility thereby increasing utilization of the health facilities. This is because, to them, this was synonymous to removing one of the barriers of access to health service. The other portions of the respondents; 5% and 3% expressed uncertainty and ignorance on the phenomenon respectively.

### 4.3 Quality of Health Care

According to the responses provided by the research respondents (figure 6), from the predetermined factors that might be perceived to constitute quality of care, the following is their perceived contribution to quality of health care;

Figure 5: Contribution of factors to quality of health care being provided and their perceived extent of contribution



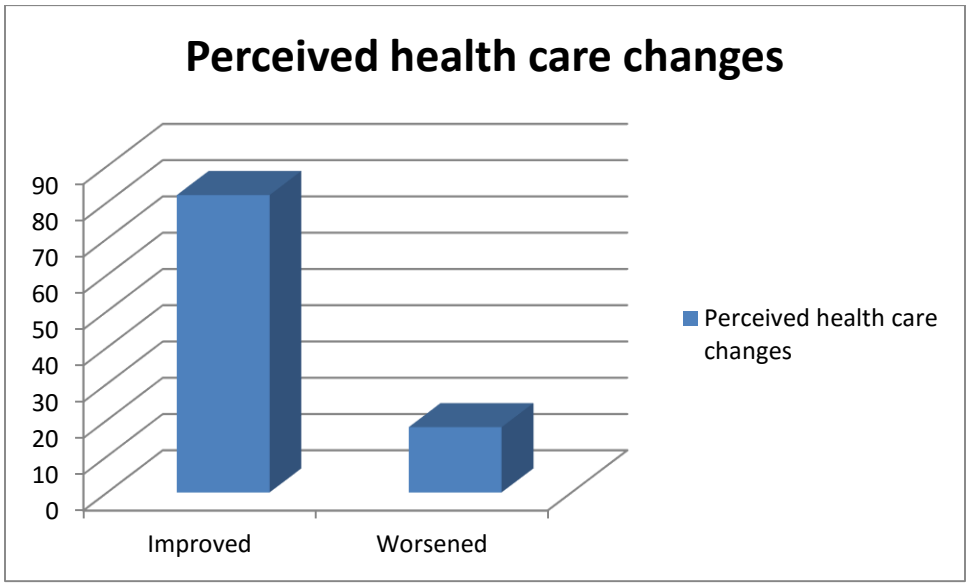

Where quality of care is concerned, the features that were predetermined were rated as follows with the most important first; Speed of being attended to (speed of attendance), cheapness or affordability of health care, availability of drugs, clean environment, available trained staff and ownership of facility.

From these findings, it can be deduced that in the perspective of the Mpika community, the removal of User Fees made their second preferred quality contributing factor a reality – Cheap or affordable health care. As such, removal of User Fees improved the quality of health care for them. With the increased utilization however (as seen from the previous sub-objective), the number of clients will increase and with the increase of clients will be the increased time that one might have to take at the facility before he is attended to. This is on the premise that the facility sees each client after the others and others have to wait for the others to be attended to before them. The loss of additional income in form of User Fees for the health providing centres might affect its ability to achieve the third and fourth factors of quality health care according to the Mpika community i.e. availability of drugs and a clean environment around the health facility.

The Mpika community has very little value for health care derived from qualified staff providing the service. This might be so because most of them don't even know the qualification of health workers and cadres. Most clients talked to referred to most male workers at facilities as doctors and female workers as nurses. The Mpika community is indifferent to the ownership of the health facility with regard to the quality of the service they will get from there. This might be attributed to the fact that there are few privately owned health providing institutions in Mpika district.

The perception of the respondents on the possible changes in health care that arose from the removal of User Fees is as represented below;

Figure 6: Perceived changes in health care quality due to abolition of User Fees




Most of the respondents thought that the removal of User Fees increased the quality of health care in the district. This can be seen from the above ranking of cheap and affordable health care being rated highly.

### 4.4 Health Systems Management

Health system management has been affected by the removal of User Fees in the following ways;

1. **Reduced alternative financing means.**

   Managers lamented the reduced alternative financing options that are currently available. In the midst of financial challenges, an extra source of finance would be appreciated. The DMO however reiterated that the estimated amount of finance that would be raised from User Fees might not really fill the finance difference between the current and estimated ideal financing level but would surely add to the basket of resources at the disposal of the managers.

2. **Increased government stake in the health sector while community stake has reduced.**

   Prior to the removal of User Fees, there was an active involvement of the community in the health sector and management found itself answerable to the community they served much more than today. Today without the User Fees, the management of health systems is inclined to provide reports and accountability to the government more than the community being served. One responded stated that, "so long we (health centres) retire the funds well with the funders we are not concerned of the opinion of issues that the community might have". RHC in-charges also indicated that with this development, the involvement of the community in health service provision has reduced since the days of the User Fees.

