

**THE IMPACT OF COST-SHARING ON THE CONSUMERS OF PUBLIC  
HEALTH SERVICES IN RURAL ZAMBIA: A CASE STUDY OF SENANGA  
DISTRICT HOSPITAL**

By



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**A dissertation submitted to the University of Zambia in partial fulfillment of the  
requirements for the degree of the Master of Public Administration (MPA).**

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July, 2007**

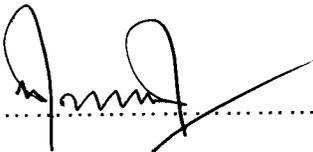
## **DEDICATION**

This work is dedicated to my late brothers Desmond Sitali Mubiana and Charles Limbambala Silumesi, for educating me, and to my wife Mercy Monde.

## DECLARATION

I, Mulemwa Mubiana do hereby declare that this dissertation represents my own work and that it has not previously been submitted for a degree at the University of Zambia or at another University.

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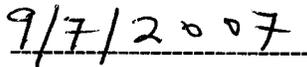
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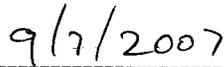
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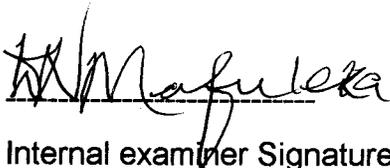
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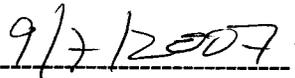
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## LIST OF ABBREVIATION AND ACRONYMS

AIDS	-	Acquired Immuno deficiency syndrome
BHC	-	Basic Health Care Package
CBOH	-	Central Board of Health
CDR	-	Crude Death Rate
FHHS	-	Female - Headed Household
HCC	-	Health Centre Committee
H	-	Hospital
HIV	-	Human Immuno Deficiency Virus
IMR	-	Infant Mortality Rate
JHHS	-	Joint- Headed Households.
MHHS	-	Male – Headed Households
MOH	-	Ministry of Health
NHCs	-	Neighborhood Health Committee
NGO	-	Non-Governmental Organization
PWAS	-	Public Welfare Assistance Scheme
SAP	-	Structural Adjustment Programme
STD	-	Sexually Transmitted Disease
TBAs	-	Traditional Birth Attendants
WHO	-	World Health Organization

## ABSTRACT

The main aim of the study was to find out the extent to which the policy of cost-sharing is a barrier to accessing public health services at Senanga District Hospital. In order to address the objective of the study questionnaires were administered to members of the local community seeking medical treatment at Senanga District Hospital.

A sample of one hundred and twenty (120) respondents were selected using purposive sampling method. The study used both qualitative and quantitative analysis and the rationale for the study was to fill an important information gap in the continuous process of updating and refining the national policy on cost-sharing.

The study examined the following aspects of the policy of cost-sharing:

- ❖ Ability to pay user fees.
- ❖ Willingness to pay user fees.
- ❖ The level of utilization of public health services at Senanga District Hospital and implementation of the policy of cost-sharing.

The study found that the policy of cost-sharing was a barrier to accessing medical treatment for a large number of the respondents. The number of respondents who fell within the low income category was significant. Consequently, the investigation revealed that a large number of the respondents were finding difficulties in meeting the costs of public health services.

It is hoped that the management of Senanga District Hospital would take necessary measures to address the factors contributing to under utilisation of public health services.

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## CHAPTER ONE

### INTRODUCTION

#### 1.1 Background

Since independence in 1964, and until the change of Government towards the end of 1991, Zambia provided free universal public health care. Not only was this a very expensive system but it was also unsustainable. Not surprisingly too, as the economic woes of Zambia deepened, the country could no longer cope with the people's demands for quality health care. Consequently acute drug shortages, deterioration of public health facilities and exodus of trained national medical personnel became common. To keep the system afloat, the Government turned to donors for funding. As expected and hoped for, donor funding increased, but this raised many concerns about the sustainability of the system.

Recognizing the difficulties of maintaining free universal public health care and in line with the on-going economy – wide structural adjustment programme (SAP), the current Government adopted, as early as 1991, the principle that every able-bodied person residing in Zambia and earning an income could contribute towards the maintenance of their health (NHHPS: 1992). The adoption of this principle was based on two major considerations: (i) The need to raise extra resources to meet the costs of a basic package of cost-effective services to be guaranteed to all Zambians, and this could be achieved through the following: self reliance and participation of individual families and communities, equity, inter sectoral collaboration, decentralization, appropriate technology, and emphasis on preventive public health services, and (ii) Desire to foster the spirit of partnership in health. The implementation of the above principle has been through the cost-sharing policy. However, although cost-sharing in the health sector had been in existence since 1989, it was only in 1993 that the Government attached much importance to it.

In spite of the written guidelines on the introduction and purpose of cost-sharing and existence of a policy framework, actual practice has however, varied widely around the country. Districts, the unit of focus in the Health Reforms, differ in

terms of levels, structure, and types of charges. In addition, utilization data from several districts and facilities show marked declines in attendance at health facilities following the introduction and/or upward revision of the user fees. However, although in few of these cases there had been some rebounding, in the majority of them the trend is still in the downward direction (see, for example, Forsberg, 2000 and Macwan'gi 2002). The general economic decline in the country is certainly one of the major factors. Another important factor to consider is the ability and willingness to pay for these services for most Zambians. It has to be recognised that the introduction of cost-sharing coincided with general economic liberalisation, which instigated price increase of virtually all commodities.

Anecdotal evidence also suggests that in many parts of the country people had little information or understanding of the purpose and structure of cost-sharing and exemptions attached thereto. This had been largely due to two major factors: (i) the speed at which policy was implemented, and (ii) inadequate sensitization of both health staff at various levels and communities. Apparently, this has led to situation where some people are not accessing public health services due to mistaken beliefs about the level of fees and despite the formal existence of exemption mechanisms.

In light of the above, this study examined four major aspects of cost-sharing in the public health sector. These were policy, practice, effect and perception about cost-sharing.

#### *In Terms of Policy*

To examine how the policy was introduced and implemented.

#### *With Respect to Practice:*

The study examined the current practices of charging user fees and granting exemptions at Senanga District Hospital and their consistency with national policies.

Assessed whether or not there was any divergence between practices and policies. Highlighted any changes that had taken place since the cost-sharing was introduced.

*With Regard to Effect the Study:*

Evaluated the effect of cost-sharing on the unitisation of such public health services OPD, deliveries, antenatal, under-five and STD clinics, and general admissions.

Explored people's coping mechanisms to the adverse effects of cost-sharing.

*Finally, on Perception the Study:*

Enlisted the client, health and community development staffs and the public's view on cost-sharing at Senanga District Hospital, particularly in terms of the rationale and understanding of the cost-sharing policy and practice, affordability, perceived benefits (in quality service delivery) and the of community involvement in determining the fee policy and management of revenues.

**1.1.1 Socio-demographic characteristics of respondents**

Below are some of the highlights of the socio-demographic characteristics based on the sample.

**1.1.2 Age Group**

**Table 1.1 Age and marital status**

Age Range Years	Marital Status				Total
	Married	Single	Divorce	Widowed	
15 -24	6(5%)	21(17%)	0	0	27(22%)
25-34	15 (13%)	10(8%+-+)	4(3%)	4(3%)	33(27%)
35-44	19(15%)	8(7%)	6(5%)	6(5%)	39(32%)
45-54	8(7%)	2(2%)	2(2%)	2(2%)	13(12%)
Above 55	5(4%)	2(2%)	1(1%)	1(1%)	8(7%)
Total	53(44%)	43(36%)	13(11%)	11(9%)	120(100%)

Source: Information obtained from the field data (2005)

\* Note: The figures in this table have been rounded off

The above table shows that the highest percentage of the respondents were between 35 and 44 years old and constituted 32% of all the respondents. 17% of

the total respondents were single and came from the youngest group of 15-24 years old. The last category in the hierarchy were married people (44%). Divorced and widowed, constituted 1% each of the total respondents.

The next group in the hierarchy was 25 -34 years old (27%). These were followed by those aged between 15-24 years old (22%). The second from the bottom of the age group were between 45 -54 years old (12%). The group with the least people was the over 55 years old that constituted 8% of the sample.

### 1.1.3 Sex

**Table 1.2 Gender and level of Education Attained**

Education Level	Sex		
	Female	Male	Total
University Education	5(4.1%)	8(6.6%)	13(10.9%)
College Education	11(9.1%)	12(10%)	23(19.1%)
Secondary Education	10 (8.3%)	10(8.3%)	20(16.6%)
Primary Education	28(23.3%)	30(25%)	58(48.3)
No formal Education	4(3.3%)	2(1.6%)	6(4.9%)
Total	58(48%)	62(52%)	120(100%)

*Source: Information obtained from the field data (2005)*

*\* Note: The figures in this table have been rounded off*

Table 1.2 above shows that the majority of the respondents were male and constituted 52%. Females constituted 48% of the total respondents. In terms of education attained, the majority of females (23%) had gone as far as primary school while 25% of men also had reached primary education. Table 1.2 shows that 48.% of the total respondents had primary education. The reason was attributed to the locality where the hospital was situated. Most people were poor hence could not afford to further their education. This is supported by JCTR (Jesuit Centre for Theological Reflection) basic Needs Basket for Senanga District for June 2003 which stood at \$154 (dollars). The World Bank Poverty assessments had also shown that Senanga had one of the highest percentages (79%) of extremely poor people.

#### 1.1.4 Economic status

**Table 1.3 Employment status and monthly income of the respondents**

Income per Month	Emplo	Retired	Self- Employ	Other	Total
Below K50, 000.00	8(6.6%)	4(3.3%)	16(13.3%)	4(3.36%)	34 (27%)
K50, 000.00 – K501, 000.00	10(8.3)	2(1.6%)	32(26.6%)	12(10.0%)	49(47%)
K501, 000.00 K1, 010,000.0	4(3.3%)	2(1.6%)	14(11.6%)	2(1.6%)	24(1%)
Above K1, 010,000.0	0	0	8(6.6%)	2(1.6%)	13(9%)
Total	22(18.)	8(6.5%)	70(58.1%)	20(16.5%)	120(100%)

*Source: Information obtained from the field data (2005)*

*\* Note: The figures in this table have been rounded off*

Table 1.3 shows that the majority of the respondents were self employed<sup>+</sup> and constituted respondents earned between K50, 000.00 to K501, 000.00. The minority of the respondents were retirees who constituted 70%. This shows that the majority of respondents were those whose income was low.

#### 1.2 Statement of the Problem

The introduction of the policy of cost-sharing has attracted a lot of controversy and debate pertaining to its implementation by various stakeholders such as members of the local community, Non-governmental organizations (NGOs) and Members of Parliament (MPs); on the negative impact of such reforms on the poor sections of the population. The level of poverty is illustrated in Central Statistical office (CSO). Living Conditions Monitoring survey report 2002-2003 which states that 67% of the population is poor, and 74% of poor people are in rural areas.

In view of the above, this study addressed the negative effects of the policy of cost-sharing on the consumers of public health services at Senanga District Hospital in the Western Province of Zambia.

### **1.3 Main Objective of the Study**

The overall objective of the study was to establish the extent to which cost-sharing is a barrier to accessing public health services at Senanga District Hospital.