3. **Improved adherence of financial management to government financial regulations.**

   Unlike in the User Fees days, when accountability of the funds raised from User Fees were questionable, today all funds received should be accounted for and reported accordingly. It was noticed that with the User Fees were lapses and loopholes that finances could be misapplied and misappropriated.

4. **Removal of User Fees has reduced the perceived value placed on health care and medical supplies by the community**.

   Communities and their members now easily walk into a health centre and demand supplies claiming they are government property, a thing that was hardly heard of in the User Fees days. It was understood that the user fee deterred people from demanding services or consumables unless really necessary and their welfare derived will be of direct and immediate benefits to them.

## 4.5 Summary of key findings

The removal of User Fees resulted in the increase of the utilization of health facilities in Mpika district in the last ten years. The quality of health care according to the Mpika community is composed as follows with the most important first; Speed of being attended to (speed of attendance), cheapness or affordability accessing health care, availability of drugs, clean environment, available trained staff and ownership of facility. A large portion of the community perceive the removal of User Fees to have contributed to improving the quality of health care in the district. On health systems management, the removal of User Fees has brought about four observed effects; reduced health financing options, increased government stake in health care provision and simultaneously reduced community stake, improved adherence to government financial regulations and reduced perceived value of health care and health commodities by the community.

# CHAPTER V

# SUMMARY, CONCLUSION AND RECOMMENDATIONS

## 5.0 Introduction

This section will provide in a concise manner a synopsis of the research objectives, its methodology and findings. It will go on to draw conclusions and recommendations from what the findings entail.

## 5.1 Summary

This research was aimed at investigating the effects of the removal of User Fees over the last 10 years in Mpika district. The research involved examining documents and holding interviews with respondents from both the health sector and the general health clients at the health facilities. The research collected data from 38 respondents and analyzed three financing documents and two utilization documents. Unfortunately, the examined documentations seemed to have inadequate information and the research relied entirely on data obtained from the respondents.

The areas of interest in investigating the effects of the removal of User Fees in the past 10 year in Mpika district were centered on the following objectives; changes in utilization, effects in the quality of health care being provided as perceived by the clients and effects on the management of the health system.

The data collected was analyzed and the depicted findings were as follows; utilization of health services increased after the removal of User Fees and the quality of health care, (according to the clients) improved due to the removal of User Fees. On the health system management part, the

following where observed; removal of User Fees reduced alternative health financing, increased government stake in the health sector there by reducing the community stake and participation, the proportion of accounted for finances increased as the removal of User Fees removed the most unaccounted for component of health financing and the removal of User Fees has reduced the perceived value of health care and medical commodities in the client's view.

## 5.2 Conclusion

The research findings have led to the following conclusions;

- The removal of User Fees has increased the utilization of health facilities in the district over the last ten years. While the data to determine to what extent the utilization has increased was scanty and couldn't be determined, there was overwhelming evidence to support the increase in the utilization of health services.
- The research revealed that the removal of User Fees increased the quality of health care (as perceived by the client) being accessed in the district over the years of free health care. Quality health care according to the clients in order of priority is; speedy attention, free health care, clean environment availability of drugs and supplies and availability of qualified staff.
- The removal of User Fees has affected health system management in four ways. These are; reduced financing alternatives, increased government stake and reduced community stake, increased accountability of funds and reduced perceived value of health care and medical commodities.

## 5.3 Recommendations

Following the above outlined conclusions on the research objectives, the following recommendations have been drawn;

- Health systems managers should seek alternative financing options that will reduce direct costs that consumers of health care in Mpika district incur in the process of seeking health care. This can be done by engaging the following;
    - Making use of health insurance and health schemes to finance health care
    - Restrict User Fees (high cost or by-pass charges) to clients who have a high willingness to pay and whose demand for health care will not be affected by the cost associated with seeking the service

  This way of financing health will pool resources among clients, allowing for access regardless of one's ability to pay and hence not affect utilization of the facilities while still keeping the facility financed.

- The health system managers in Mpika and like districts should prioritize elements of the health delivery system in the order given below; the reduction of clients waiting time, reduction of direct costs associated with accessing health, keeping the environment from which health is being provided clean and making drugs available. The populace of Mpika rated the above factors to be significant contributors to the quality of health care being offered in the district.
- The health system managers should improve community partnership by increasing accountability towards the community on how the health system is run. This can be done through one or more of the following;

- Actively involving the community on the planning, implementation and evaluation of health programs.
- Educating the community on the objectives of the health sector and stating clearly the role that the community will play in achieving the objectives.
- Disclosing the resources available for the implementation of the community programs and what their dues are upon successful completion of the program implementation.

- Treat all health financing alternatives with the same level of accountability. If possible, subject all financial resources to the standard government financial regulations so as to increase accountability of all financial resources injected into the health system.