#### **1.3.1 Specific Objectives**

To examine the way the policy of cost-sharing has been implemented,

To assess the Community's ability to pay user fees,

To assess the Community's willingness to pay user fees,

### **1.4 Research Questions**

The research was guided by the following questions:

- (i) What is the socio-economic background of consumers of public health services?
- (ii) What coping strategies has the local community devised to raise money to meet part of the fees they are expected to pay?
- (iii) To what extent are patients able to meet their medical fees?
- (iv) To what extent is cost-sharing a barrier to accessing public health Services at Senanga District Hospital?

### **1.5 Significance of the Study**

The debate about the impacts of cost-sharing in public health sector on vulnerable groups has been marked by a rather piecemeal approach in which sometimes conflicting generalizations have been based on a limited number of methodologically non-comparable studies. The use of generic categories such as, the 'very poor' or 'vulnerable groups' leads to insufficient desegregation of the impacts of changes in the terms on which public health service is provided.

The study therefore, brought out important findings that would be of interest to consumers of public health services, Senanga District Hospital management, and the government policy makers. The findings also on how consumers of public health services raised money to meet the requirement of cost-sharing would be of help to government policy makers, non-governmental institutions (NGOs) and the hospital management. In view of the above, this study seeks to find out the extent to which cost-sharing is a barrier to accessing public health services at Senanga District Hospital

Finally, the information will also prove useful to fellow researchers in social research as well as other interested parties.

### **1.6 Limitations of the Study**

Time allocation for the research programme was too short, while funds for the research program were not enough, high transport costs and non - availability of free transport and stationary meant for research was not enough. Other problems which were encountered by the researcher were the respondents' reluctance to fill the questionnaires for example, out of one hundred and sixty(160) questionnaires distributed to respondents only one hundred and twenty(120) were successfully completed and submitted to the researcher.

#### **1.7.0 Definition of terms as used in the study**

##### **1.7.1 Patient**

This refers to a person under medical treatment.

##### **1.7.2 Payment in Kind**

This refers to using forms of payment other than cash.

##### **1.7.3 Utilization**

Making use of something by people.

##### **1.7.4 User Fees**

This refers to the payment made to a hospital or health facility by consumers for the services received.

##### **1.7.5 Public Hospital**

A hospital owned and funded by the government to provide health care to the public.

##### **1.7.6 Attitude**

This refers to behaviour of health workers towards health consumers and the way consumers of health services view user fees.

##### **1.7.7 Public Health Consumer**

Any person who makes use of a public health facility.

##### **1.7.8 Health**

The state of a person being well in body or mind.

**1.7.9 Accessibility of Public Health Services**

This refers to the extent to which members of the Public are able to obtain public health services.

**1.8.0 Coping Strategies**

This refers to ways devised by the community to meet the requirements of the cost-sharing obligation

**1.8.1 Human Capital**

The value of human acquired abilities

**1.8.2 Impact**

Strong impression and effect of thing on another.

**1.8.3 Policy Makers**

People who make plans of action in government and non-governmental organizations

**1.8.4 Pandemic**

An out-break of diseases affecting the population of an extensive geographical area of the world.

**1.8.5 Partnership**

This refers to a co-operative arrangement between public health providers and other parties.

**1.8.6 Vulnerable**

This refers to discomfort or uneasiness of mind and body.

**1.8.7 Prepayment**

This refers to a premium paid by members of the public on a regular basis to enable them access public health services as the need arises.

**1.9. Literature Review**

The literature on the impact of the introduction of cost-sharing on the consumers of public health services was somewhat scanty and might even be entirely non-existent when it came to the actual location of study. Much effort was made to select researches that were as similar as possible to the topic and as close as possible to the type of location of the study.

The Government introduced the policy of Cost-sharing in the health sector due to the limited availability of public resources and the declining economy. This meant

that the patients and the beneficiaries were to contribute towards the provision of public health services in terms of drugs, uniforms, transport, building of infrastructure and food.

This was because the government budgetary allocation alone could not be sufficient enough to ensure quality health care. It also reduced the health sector spending from 5 or 6 % in the mid eighties to 2.5% of the GDP (Oxfam JCTR2000).

Literature review had indicated that cost-sharing had been introduced in many countries of the world. Both empirical and theoretical evidence of the effects of cost-sharing on the utilization of public health services were reviewed.

The reviewed literature had shown that there was no much work done on the effects of introduction of cost-sharing in developing countries. However, studies carried out in developed countries provided a clear view on the importance of cost-sharing for the sustenance of public health services in the wake of reduced financial allocation by the government and also its criticisms had been spelt out.

It is widely believed that today, the provision of public health services is a social expression of the community's concern for its health and well being. However, a large segment of the population is discontented with the role of public hospitals. Public hospitals have been described as systems characterized by entropy, a law of nature in which organizations move towards disorganization and death.

Shaw (1995) argues that in view of the fact that public hospitals cater for the low social class as well, a constant effort must be exercised to keep the hospital costs low by a combined effort of the hospital, the government and its agencies, our society must be protected for them to access the public health services.

On the modalities of public health services delivery, Chiduo (1991) argues that people differ in opinions about how best the public health services can be organized in order to promote and preserve them, meet their costs and apportion them between the individual and the state. In many countries, the well being of the National Health Service is endangered and its development is affected by under funding, a state of affairs likely to persist as long as public hospitals depend solely

on money from the government. The public should reconsider its attitude to the imposition of health charges and marketing of public health services.

Many people think public hospitals should make an attempt to breakout the old traditional and conservative model. They feel hospitals should introduce new inputs by listening and relating to other groups which include consumers especially the poor. It is plain truth that public health care is too important to be left solely to government. In order to develop health care system that will be available to every citizen, active consumer participation in the governance of the system including cost-sharing is needed.

Chiduo (1991) further argues that although people have to pay for the public health services, one should bear in mind that public health care is no longer a "Privilege" but rather a "right". The government as guardian of its citizens is obliged to see to it that the status of a person does not block his access to public health services. Instead of charging people that are very poor for public health services, the able-bodied should pay within their means, in order to bear some of the cost of the service they use.

The World Health Organization's (W.H.O) report (1988) states that in other countries like Sweden, certain public health services are provided free of charge to eligible population groups while the rest pay. Persons with certain specific conditions can obtain free drugs necessary for treatment. Examples of such people are those with mental handicap, diabetes mellitus and others.

The World Health Organization's report points out that in the developing world, the organization of the public health services is in general a reflection of the policy and organization established in the home country of the ruling powers. For instance some countries charge for public health services while others give them to their citizens free of charge.

The World Health Organization (W.H.O) s committee on African response to the global philosophy of action for health advised African governments to make political commitment, including the introduction of health reforms which are essential if

health development is to become a reality. The universal declaration of human rights and WHO constitution could be used as the basis for these reforms, since they both insist on the right of every human being to an adequate level of health. WHO report went on to say that political commitment was very essential for the attainment of health for all. For example, Cuba after the revolution, took steps in the field of health which had an immediate impact on society. The steps included cutting the price of medicaments, getting up rural medical services, starting many hospitals and increasing health budget allocation. In this way it has continued to subsidize Health costs.

However, other developing countries have not been as fortunate as Cuba. A number of countries were found to have administrative problems in the development of Health programs because the amount of budget allocation of the public health service was found to be insufficient.

The ability of a country to absorb the cost of public health services depends on its economic capacity. As a result there is a difference in the way public health services are offered to the consumers. Besides there is a substantial variation of hospitals. While some hospitals suffer financial distress other remains relatively in sound condition.

On the reasons for cost-sharing, Kamwanga and Macwan'gi (1999) argue that the rapid rise in health care costs has created a great deal of interest in the hospital industry. Health policy makers are asking how they can cope with cost-sharing. In order to improve the efficiency of health care, emphasis must be placed on achieving proper allocation of funds and making the user of public health services pay for them.

Apart from improving the efficiency of public health care, the bad picture painted by the public of cost-sharing has to be removed. Introduction of cost-sharing would enable public hospital earn some revenue in addition to the budgeting allocation by the state. In this way the standards of public health services may be improved. Again if health improvements have to be made for those living in rural areas, policies which seek equity and maximize the existing resources must be made. The

scarce resources must be allocated to those that lack access to both services and opportunities in order to improve their health.

Wamayi (1992) revealed that basically there are two views of people about cost-sharing for public health services. One group of people support the move while others dismiss it as a cunning way of placing financial burdens on people. Although they acknowledge that re-orientation and re-organization are required in order for public hospitals to remain viable and effective, they emphasize adequate financing by the state as the most important. They further believe that public hospitals represent a system in which a patient can easily find his way despite the serious deficiency in services.

On the contrary other people have seen cost-sharing as the only way public hospital will pull through their poor state of public health and dilapidated infrastructure. They believe that civic participation is a fundamental aspect of civic life and democratic tradition. This group of people further says that a comprehensive assessment of a voluntary hospital is required to measure the extent to which the hospital is providing services for which consumers are willing to pay. In this way hospitals will earn sufficient income to cover the expenses and accumulate new capital.

However, though cost-sharing has to be introduced, the government should have continued for sometime to allocate money to the public hospitals. It is necessary to focus attention on low-income people so that their financial disability does not block the access to public health services.

Other studies on the impact of cost-sharing which have provided this aggregated data include Creese (1991) who found that following the introduction of cost-sharing in public health institutions, the largest drop in the utilisation of public health services was among children under 14 and adults over 45 years. Waddington and Enyemayew (1989, 1990) found major differences between economically well off and poor areas in Ghana. Three years after the introduction of cost-sharing, utilization rates recovered to their pre-charge levels in economically well off

households, but in poor ones the downward trend continued. They also found that the proportion of female users declined significantly.

A study in Nigeria suggested that maternal mortality rate (MMR) could provide a suitable proxy for monitoring changes in health status in the context of cost – sharing. It was noted that between 1983 and 1988, cost-sharing introduced for most aspects of health maternal deaths in the Zaria region increased by 55 percent. This coincided with a decline of 46 percent in the number of deliveries in the main hospital and a threefold increase in obstetrics complications. Also the interval between admission and surgery (where user fees were paid) increased strikingly as relatives often spent a long time looking for money (Ekwempu, et al 1990).

One of the few studies to take gender as a variable in examining the impact of cost-sharing of public health services utilization is Moses et al., (1992), which looked at attendance at an STDs referral clinic in Kenya. This found that before the introduction of cost-sharing, smaller numbers of women attended the clinic than men. However, after cost-sharing was introduced, male attendance dropped, by more than that of women. After charges were abandoned men's attendance rose to only two third's of its pre charge level, where as women's attendance rose to only two thirds of its pre charge level. But Moses concluded that, without more understanding of the rationale behind men's or women's health seeking behaviour in relation to STDs, it was difficult to draw any wider conclusions from this study other than to make the obvious point that introducing cost-sharing for public health services is counter –productive.

A paper presented at the inter-regional meeting on economic Distress, SAPS and rural people, also argues that, SAPs had adverse impacts, particularly on the rural communities in Zambia. The paper states the specific components of the SAP like the removal of subsidies on food, decontrol of prices, re-introduction of fee paying structures in education and health, and so forth, had adversely affected most people, particularly those in rural areas. The paper articulates that because of their roles as food producers, home makers, mothers and social organizers, rural people were a more vulnerable group of the population than their urban counterparts (GRZ/ NCDP (WID); 1991).

Mulenga and Mwansa (1991) also in their study entitled "Vulnerable population and rapid economic change in Zambia," revealed that the benefits of development had not been equitably distributed across regions, classes or sexes. They stated that the effects of economic restructuring in Zambia on certain population groups appeared to have been adverse. The paper attempted to isolate categories of Vulnerability, such as certain Female Headed Households (FHH), Youth, disabled and children. However, the study stated that not all FHH were vulnerable. Household with little education, training and skills were more disadvantaged than those with some good education, vocational training and marketing skills.

Muntemba (1987) and Spence (1988), who analyzed the impacts of SAP on vulnerable Groups, examined the impacts on people of each component of SAP, such as decontrol of prices, lifting of subsidies and decrease in public expenditure, especially social services like health and education. Both papers concluded that the socio-economic position of people in Zambia had deteriorated after the SAP was implemented.

Perker (1991) in his empirical analysis in Bamako found that there was a strong relationship between the number of visits to the hospital and the financial standing of an individual. Generally, the wealthier an individual was, the more he saw the physician of his choice.

In a similar study in Tanzania Mujinja (1990) argued that the impact of cost -sharing appears to be universal. The main argument put forward by the respondents were economic. He found that in many income groups, over 70% of the people could not afford the medical fees, as their incomes were seasonal, which meant that the capacity and ability to earn sufficient income to meet the medical fees fluctuated.

An analytical study by Ehren Reign at Keele University (1990) on the impact of medical fees in hospitals had recommended that Health care should not be a commodity to be bought by 'consumer' and sold by 'providers but should be free at the point of delivery. The costs should be borne by the entire society through an

equitable tax system. The medical empires should be decentralized and be subject to community and worker control.

The study also found that over sixty percent (60%) of the respondents felt that in all the health institutions, priority could be put on patient care, with emphasis on preventive health services. In short, the study concluded that the health care system could be recreated as a democratic system in which patients, were participants not 'objects' – and health workers from physicians to maid were all colleagues in common undertaking.

It was clearly stated that for basic curative services, there had been a slight drop in out –patient attendance in public district hospitals. On preventive services, which were entirely delivered free, for example, to pregnant women and children under five years old, in public district hospitals, there had been an increase in the annual total number of out-patient deliveries after the introduction of cost-sharing. Wamayi (1992) found that increases in the user fees were followed by decreases in patient load and that there was no increase in the number of people who were unable to pay. So where did these patients go and what did they do? One response by the "lost patients" was that they had resorted to self medication. Another was that they simply did without care. Wamayi (1992) reported that at Kasangani Health centre in Uganda, the number of indigents remained constant, while the patient load dropped in relation to an increase in charges because many patients preferred not to be categorized as indigent because they considered it to be a social stigma. Pango and Lerberghe (1990) found a similar situation in the former Zaire.

The World Bank's policy study on health financing (Allan Birdsall and Deferrante, 1987) suggests several ways in which user charges for publicly provided health services could lead to greater efficiency in the health sector than when services are provided free of charge.

Some of the benefits resulting from cost - sharing are listed here below:-

- Fees provide a significant and flexible source of revenue for the health facilities
- Fees prevent unnecessary use of services

- Fees encourage appropriate use of the first contact and referral facility

On the other hand, considerable evidence has been gathered regarding the consequences of imposing charges for public health services in developing countries as regards equity, efficiency and consumer satisfaction. Studies in many countries, including Bangladesh, Ghana, Lesotho, Peru, Swaziland and Zambia, as well as Kenya, have shown that poor people are less likely to utilize the services than the rich (Joseph Kurtz, 1987). Poor people were also likely to be put off by price increases than the rich (Creese 1990).

According to one study Malambo: 1999 people had adequate knowledge in Co-financing and were willing to continue participating in future only if there was an improvement in the quality of services delivered. This means that the imposition of the charges on health care was likely to yield substantial progress towards the goal only if individual institutions created public satisfaction. This could be achieved by meeting the following expectations: Providing a wide variety of services, improved infrastructure and maintaining an affordable supply of drugs. People equate the availability of drugs with higher probability that they would receive effective treatment. The extent to which drugs were available in public health facility had an important positive impact on the demand for the services in the facility (Hansson and Mc Pake 1993 Mwaambu Answill and Nyamete 1993).

The review of literature in the major areas of this study has revealed some significant findings which have been summed up. Several writers have documented research evidence indicating a catalogue of benefits that emanate from several arguments that the practice of the policy of cost-sharing is not only negatively perceived but it has also reduced most people's access towards the public health facilities in the rural areas.

Although some other literature has highlighted major barriers to accessing public health services in other countries. It was important for the study to establish the negative effects of the policy of cost-sharing.

It was hoped that the findings would enhance their judgment on the ability of consumers of public health services to meet the requirement of cost-sharing and how cost-sharing has impacted on the local community in financing their public health services under the economic condition that prevailed.

## **1.10 Methodology**

### **1.10.1 Research Design**

In order to assess the impact of cost-sharing on the consumers of public health services at Senanga District Hospital, a descriptive design was developed. This was thought to be appropriate for this purpose because it involved systematic collection of data to give a clear picture of the phenomena under study. Both qualitative and quantitative methods were applied as appropriate. Quantitative methods in the form of percentages and frequency tables were also used to analyze data. In this study, the dependent variable was the level of utilization of public health services by consumers. The independent variable was Cost-sharing.

To this effect variables, as set out in the questionnaire, were interpreted and discussed in the following order: Five Socio-demographic characteristics namely, age, gender, education, marital and economic status were analyzed first. There after, variables that characterize barrier to accessing public Health services at Senanga District Hospital due to introduction of cost-sharing policy were isolated and discussed separately as follows :-

**1.10.2 The main variables that characterized barrier to accessing public health services at Senanga District Hospital due to the introduction of cost-sharing policy.**

**Table 1.4 Variables that characterized barrier to accessing public health services**

Variables	Factors	Indicators
cost-sharing policy	Level of policy knowledge, level of community involvement, perception and practice	Number of correct responses to questions on Cost-sharing by people with knowledge.
Willingness to pay user fees	Level of Utilization	Type of responses from respondents on acceptability
Ability to pay user fees.	Affordability of charges and effects of the policy	People able to pay
Quality of care	Positive / negative of the service offered	Attractiveness of the services (Availability and non availability of drug.)
Drugs	Amount of drugs available	Stocks of drugs (availability)
Staff attitude	Relationship with the consumers of public health services	Types of responses from respondent's i.e. good satisfactory or bad.

**Source: information obtained from the field data 2005**

**1.10.3 Study Population**

The study population comprised members of the local communities seeking medical treatment at Senanga District Hospital and these were drawn from Mulamba Township, Zuli and Limoneno Compounds. Others were from Itufa, Nande and Lukanda areas within Senanga Central Constituency. The other category was health workers drawn from the hospital departments within Senanga District Hospital. The target population for the study in total was 9,000 people.

#### **1.10.4 Research Setting**

Senanga District Hospital, which was selected for this study, is found in the southern part of Western Province of Zambia. The choosing of Senanga District was based on three main factors. First, the World Bank's Poverty Assessment (1994) study, the CSO's *priority survey* (1991), and other studies had shown that as one moved towards the Western part of Zambia, there was a tendency for the incidence of poverty to increase. Indeed, the *priority survey* shows that Western Province, of which Senanga District is a part, had the highest percentages (79%) of extremely poor people. Secondly, Senanga is quite remote from Lusaka. It covers an area of 229,907 km<sup>2</sup> and had estimated population of 156570 (CSO) 2002 – 2003 *living conditions monitoring survey report*. The District Hospital acts as a referral hospital of 23 rural health centers and had a catchment's population for 130,316. This study however, only covered part of Senanga central constituency.

The main economic activities in the District include, subsistence farming, animal husbandry, fishing, beer brewing, marketeering, salaula trading, and formal employment in government departments, district council and non-governmental organizations. It is, however, important to note that Senanga district has three main ecological zones, which condition the types of economic activities the inhabitants could engage in. Firstly, the central part of the district spans the Zambezi River and the flood plains. This forms the "bread basket" of the district and is, hence, densely populated. Secondly, the eastern part of the district is predominantly woodland and therefore sparsely populated. Thirdly, the western part of the district has some of the poorest areas in the country, and it is drought prone. The most prevalent health problems in the District are malaria, diarrhoea, anemia, malnutrition, worm infestation, meningitis, TB, STDs, coughing, dysentery, Malaria occurs throughout the year due to tall grass which provide good breeding grounds for mosquitoes.

#### **1.10.5 Sample Size**

A sample size of 120 respondents was taken from the population of about 9,000 people. Out of the 120 respondents 72 were members of the local community in Senanga Central Constituency, 18 were junior and 30 senior members of staff

drawn from seven (7) hospital departments within Senanga District Hospital, such as the female, male, and maternity, children's, wards, out-patient department. Laboratory section and administration section.

#### **1.10.6 Sampling Procedure**

The sampling procedure used in this study to select one (1) township, two (2) compounds and three (3) areas within Senanga Central Constituency was purposive sampling. The reason for the choice were limited time and resources. In addition, the three (3) different residential areas, Zuli and Limoneno compounds are high density areas, while Mulamba Township is a medium density area. Consequently the researcher was able to collect data from three (3) categories of respondents who were affected and influenced by different factors.

In this study, a lottery method was used. In this method the names of individuals were extracted from ward lists of Senanga Central constituency. To arrive at the sample size of hundred and twenty (120) respondents, names were written on slips, mixed and shuffled, and finally picked twelve (12) respondents each from six (6) wards within Senanga Central constituency.

The forty eight (48) health workers were separately chosen at the convenience of the researcher. Participants were those public health workers who were found at the hospital at the time of the focus group discussion and those who shared interest in discussing a topic on cost-sharing. The selection of the group was done with the help of section supervisors. The purpose of using sections supervisors was to look for quality rather than quantity information. In order to obtain accurate and reliable information from health workers, the number of public health workers was limited to the departments that had associations, directly or indirectly with patients. The study considered female and male respondents.

#### **1.10.7 Data Collection Instruments**

A semi-structured questionnaire with both closed and open-ended questions was used as a data collection instrument. The questionnaire was self administered and was used to facilitate obtaining reliable information from all the subjects in the sample and to allow for minimum information distortion as they obtained direct responses from the respondents without need for further interpretation. Structured

personal interviews were also conducted to obtain more information relevant to the topic under study.

#### **1.10.8 Data Analysis**

Data was analyzed using both qualitative and quantitative procedures. The qualitative data was analyzed using themes while quantitative data analysis used percentage and frequency tables. Cross tabulations were also done for variables and other appropriate tables, graphs, charts, bar charts and figures.

#### **1.10.9 Ethical Consideration**

In order to observe ethical considerations and respect for the persons and group under study, permission was sought from the District Director of Health to conduct the study. Informed consent was obtained from all the participants in the focus groups. An information sheet was made available to all participants. The information sheet provided brief information about the study, freedom of participation and issues of confidentiality. Participants were also informed of their right of unconditional withdrawal from participation. This means that the researcher followed a certain code of conduct or a set of principles during the research to ensure that the participants enjoyed their rights to privacy dignity and self-determination.