## 5.4 Further evaluations and replication of findings

Recommendation is made for further studies using alternative means to determine the exact measure by which utilization has increased due to removal of User Fees controlling for population growth and migration of populations. Such a study can help inform health financing policy on the possible responsiveness of the populace towards costs to accessing health care and thereby determine the best cost levels that can optimize accessibility of health care while still maintaining desirable quality of health care.

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CHAPTER VII

# APPENDICES

**Appendix 1. Data capture tools**

# THE UNIVERSITY OF ZAMBIA

## RESEARCH QUESTIONNAIRE

### Health Workers

### Questionnaire Number:….

Evaluation of the impacts of free primary health service in Mpika district for the last 10 years

Dear Respondent;

I, Tamani Phiri, request your candid response to the questions contained herein. This research is being done in partial fulfillment of the requirement for the award of Master of Business Administration (MBA) at the University of Zambia.

Be assured that the information given will be solely for academic purposes and that the information provided will be treated with the deserving confidence.

## Section one

1.0 Personal information

1.1 Select the age group within which you fall

20-30 ☐ , 30-40 ☐ , 40-50 ☐ , 50-60 ☐ , Above 60 ☐

1.2 What gender applies to you?

Male ☐ Female ☐

1.3 What marital status applies to you?

Single ☐ , Married ☐ , Divorced ☐ , Widowed ☐ , Others ☐

1.4 How many years have you been in service?

Over 10 years ☐ Less than 10 years ☐

1.5 How many years have you served in Mpika district?

< 2 ☐ , 2 < x > 5 ☐ , 5 < x > 7 ☐ , 7 < x > 10 ☐ , >10 ☐

1.6 At what service level are your serving currently?

Health Post ☐ Rural Health Centre ☐ Health Post ☐

1.7 What are of service are you serving in?

Support (Administrative roles) ☐

Core Health Units (Clinical, Diagnostics, Public Health etc) ☐

## Section Two

2.0 Quality of health care

2.1 To what extent do you think each of the following affects quality of health care?

a). Being attended to fast

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

b). Availability of medical supplies and drugs

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

c). Availability of trained and qualified Health Staff

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

d). Clean and tidy environment at the health facility

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

e). Cheap/Affordable health care

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

f). The ownership of the Health providing institution i.e. Government or Private

No at all ☐ Fairly ☐ Very Much ☐ Extremely ☐

2.2 How do you think the quality of health care has been affected by the removal of user fees in 2006?

It improved ☐ It worsened ☐

## Section Three

3.0 Health Systems Management

3.1 In your own words, what are the effects that the removal of user fees in the last 10 years has had on the way health systems are managed?

# THE UNIVERSITY OF ZAMBIA

## DATA EXTRACTION TOOL

### Health Centre

### Data Capture tool Number:….

Evaluation of the impacts of free primary health service in Mpika district for the last 10 years

Dear Respondent;

I, Tamani Phiri, request your candid response to the questions contained herein. This research is being done in partial fulfillment of the requirement for the award of Master of Business Administration (MBA) at the University of Zambia.

Be assured that the information given will be solely for academic purposes and that the information provided will be treated with the deserving confidence.

# Section one

1.0 General Data

1.1 Facility Name:_____

1.2 Population in catchment area:_____

1.3 When facility was opened:_____

# Section Two

2.0 Health facility Utilization

2.1 Collect Health Facility first attendants for at least the last 20 years

| Year | First attendants | Source |
|---|---|---|
| 2015 | | |
| 2014 | | |
| 2013 | | |
| 2012 | | |
| 2011 | | |
| 2010 | | |
| 2009 | | |
| 2008 | | |
| 2007 | | |
| 2006 | | |
| 2005 | | |
| 2004 | | |
| 2003 | | |
| 2002 | | |
| 2001 | | |
| 2000 | | |
| 1999 | | |
| 1998 | | |
| 1997 | | |
| 1996 | | |

# THE UNIVERSITY OF ZAMBIA

## RESEARCH INTERVIEW GUIDE

### Heads of Units/Departments

Evaluation of the impacts of free primary health service in Mpika district for the last 10 years

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## Section one

1.0 Health facility Utilization

1.1 In your official capacity, what has been the trend of health facility utilization the last 20 years or so?

1.2 Would you attribute your observation in 1.1 to the removal of user fees from the health sector?

1.3 What other impacts do you think the user fee has had on utilization of Health Facilities in Mpika district?

## Section Two

2.0 Quality of Health Care

2.1 In your own way, what constitutes quality if health care?

2.2 In what way, if any, do you think the removal of user fees has affected the quality of health care being provided in Mpika district?

## Section Three

3.0 Health System Management

3.1 From your perspective, what way has the removal of user fees impacted on health system management?

## Section Three

4.0 Recommendations

4.1 What recommendations would you make on the ideal form of health financing in Mpika?

4.2 Is there any significant correlation between the quality of health service being provided and the health financing?