## CHAPTER TWO

### IMPLEMENTATION OF THE POLICY OF COST-SHARING

#### 2.1 Overview

Cost-sharing policy of one form or another, in the health sector was first introduced in 1989. It should however, be emphasised that it was not until 1993 that the Government attached much importance to the issue of cost-sharing. This stems from the observation that implementation of the current health reform began in 1993. In addition cost-sharing policy was considered to be a major element of the reform process because the policy shift was aimed at addressing the severe resources constraints. It was the general expectation of the policy makers at the central level that implementers would make modifications to the general policy guidelines to suit their own environment. This was particularly important bearing in mind the emphasis the general policy documents placed on decentralization, equity, sustainability, accessibility, and affordability.

#### 2.2. *Understanding of the policy of cost-sharing.*

The general picture that emerged from the interviews and focus Group Discussions (FGDs) with different segments of the various communities in Senanga Central constituency was that of ignorance. For instance, the FGDs and the interview in Senanga revealed that not only were the communities ignorant about the rationale for the introduction of the policy of cost-sharing, but they also resented. In fact, they were not at all clear as to why free medical facilities were discontinued. For most of them the policy of cost-sharing represented a new form of tax. In Senanga there was also the feeling within the community that the Government introduced the policy of cost-sharing because it was broke. In this regard, the community saw paying user fees as a way of helping the Government to raise some money.

There was also a general feeling that due to rampant poverty in the district the majority of the people could not afford the fees. They contended that the little money they had or raised was allocated to food. This view was, however, not shared by the service providers who claimed that the majority of the people could afford the fees, only a few could not. In terms of acceptability, the few that

understood the rationale for Cost-sharing policy had come to accept them. Naturally for those not conversant with the rationale of cost-sharing it was hard for them to accept them. The lack of understanding was blamed on lack of information.

On the basis of the foregone discussions, the researcher observed that the community had little or no understanding at all of the policy of cost-sharing and its implementation. They attributed this mainly to lack of information. This meant that the rationale for the introduction of the policy of cost-sharing was not clearly understood at the local level hence little or no input could reasonably be expected from there.

Introduction of the policy cost-sharing in the health sector represented a significant departure from the past tradition where the government provided all social services free of charge. There was no doubt that many Zambians appreciated the need for them to contribute towards their own health care, as the government would like them to, but the way it was done needed careful scrutiny. Failure to do so would render the old adag **"Throwing the baby out with bath water,"** reign supreme.

There were probably many very good reasons why this caution must be exercised, but here the researcher only presented a few. First, for close to three decades Zambians were accustomed to getting free universal health care. Surely this mentality was not going to change overnight. Patience coupled with a strong public awareness campaign as to why this shift is necessary was a virtue.

Secondly, the introduction of Cost-sharing policy came at a time of worsening economic situation in the country and in fact it was this very factor which in large measure brought the change in the policy regime. But one must not lose sight of the effect of the same factor on the people themselves. The brunt of the economic hardships was borne, squarely, by the people. Thus creative ways of cushioning those who could not cope had to be devised. A gradual approach with "small bites" was one such means that could be tried first.

Third, we ought to remind ourselves of the different scenarios under which any given initiative may operate. To illustrate, here were two major policy scenarios

with several subsets. The first scenario was what a researcher termed as "Do not understand it (policy)". Under this scenario you might in addition have a situation where people not only did not understand the policy but they also did not like it.

The second scenario was "understand it (policy)". Under this we might have the following situation; firstly, one might understand the policy perfectly well, but do not like it. This had the implication that one would therefore, not support it. Secondly, one understood the policy, liked it, and was quite enthusiastic to support it, but lacked the necessary supportive apparatus. "Do not understand scenarios, doubtful. Finally, one understood the policy, liked it and had the requisite support. This of course was an ideal situation we would all hope to have. The experience has shown that this was quite elusive. Frequently, we were faced with the second situation under the "understanding" Scenario hence, the need to tread carefully. In addition, to the foregoing discussion, it was important to emphasize that for any policy imitative to be successful and sustainable, consistency was a necessary pre-condition. This unfortunately had not obtained in Zambia. There has been some vacillation in policy pronouncements, which left implementers, not to mention the people, confused.

It had been noted that in virtually all the areas visited people said that the health personnel at the district level received the policy on Cost-sharing as a directive from the Ministry. Similarly, the communities were only informed about the implementation of the policy. It was therefore; recommended that there should be maximum consultation at all levels prior to the policy formation and implementation. For this to work would obviously require devising the necessary mechanisms. The study revealed that communication on the introduction of the policy on cost-sharing was in some cases done through the radio, TV, and Newspapers, all which were not accessible to the general public. It was recommended that communication be done at local level through MPs, Councillors, Church leaders, and other influential leaders in the communities. The message also needed to be made available in the local languages. It was not always very helpful to display information on notice boards in English as it was done in Senanga. It was also revealed that revenue collected from user fees at the hospital in some cases was surrendered to the district office for safe keeping and re-allocation. This was contrary to the idea of

improving quality public health services provided at these places. There was therefore, need to enforce the rule that (75%) of the revenue collected was retained at the point of collection. In addition, more deliberate effort could be made to involve the communities in the decision-making process, in general and with regard to the use of the revenues, in particular.

It was observed in Senanga District that payment at hospital was linked to availability of drugs rather than consultation. In this connection it was recommended that this system should be modified. The modification proposed was that rather than ignoring consultation altogether, a small percentage (say 25%) of the fee could go towards this purpose. This was because of the importance consultation had in health care. Without consultation we run the risk of too much quackery, proliferation of self diagnosis, and hence drug abuse. Another point to be taken into account was the differential costs of drugs. Some drugs were more expensive than others, so the fee should be graduated accordingly.

The researcher also observed that there was no much help rendered to the Core-poor for them to have easy access to health care. It was therefore, recommended that the Social Welfare Department (SWD) should work hand-in-hand with the local leaders in the various communities to identify the vulnerable.

It was our expectation that if the policy environment was right, people at the local level would have the opportunity to interpret and adapt the national policy according to their circumstances. As it turned out, there was little or no adaptation at all. In almost all the cases, the National policy was treated as a directive which needed none of their input. Generally, it seemed that the only notable input the service providers felt they could make was that of setting the fee levels.

It was the intention of the study to assess whether or not local practices diverged from the policy pronouncements (Local or National) and to establish the nature and extent (where possible) of that divergence where it existed. As it turned, to some extent, the areas visited treated the National policy as a directive and therefore felt that they could not adapt it to their own situation. There seemed to have been an

implicit assumption on the part of the hospital that the only adaptation they could make to the National Policy was in the setting of the fee levels.

Consultation was one of the basic fundamentals of any democratic process. It was an important means through which a sense of belonging and ownership on the part of the communities could be engendered. These, in their turn, were critical factors in fostering an effective and sustainable decentralized system. Contrary to repeated pronouncements by the Government to make the District Hospital the nucleus of decision making and in spite of the stated desirable qualities of decentralization, attainment of this goal had proved quite elusive. In Senanga, to some extent, decision making and authority had yet to devolve to the provincial Headquarters. As regards consultations, in virtually all the cases communities were never consulted. Even among service providers the fee policy was pretty much a directive from the hierarchy. In one case, in Senanga when the Health Advisory Committee raised questions about the cost-sharing they showed some resistance to their introduction.

As a prelude to evaluate the effectiveness of a particular policy initiative it was often a good idea to start by examining the involvement of the stakeholders in its formulation and implementation. The less involved the stakeholders were, the lower the probability of success or effectiveness in this case.

In light of the foregoing, it was therefore, not only surprising, but also disheartening to find out that in all the study areas, community involvement was overlooked, be it in fee policy determination or revenue management. Very little regard seemed to have been given to the important role the communities play in these aspects of health reform process. There seems to have been some impatience on the part of the policy makers at the central level to consult or involve the people at the grass root level. As result, the issue of ownership was down played and yet it is important indicator of success and sustainability.

Lack of community involvement coupled with poor public awareness campaign led to feelings of resentment towards Cost-sharing in Senanga District. . It was also; hard for some people in Senanga District to understand that the government could have no money to pay for their public health services as it had done before.

### **2.3 Policy Implementation**

In recognition of these problems and in a bid to revitalize the health sector and improve the health status of Zambia, the Senanga District Hospital charged a flat fee of K 1,500.00 which was determined by the DMO. At the hospital Zambians upon verification of nationality, were charged a flat fee of K 1,500 for registration, consultation and medicines. The corresponding fee for non-Zambians was K 5,000. A general rule of thumb was that non-Zambians must pay more than Zambians. In addition to these fees the Hospital charged extra fees for specialized services. For Zambians these ranged from K 2,000 for urine, haemoglobin, stool, and sickling tests, to name but a few, to K 10,000 for post-mortem. With regard to admission, in general wards patients had to pay an advance deposit of K 2000 for three days, broken-down into K 1,500 for lodging and K 500 for discharged slip or death certificate. In fee paying wards, a daily charge of K 6,000 was applied and an advance deposit of K 18 000 for six nights was required.

In Senanga District, two sets of fees were levied, one set for the District Hospital and another set for the Rural Health Centres. Each of these sets was then divided into two to three. In the case of Senanga District Hospital the fees were divided into three levels, adults above 15 years old, children between the age of 7 and 15 years old, and children below 7 years old.

However, it was interesting to note that the Hospital Board further divided the fees into two sets, one set catering for patients seeking assistance during the normal or regular working hours, i.e., between 8:00 and 17:00 hours, on week days for off regular hours for another set of fees which was between 25 and 67 percent higher than those for regular hours applied for off regular working hours. This was quite creative on the part of the Hospital Board and had three potential benefits to the Hospital, the patients or clients, and the business community. On the part of the Hospital the measure could reduce the congestion that often characterized restricting service provision to regular hours and also enable it raise additional revenue at the same time, reduced congestion was equally beneficial to the clients or patients. With regard to the business community the benefit was in the form of reduced absence from work. Of course, this was not cost-free. Workers and/or employers would have to meet the extra expense.

**Table 2.1 Charges at Senanga District Hospital**

Service	Remarks	Charg
OPD (All ages)	Registration/Episode/Wk (Regular Hrs)	1500
	“ “ “ “ (After Reg. Hrs)	
Delivery	without National Registration Card (NRC)	2000
		5000
Ante-Natal	With NRC	2000
	Without NRC	4000
Post-Natal		2000
Family Planning		2000
Medical Report		10000
Blood slide		1500

*Source: District Hospital reference manual book 2005*

Figure 2.1 above might help to elucidate on the various charges that were applied at Senanga District Hospital in 2005 at the time when the research was conducted.

This was based on the partnership principle alluded to earlier. The current Government adopted and stepped up implementation of Cost-sharing policy introduced earlier by the previous government. The NHPS (1992:34) stipulated that, initially, all Government health facilities except rural health centres, (secondary and tertiary) would charge a flat registration fee for out-patient (OPD) and in-patient services not covered by the insurance schemes. All expatriates on the other hand, would be required to pay a fee equivalent to the full cost of the services rendered. Similarly, Zambians would pay full-cost user fees for non-preventive and non-curative related services such as medical examinations for employment, accident reports, autopsies, and sick reports. As for people who opted to go directly to a referral hospital than being referred by a rural health center, they would attract a by-pass fee that would be higher than service level. Finally, drugs would also be subject to charges at all levels of health institutions, except Rural Health Centres and Health Centers in Slum areas.

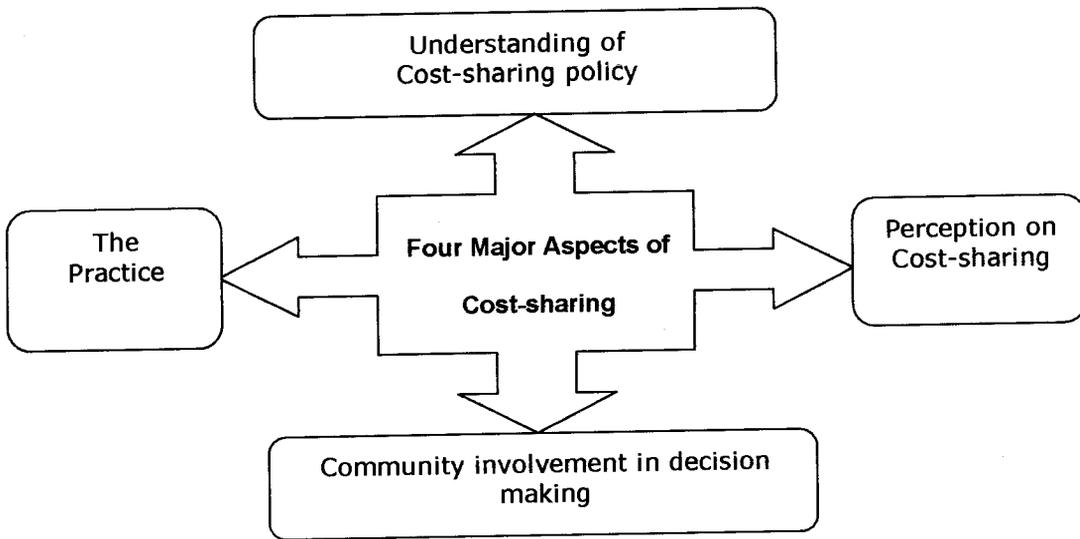
Recognizing the inability of some Zambians to contribute towards the cost of their health care, some exemptions were offered. The initial policy stand was

that "epidemics, chronic infections diseases, and natural disasters were exempted from charges (NHHPS, 1992). In addition, Women's Health, Child Health and family planning were considered as priority areas for Social Action Programme Support.

Over time there had been some further refinements to these exemptions. The current policy, as outlined in the Ministry of Health's Health care financing policy, included, generally, exemptions for individuals covered under the Public Welfare Assistance Scheme (PWAS) and temporary exemptions for those in areas declared as "disaster areas". Other specific exemptions would be for services in the following areas: preventive measures including immunization, ante-natal care, six-week post-natal visit family planning, delivery, and growth monitoring, screening of STDs including HIV/AIDS; contact tracing for TB, treatment of chronic conditions such as asthma, hypertension, diabetes, cholera, dysentery, measles, meningitis, accidents and medical emergencies.

In light of the above, this chapter examined four major aspects of cost-sharing. The four major aspects examined were as indicated in the diagram below:-

**Figure 2.1 The four major aspects of the policy of cost-sharing**



**Source: information obtained from the field data.**

Figure 2.1 above shows the four major aspects of the policy of cost-sharing as discussed in chapter two of the study.

## **CHAPTER THREE**

### **THE EFFECTS OF COST-SHARING POLICY**

#### **3.1 Overview**

The chapter presents the results of the research findings. These were presented in the following order: the views of the local communities on the negative effects of the policy of cost-sharing, community's ability and willingness to pay user fees, mode of payment and access, availability of drugs, quality of care and staff attitude at Senanga District Hospital.

#### **3.2 Views of the local communities on the effects of cost-sharing**

In view of the above subject, it was therefore, important for this study to analyse the views of the local communities on the effects of cost-sharing in all areas visited as highlighted below.

##### ***3.2.1 Views of the local communities of Nande, Lukanda and Itufa areas***

The participants indicated that the practice of the policy of cost-sharing was not only negatively perceived but it has also reduced most people's access towards public health services.

##### ***3.2.2 Views of the local communities of Mulamba, Zuli and Limoneno compounds***

In principle, the communities felt that cost-sharing was not acceptable and affordable. However, there was also a feeling of resentment due to lack of consultations. They contended that they were never consulted on the matter. In this regard, they thought that the area Member of Parliament could have played a useful role of informing them. Within these communities some members wished they had been involved in the fixing of the fee levels as the current ones appeared to be too high for some of their poor colleagues. It was observed that there was no much help rendered to the core-poor to enable them access health care facilities easily.

Finally, introduction of cost-sharing in Senanga was seen to have had a positive effect on the utilization of various services. Caution must however, be exercised not to make them too expensive for many people. Situations such as what happened in

January 2005 when the proposed increases in fees by the Federation of Hospital Boards were found to be too high for most people. This should be scrutinised carefully prior to implementation.

### **3.2.3 Views of the Service providers (staff) of Senanga District Hospital**

There was a general feeling that due to rampant poverty in the District the majority of the people could not afford the fees. They contended that the little money they had or raised was allocated for food. In terms of acceptability, the few that understood the rationale for the user fees have come to accept them. Naturally for those not conversant with the rationale for user fees it was hard to accept them. The lack of understanding was blamed on lack of information.

### **3.3 The negative effects of cost-sharing on the utilisation of services at Senanga District Hospital**

This section covers the following subjects; the community's ability to pay user fees, gender and ability to pay user fees, willingness to pay user fees and utilisation, level of income and utilisation; mode of payment and access to services and the availability of drugs at Senanga District Hospital.

#### **3.3.1 Community's ability to pay user fees**

**Table 3.1 Community's ability to pay user fees and access public health services**

<b>Ability to pay use fees</b>	<b>Access</b>	<b>No Access</b>	<b>Total</b>
Able to pay	25(20.8%)	17(14.1%)	42(34.9%)
Not able to pay	20(16.79)	58(48.3%)	78(65%)
Total	45(37.5%)	75(62.4%)	120(100%)

*Source: information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

One of the issues emphasised in the vision of health reforms, was equity of access to quality public health care. By equity of access, meant to ensure that services are affordable for both the rich and the poor.

Table 3.1 shows that 65% of the respondents said that they were not able to pay user fees whilst 34.9% of the respondents indicated that they were able to pay user fees.

The majority of respondents interviewed said that the policy of cost-sharing had adversely affected their access to public health services. According to respondents in Nande area, women gave birth at home because they did not have money to pay at the hospital. Other examples were given in areas like Lukanda where a child of 11 years old died because of denial to health care. The study revealed that a peasant farmer of Lukanda village became a victim of denial to health care due to lack of money for medical fees. She described how her 11 year old daughter was left to die at the Hospital. Towards the end of 2004, her daughter fell ill from suspected malaria. After an initial payment of K 1,500 for treatment, her daughter became critically ill. Two days later, she went back to the hospital about 15 Kilometers from her village. Upon arrival at the Hospital, the Health staff refused to treat her daughter unless she paid K 5,000 which she did not have. She tried to explain to them that her daughter had been there two days before and that she had paid. But they insisted that she had to pay again before her daughter could be seen by a medical officer. As time went on, her daughter died without treatment.

**Table 3.2 How respondents paid for public health services**

Method of payment	Cash	Scheme	Do not Pay	Payment in kind	Total
<b>Total</b>	18(14.9%)	19 (15.8%)	60(49.9%)	23(17.1%)	120(100%)

*Source: information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.2 shows how respondents paid for their public health services. What is evident in table 3.2 is that 14.9% said that they paid in cash, 15.8% through the

hospital medical scheme. 17.1% paid in kind while the remaining 49.9% did not pay user fees.

These findings show that half of the respondents, 50.1% in this case, found cash payment and scheme programme convenient. However, 49.9% were in the category of do not pay user fees. This group comprises the exempted, can not afford and who do not want to pay user fees.

### 3.3.2 Reasons for not paying user fees

**Table 3.3 Reasons for not paying user fees.**

Reasons	Exempted	Could not afford	Do not want	Total
Total	15(25%)	35(58.4%)	10(16.6%)	60(100%)

*Source: information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.3 shows reasons for not paying user fees. It is observed that 58.3% could not afford to pay user fees. The second in hierarchy were those in the category of exempted 25%. The least in the group were those who did not want to pay constituted 16.6%.

The 58.4% under they could not afford to pay user fees gave reasons of lack of money. The 16.6% who belong to the do not want category gave reasons of having Home Remedies and Traditional Healers as an alternative.

The 25% under the exempted category were allowed through the government exemption policy. The Government Health Reforms introduced in 1992 exempted the aged from 65 years and above, children under the age of 5, those suffering from Chronic diseases like TBs Asthma, HIV/AIDS diabetes and emergencies (accidents).

### 3.3.3 Gender and ability to pay user fees

**Table 3.4 Gender and ability to pay user fees**

Ability to pay	Male	Female	Total
Yes	25 (20.8%)	17 (14.1%)	42 (34.9%)
No	20 (16.7%)	58 (48.3%)	78 (65%)
Total	45 (37.5%)	75 (62.4%)	120 (100%)

*Source: information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

The general picture that emerged from the interviews and Focus Group Discussions (FGDs) with different segments of the various communities was that both men and women were not able to meet cost-sharing.

The study revealed that when women's access to public health services was considered in general, the introduction of cost-sharing had brought a reduction in access. The majority of the women interviewed said that cost-sharing had adversely affected their access to public health services.

Table 3.4 shows that 65% of the respondents said that they were unable to pay user fees from the time they were introduced. 34.9% of the respondents indicated that they had been paying the fees.

Table 3.4 also shows that there were more female consumers who could not pay for their public health services than the male consumers. The female consumers were 48.3% whilst male consumers constituted 16.7%.

### 3.3.4 Willingness to pay user fees

Data of the unwillingness to pay user fees are based on the responses on members of the community to the question whether or not approval of the policy of cost-sharing. Approval of the policy was assumed to be indicating the willingness to pay user fees.

**Table 3.5 Approval of cost-sharing and utilization.**

<b>Approval Vs Disapproval</b>	<b>Utilisation</b>	<b>Not utilised</b>	<b>Total</b>
Approval	27 (22.5%)	11 (9.1%)	38 (31.6%)
Disapproval	56 (46.6%)	26 (21.6%)	82 (68.2%)
<b>Total</b>	<b>83 (30.8%)</b>	<b>37 (30.8%)</b>	<b>120 (100%)</b>

*Source: information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

Table 3.5 shows that 68.2% disapproved the policy of cost-sharing. The respondents gave reason that user fees were not affordable and payment does not improve services at the hospital. For those who approved the policy of cost-sharing 31.6% of the respondents gave improvement of services as the reason.

The findings in table 3.5 are based on the assumption that approval of the policy of cost-sharing indicated the willingness to pay user fees while the disapproval of the policy of cost-sharing indicated the unwillingness to pay user fees.

### 3.3.5 Level of income and utilisation

**Table 3.6 level of income and utilisation**

<b>Income</b>	<b>Utilised</b>	<b>Not Utilised</b>	<b>Total</b>
Below K50,000.00-	10 (8.3%)	20 (16.6%)	30 (26.6%)
K50,000.00- K501,000.00	12 (10%)	44 (36.6%)	56 (46.6%)
K501,000.00- K1,010,000.00	06 (4.9%)	16 (13.2%)	22 (19.1%)
Above K1,010,000.00	02 (1.6%)	10 (8.3%)	12 (9.9%)
<b>Total</b>	<b>30 (24.8%)</b>	<b>90 (74.7)</b>	<b>120 (100%)</b>

*Source : Information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.6 shows the level of income and utilisation. It was observed that 46.6% of the respondents were in the income category of between K50,000.00 to

K501,000.00 per month. This was followed by those in the income category below K50,000.00 26.6%. The third in the hierarchy constituted 19.1% and the least in the group constituted 10%.

This shows that the large number of the respondents were those whose income was low. The analysis given above is in line with the food basket at the time of the study, JCTR food basket was at US\$78 (K312,000.00). per maximum of 6 households (Jesuit Centre for Theological Reflection, A comprehensive overview, 2005). All those who got a monthly income of K50,000.00 to K501,000.000 belong to the low income category therefore, the trend that could be observed from the table was that the lower the income the greater the level of non utilisation of public health services

### 3.3.6 Mode of Payment and access

**Table 3.7 Respondent's mode of payment and access**

<b>Mode Of Payment</b>	<b>Access</b>	<b>Not access</b>	<b>Total</b>
Pay cash	10 (8.3%)	8 (6.6%)	18(14.9%)
Medical scheme	10(8.3%)	9(7.5%)	19(15.8%)
Don't pay	20(16.6%)	40(33.3%)	60(49.9 %)
Payment-in-kind	5 (4.1%)	18 (15%)	23 (17.1%)
Total	45 (37.5)	75 (62.5%)	120 (100%)

*Source: information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.7 shows that 49.9% of the respondents indicated that they did not pay for their public health services. The second in the hierarchy were those in the category of payment-in-kind and constituted 17.1%. The third in the group were those who used the medical scheme and the least 14.9% indicated that they paid cash.

The findings show that large number of the respondents, 49.5% in this case did not pay. It was observed that a high percentage of respondents in the category of do not pay (33.3%) were unable to access public health services at all times,

reflecting that the policy of cost-sharing was a barrier to accessing public health services.

### 3.3.7 Availability of drugs at Senanga District Hospital

**Table 3.8 Frequency of prescription since the introduction of cost-sharing**

Given a prescription to buy medicine from the pharmacy.	Always	Sometimes	Rarely	Never	Total
<b>Total</b>	60 (49.9%)	23 (19.1%)	19 (15.8%)	18 (14.9%)	120 (100%)

*Source: Information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

Table 3.8 shows that 49.9% of the respondents indicated that they were always asked to buy medicines. The second in the hierarchy were those who were sometimes asked to buy the medicine and constituted 19.1%. Third group were those who indicated that they were rarely asked to buy the medicine 15.8%. The least 14.9% indicated that they were never given prescriptions to buy medicines from the pharmacy.

**Table 3.9 Respondent's Ability to buy prescribed medicine from pharmacies**

Ability to buy medicine	Able	Unable	Total
<b>Total</b>	41 (34.1%)	79 (65.8%)	120 (100%)

*Source: Information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.9 shows that 65.8% of the respondent, indicated that they were unable to buy medicine on prescriptions after paying the registration fee of K1,500 at the

hospital. The other 34.1% indicated that they were able to buy medicines in spite of paying the registration fee of K1,500 at the hospital.

**Table 3.10 Extent of Inaccessibility to public health services when given a prescription after the introduction of cost-sharing**

Reason	Medicine expensive	Medicine Not available	Not specified	Total
<b>Total</b>	19 (15.8%)	83 (69%)	18 (14.9%)	120 (100%)

*Source : Information obtained from the field data 2005*

*\* Note: The Figures in the table have been rounded off*

Table 3.10 shows that 69% gave medicine being not available at the hospital as the reason. Next in the group were those who indicated that the medicine was expensive 15.8%. The least were those who did not specify 14.9%.

### 3.4 Other negative effects of cost-sharing

This section focused on the negative effects of cost-sharing that are not related to user fees. The order of presentation is as follows:- Quality care and staff attitude.

#### 3.4.1 Quality of care

**Table 3.11 Cost-sharing and Quality of care**

Quality	Improved slightly	Deteriorated	Total
<b>Total</b>	52 (43.2%)	68 (56.6%)	120 (100%)

*Source: information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

Table 3.11 shows that 56.6% viewed public health services to have deteriorated as against 43.2% whose views were that public health services had improved slightly.

These findings reflect that public health services had not improved significantly contrary to the expectation of the local communities.

### 3.4.2 Staff attitude and quality of care

**Table 3.12 Level of staff attitude and quality of care**

Staff attitude	Quality of Care		Total
	Improved	Not improved	
<b>Good</b>	11(9.1%)	37(30.8%)	48(39.9%)
<b>Bad</b>	26(21.6%)	46(38.3%)	72(59.9%)
<b>Total</b>	37(30.7%)	83(69.1%)	120(100%)

*Source: Information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

Quality health care also include good staff attitude apart from the other attributes not mentioned here. This usually leads to higher consumer satisfaction utilisation of public health services. This situation at Senanga District Hospital is contrary. The study revealed that members of staff have bad attitude towards patients. 59.9% of the community confirmed this as shown in table 3.12 above.

### 3.5 Other barriers to accessing services apart from user fees

**Table 3.13 Distance and transport barriers**

Other Reasons	Distance	Lack of money to cover transport cost	Other	Total
<b>Total</b>	28 (23.3%)	70 (58.1%)	22 (18.2%)	120 (100%)

*Source: Information obtained from the field data 2005*

*\*Note: The Figures in the table have been rounded off*

The table 3.13 shows that the majority, 58.1% of the respondents indicated that they were unable to come for treatment at times gave lack of money to cover transport cost. Those who gave long distance as a reason constituted 23.3%. The 'other' reasons category had 18.2%.

### **3.6 User fees and utilization of various services at Senanga District Hospital**

This section discusses the following: utilization of out-patients department (OPD), utilization of delivery , Ante-natal, under-five, sexual transmitted diseases and general admission services at Senanga District Hospital.

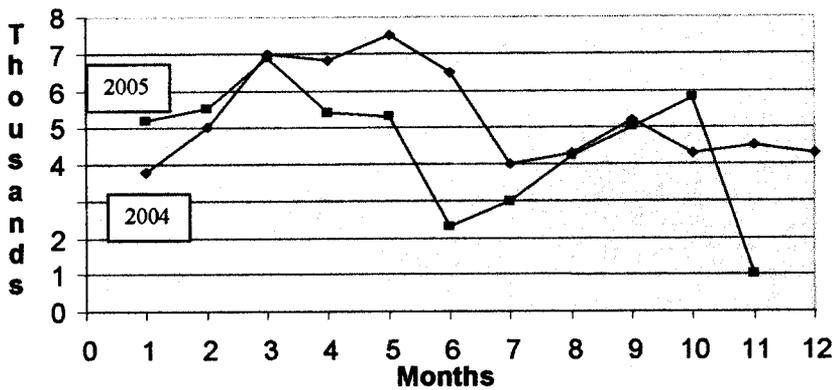
#### **3.6.1 *Utilization of Out-Patient Department (OPD) services, at Senanga District Hospital 2004-2005***

The out-patient department (OPD) was one of the most frequent sought basic and primary services by all individuals and was provided by virtually in all clinics, health centres, and Hospitals. Evaluation of the utilization of the service following introduction of the cost-sharing policy should therefore, offer some useful insights not only into the service itself, but also into the entire health care financing system.

The foregoing notwithstanding, the available information showed that since March 2005 and except for October 2005, utilization of out-patient department (OPD) services was lower in 2005 than in 2004. Moreover, over the periods 2004 to 2005 there was a noticeable, albeit unstable and general decline in the utilization of the service.

Comparative information on utilization of OPD services at five health facilities, Maternity wing (Delivery and Ante natal services), male (utilization of services for STDs). Children's ward (Utilization of under-five services), out-patient (utilization of general admissions) and laboratory section (utilization of STDs). All these facilities exhibited a general reduction in utilization of Out-Patient Department (OPD) services in June and July in all years and followed by steep drop in November and December for both years. This reduction was attributed to the period when people have run out of money and were busy preparing for the next year crop yield.

Figure 3.1 Utilization of OPD Services, 2004-2005



Source: information obtained from the field data 2005

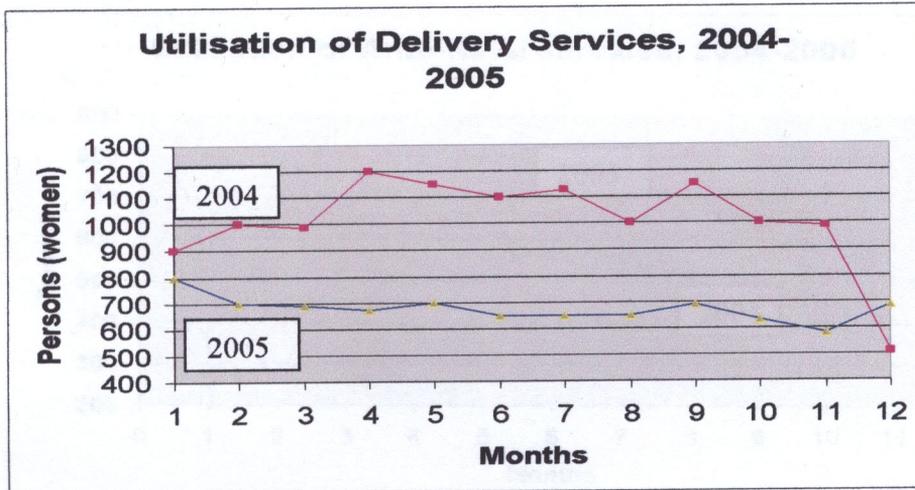
### 3.6.2 Cost-sharing policy and Utilization of Delivery Services at Senanga District Hospital

Delivery services were closely linked to Ante-natal services, thus it was usually the case that mothers who sought ante-natal services ended up delivering at the facilities where they obtained these services.

Another point to take into account was that delivery services were increasingly performed by traditional birth attendants (TBA) outside of the formal medical facilities. It was interesting to note, however, that in 2005 relatively more mothers than in 2004 opted to deliver at the Hospital.

The delivery service as shown in the graph indicates that delivery services was high in 2005 than in 2004. The delivery services was stable in all months except in November and December when there was a steep drop in both years. The reason could be that the traditional birth attendants performed their duties well in both years in those two months indicated above.

Figure 3.2



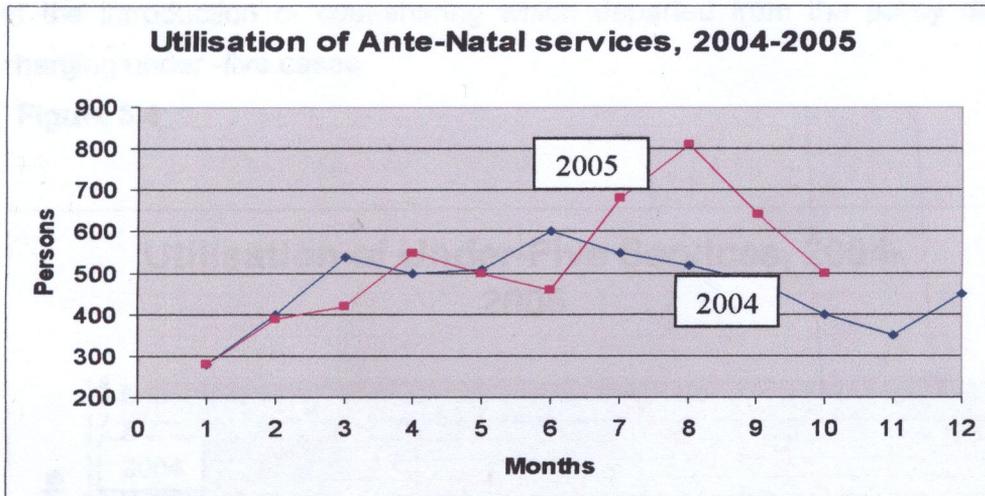
Source: information obtained from the field data 2005

### 3.6.3 Cost -sharing policy and utilization of Ante-Natal Services at Senanga District Hospital

According to the NHPS (1992), ante-natal services were among those health services that were supposed to be provided free of charge. Most health providers also acknowledged that these services were not supposed to attract any fees.

From January to April Ante-Natal Services were fluctuating in both years and went up in July 2005 while from July 2004 the Ante-Natal Services dropped and went up from November and December. The other year the Ante-Natal Services dropped in November and December. The reason for this punctuation was attributed to the fact that the exemption scheme was not at all clear to the people who should administer the exemptions. These people included not only the junior staff who register new cases at the hospital but also staff in the Social Welfare Department who were supposed to pay for those who can't pay for themselves.

**Figure 3.3**



**Source: information obtained from the field data 2005**

### **3.6.4 Cost-sharing policy and utilization of under-five clinics at Senanga District Hospital**

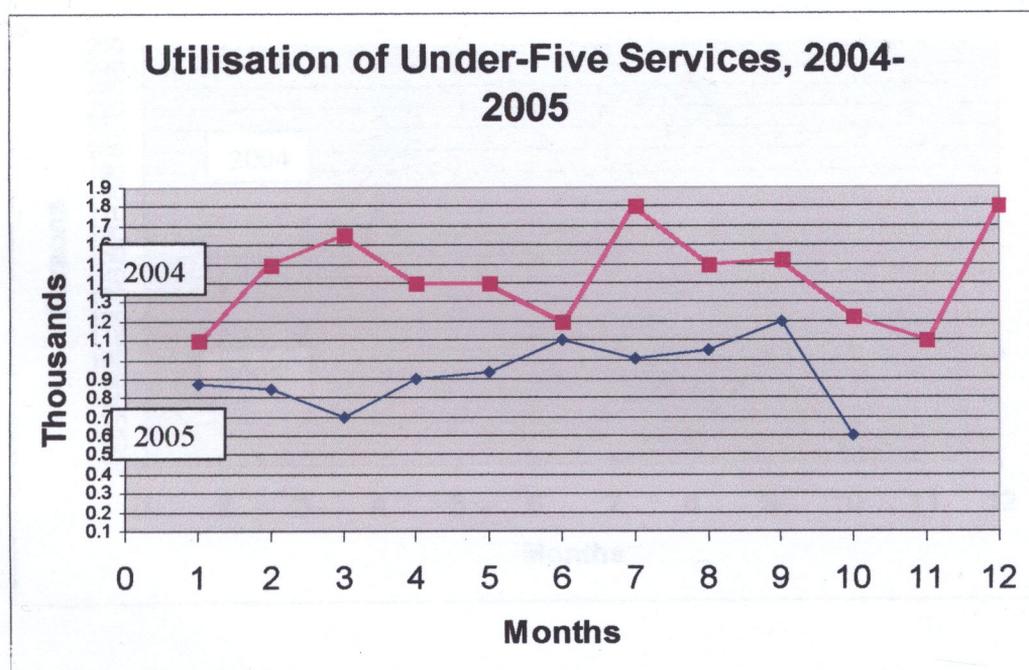
As in the case of ante-natal services, under-five services were not supposed to be subjected to payment of user fees, however, practice tended to depart from the policy directive. As a matter of fact, the researcher witnessed an incidence in Senanga where a child who was by all accounts under-five years old being turned away because the parents could not pay the required fee. Another variation to the policy that service providers introduced was that of exempting children whose mother or father or guardian were members of a pre-payment scheme. But even then there was an incidence where a child could not be attended to because the father on whose card the child was registered was not available. This was in spite of the fact that the mother who took the child to the Hospital had all the necessary documentations.

In view of the above, there appeared to be some evidence that cost-sharing policy has tended to discourage utilization of under-five services as seen in the diagram below.

From the month of January and May the gap in months for 2004 and 2005 widened thereafter, between May and June the gap for 2004 and 2005 reduced and widened between June and July and thereafter, dropped from September to December in

both years. The drop shown in years from September to December was as a result of the introduction of cost-sharing which departed from the policy directive by charging under-five cases.

**Figure 3.4**



**Source: information obtained from the field data 2005**

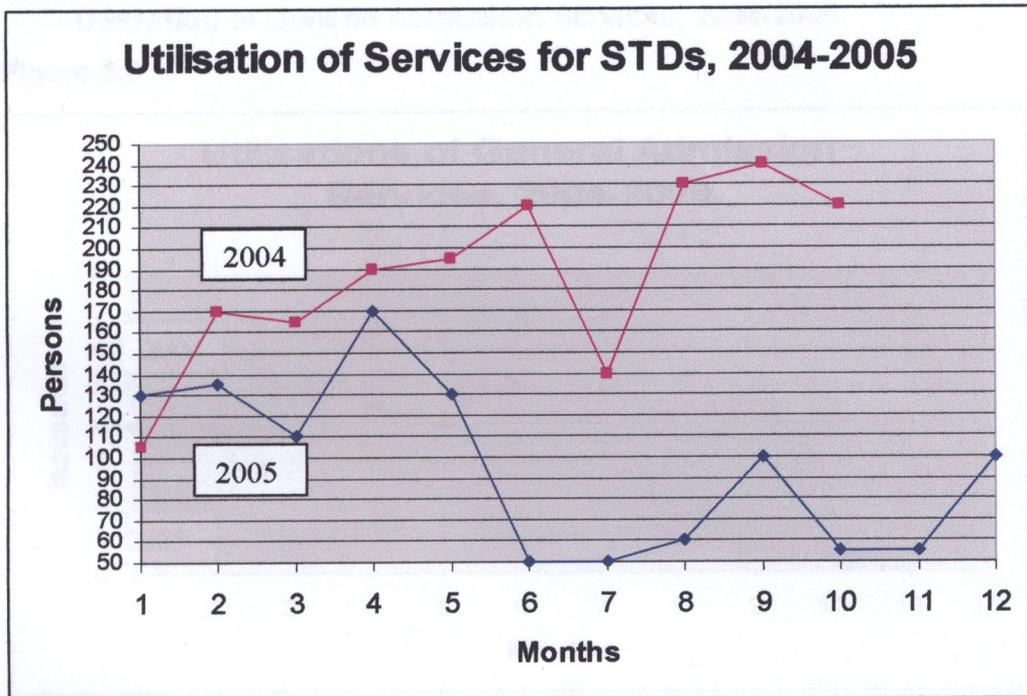
### 3.6.5 Cost-sharing and Utilisation of services for STD's at Senanga District Hospital

STD's were regarded as a "social bad" and as their treatment was supposed to be free of charge. However, in practice, as in the cases of ante-natal and under-five services, this did not happen. Moreover, it was only that Zambians became relatively comfortable to sought treatment for STD's from Hospital or specialized clinics. As could be seen from the diagram below, utilization rate reduced tremendously in 2005.

Utilization for Sexual Transmitted Diseases (STDs) services for 200 - 2005. As could be seen from figure 1.10 utilisation rate increased tremendously in 2004 and reduced in 2005. To some extent this coincided with the introduction of chieftains Matauka STDs Project in the area.

## Utilisation of Services for STDs, 2004-2005

Figure 3.5



Source: information obtained from the field data 2005

### 3.6.6 Effects of cost-sharing policy on general admissions at Senanga District Hospital

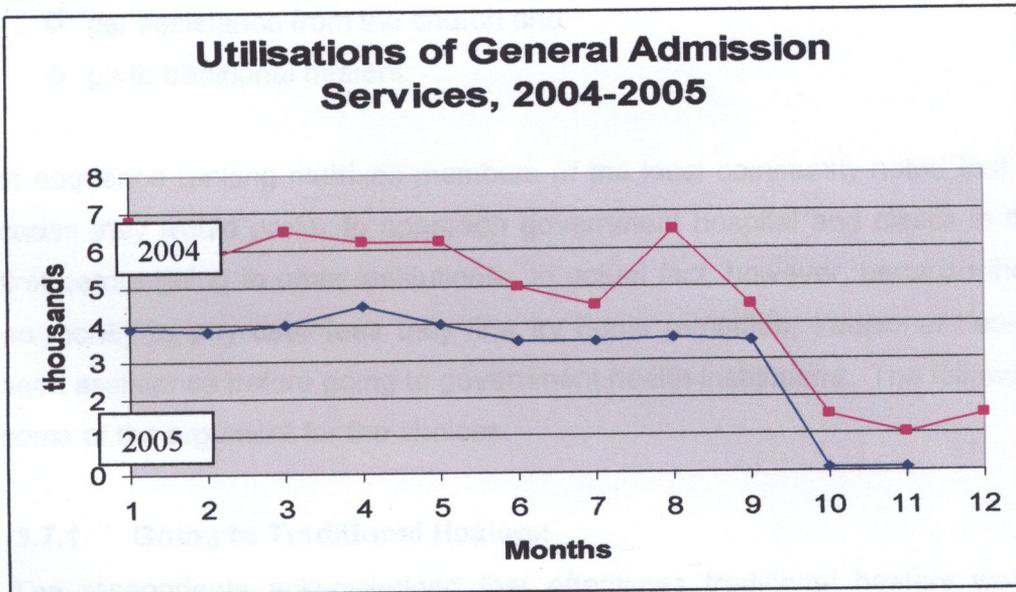
General admission services were to some extent as basic and commonly provided as Out-Patient-Department (OPD) services. Virtually all the Health facilities provided these services. It should also be borne in mind that a number of health institutions these days provide two types of admission services Low cost and High cost. As figure 3.5 shows, there appeared to be a close negative relationship between cost-sharing and utilisation of admissions services.

The information from the graph shows that utilization of general admissions was higher in 2004 than in 2005. From January to September the admissions were stable in both years thereafter, there was steep drop between October to December in both years. The reason attributed to this might be that between October and

December people have spend all what they sold from their harvest hence sited lack of money as a major problem in the area during this period in both years.

**Utilization of General Admission Services, 2004-2005**

**Figure 3.6**



**Source: information obtained from the field data 2005**

From the discussions given above in all cases, the majority of the people said that the introduction of cost-sharing policy was not seen as a way to involve the users in the service, but disowned and excluded them from having a say in the running of the hospital. The findings showed that up to one in four of the population stopped using the hospital altogether after the introduction of cost-sharing policy.

**3.7 Coping Mechanisms**

This section presents the methods devised by consumers who can't afford to pay user fees at Senanga District Hospital in their quest to cope with cost-sharing policy. The presentation was in the following order: going to traditional healers, stay at home, get family assistance, Government assistance and church assistance.

In view of the current economic hardships facing the majority of Zambians and diminished or lack of ability to pay for public health services and other services one

would ask the question. What do people do when become ill and they have no money to pay user fees? The following responses came out:-

- ❖ just stay at home and wait for the body to heal itself or for death.
- ❖ get family assistance
- ❖ get government Social Welfare Assistance
- ❖ get assistance from the church and
- ❖ go to traditional healers.

In sequence ranking matrixes members of the local community noted that in most cases they would prefer to approach government hospital and clinics in the area first before going to other institutions. In actual fact, however, because they have no money to pay user fees they first try home remedies, traditional healers and seek assistance before going to government health institutions. The following were some of the argument for the choices.

### **3.7.1 Going to Traditional Healers:**

The respondents acknowledged that oftentimes traditional healers were more expensive than modern medicine at government hospital but they pointed out to deferred payments which traditional healers demand for example. At the hospital you either have the money and you get attended to or you have no money and you are left to die. When you have no money you can bring in a token payment in the form of a chicken or white beads to traditional healers and would be attended to. Full payments could be made later. Indeed some healers insisted that could be paid only when the patient had fully recovered. In view of these favourable conditions and facilities for payments people tend to go straight to the healers even for ailments they normally would go to hospitals, eg malaria. Traditional healers were not all that rosy. A number of people, especially in Nande, Lukanda and Itufa areas, said that they would go to these only as last resort.

Reasons:-

- ❖ no proper diagnosis of ailments
- ❖ no proper dosage of drugs
- ❖ they cause a lot of misunderstanding and conflicts among members of the community.

**3.7.2 Use of Home Remedies:-** (i.e. herbs and other traditional panafaria), self diagnosis (including advice from relatives and friends) self prescription and procuring drugs from make-shift "drug store" in community markets and people's homes. The researcher found that home remedies were the most preferred ones in villages.

### **3.7.3 Seeking Assistance**

Seeking assistance from well wishers constituted another form of coping with cost-sharing. Relatives and the church constituted a source of financial resource for some of the consumers. Most of the respondents disclosed that they sought the assistance from relatives as one male consumer explained; "I ask financial assistance from relatives like, brothers, cousins, nephews, uncles and friends." About 10 patients had knowledge of other patients who were assisted by relatives financially however, this resulted into many complaints especially from economically better off families that there were too many relatives coming to seek for financial assistance too often.

## **CHAPTER FOUR**

### **CONCLUSION AND RECOMMENDATIONS**

#### ***4.1 Conclusion***

This section concludes the findings of the study and makes recommendations based on the findings. The conclusion is closely tied to the main objective of the study. The main objective of the study sought to establish the extent to which cost-sharing is a barrier to accessing public health services at Senanga District Hospital

Introduction of the policy of cost-sharing in the health sector represented a significant departure from the past tradition where the government provided all social services free of charge. For close to three decades, Zambians were accustomed to getting free universal health care. Surely, this mentality is not going to change overnight. It was also hard for some people in Senanga to understand that government could have no money to provide for public health services as it had done before. Under the circumstances, they were led to believe that cost-sharing was some form of punishment to them. Consumers of public health services did not understand why government introduced the policy of cost-sharing.

The introduction of the policy of cost-sharing came at a time of worsening economic situation in the country and in fact it was this very factor which in large measure brought about the change in the policy regime on the issue of policy implementation.

The study established that the community involvement was overlooked by government. There seems to have been some impatience on the part of the policy makers to consult or involve the people at the grassroots level.

Lack of community involvement coupled with poor public awareness campaign led to feeling of resentment towards the implementation of the policy of cost-sharing.

The policy of cost-sharing has proved to be a barrier to accessing public health services for the local people in Senanga District.

The user fees were found to be a significant barrier to accessing medical treatment for the low income and no income groups (poor) at the District Hospital. The disapproval of the policy of cost-sharing was evident by the consumers' unwillingness to pay user fees.

However, the policy of exemption offered to the aged, ante-natal, people with disabilities, chronic diseased and emergencies has helped the most vulnerable group to access public health services at Senanga District Hospital.

The general lack of medicines at the District Hospital severely affected accessibility to health care. Lack of medicines at the hospital resulted in patients being given "prescriptions," to buy their own medicines from pharmacies. The majority of the respondents' in the sample could not afford the medicines at the pharmacies.

The patient-health worker relationship was also found to be poor. Going by this indication, it was concluded that though patients may receive treatment at Senanga District Hospital, many may be doing so due to lack of an alternative health facility. This is in itself a significant barrier to accessing health care.

Distance from Senanga District Hospital was found to have a "pull effect" on the patients use of the health facility. The nearer the patient was to the hospital, the more the preference of using that facility. Therefore, distance from the hospital was found to be another barrier.

The general lack of medicine, lack of information on the implementation of the policy and bad staff attitude at Senanga District Hospital were also significant and this severely affected accessibility

#### **4.2 Recommendations**

It has been noted that in virtually all the areas visited, the health personnel at the district level received the policy of cost-sharing as a directive from the Ministry. Similarly, the communities were only informed about the implementation of policy. It

is therefore, recommended that there should be maximum consultation at all levels prior to policy formulation and implementation.

It was observed that communication on the introduction of cost-sharing policy was done through the radio, TV and newspapers all of which are not accessible to the general public. It is recommended that communication be done at local level through MPs, Councillors, Church leaders, and other Influential leaders in the communities. The message also needs to be made available in the local languages. It is not always very helpful to display information on a notice board in English as is done in some case at Senanga District Hospital

Revenue collected from cost-sharing policy at Senanga District Hospital was surrendered to the district office for safe keeping and re-allocation. This goes contrary to the idea of improving quality of services being provided at Senanga District Hospital. For the policy of cost –sharing to be acceptable there is need to enforce a rule that community members must see a link between the resources which they contribute and improvements in quality of care. One hundred percent (100%) of revenue collected should be used by the collecting facility. The revenue should be used to improve some aspect of quality of care identified by the community. Ninety percent (90%) of the funds should be used for community initiated activities while the remaining ten percent (10%) should be used to pay performance related incentives.

It was observed that there was no much help rendered to the core-poor people to enable them access public health services easily. It is therefore, recommended that the Social Welfare Department (SWD) work hand-in-hand with local leaders in various communities to identify the most vulnerable people. Emergency cases and critically ill patients should never be turned away from a health facility due to inability to pay for health care. They should be treated and then arrangements be made to help them contribute to the cost of their health care. This rule ensures access to care for all.

The policy of cost-sharing should be developed in collaboration with local communities. Communities should be involved in deciding how revenue from the

policy of cost-sharing policy is used. Cost-sharing in Zambia is being used to supplement (not replace) government financing. The income and expenditure from cost-sharing should also be discussed with the local community's in order to make them understanding the benefits.

All health facilities should clearly and visibly display the list of fees charged at the health facility, in addition, services and the exemption policy must be equally displayed. Details of the payment scheme should also be displayed in a similar manner. This information should be written in a language which local people can understand. The rule encourages transparency and accountability.

The following services should be provided free of charge: treatment of chronic illnesses such as TB, HIV/AIDS, treatment of STDs, family planning, children under-five years of age and people over the age of 65 years old. The most vulnerable group with evidence from the Social Welfare Department, indicating that they cannot afford to pay user fees should be also provided free.

It may be necessary to carry out larger-scale evaluation in order to address issues of particular concern to local management. The mandate is for District Health Management team to conduct regular monitoring. Monitoring is critical to ensure effectiveness in policy implementation and announcements that medical fees will be implemented or that an increment will take effect should be made months in advance so that the community can adjust both financially and psychologically.

Effort should be made to explain to the consumers of public health services. For example, the fees might be used to reduce waiting time, or express services would be offered as doctors and nurses would be available on a 24 hours basis. A list of these anticipated improvements should be placed in waiting area to allow patients to observe if any improvements are being achieved and the drug situation at district hospital must be improved in order to reduce the severe inaccessibility to basic health care for the majority of the patients.

Finally, a patient-doctor feedback mechanism must be devised in order to check if the prescriptions are being unutilised. It is, therefore, recommended that this follow

up mechanism be instituted urgently, as it is no use giving out prescriptions to patients who later do not utilise them.

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# THE UNIVERSITY OF ZAMBIA

## DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES

**TOPIC: THE IMPACT OF COST-SHARING ON THE CONSUMERS OF PUBLIC HEALTH SERVICES.**

QUESTIONNAIRE FOR MEMBERS OF THE LOCAL COMMUNITY ONLY

### INSTRUCTIONS:

Please note that this is an academic research on the impact of cost-sharing on the consumers of public health services in rural Zambia. The questionnaire is part of the requirements for the Master of public Administration (MPA) degree at the University of Zambia. The information you give will be strictly treated in confidence.

Instructions: indicate a tick, put a word or sentence as appropriate.

Example

What is the provincial headquarters of Western Province?

- a) Kalabo [ ]
- b) Lukulu [ ]
- c) Senanga [ ]
- d) Mongu [ ]

If it is Mongu therefore, you tick (d)

Section A

Now answer the following questions

1. Sex
  - a) Female [ ]
  - b) Male [ ]
  
2. What is your age? ..... Years

3. What is your age group (to be completed by interviewers?)

- Below 21 years old [ ]
- 21 –30 years old [ ]
- 31-40 years old [ ]
- 41-50 years old [ ]
- 51-60 years old [ ]
- Above 60 years old [ ]

4. What is your marital status?

- Single [ ]
- Married [ ]
- Divorced [ ]
- Widowed [ ]

5. What is your level of education attained?

- No Formal Education [ ]
- Primary Education [ ]
- Secondary Education [ ]
- College Education [ ]
- University Education [ ]

6. What is your employment status?

- Employed (formal Employment) [ ]
- Unemployed [ ]
- Self employed [ ]
- Retiree [ ]
- Other specify [ ]

7. If you are employed, what is your occupation .....

8. Are you the head of household?

- Yes [ ]
- No [ ]

9. What is the number of people in the household? (Family size to be completed by interviewer).....

10. What type of residential area do you reside in?

- 1 Low density township [ ]
- 2 Medium density [ ]
- 3 High density Township [ ]
- 4 Village [ ]

11. What is your monthly income?

12. State your monthly income .....

13. What is your income bracket (to be completed by interviewer)

- 1. below K50, 000.00
- 2. K50, 000.00 – K200, 000.00
- 3. K201, 000.00 – K500, 000.00
- 4. K501, 000.00 – K1, 000,000.00
- 5. K1, 010,000.00 – K2, 000,000.00
- 6. K2, 010,000.00 - K5, 000,000.00
- 7. K5, 010,000.00 - 10,000,000.00
- 8. More than K10, 000,000.00

14. What is your most important source of income?

- 1. Formal Employment [ ]
- 2. Self employment [ ]
- 3. Family and friends [ ]
- 4. Others specify [ ]

15. If your most important source of income is self employment, what economic activity are your most important sources of income?
- |                          |     |
|--------------------------|-----|
| 1. Selling fish          | [ ] |
| 2. Selling farm products | [ ] |
| 3. Selling timber        | [ ] |
| 4. Other Specify         | [ ] |

### SECTION B

16. Have you ever paid for public health services since the new policy of cost-sharing was introduced by government?
- |        |     |
|--------|-----|
| 1. Yes | [ ] |
| 2. No  | [ ] |
17. Do you approve of the new policy of Cost-sharing in the public health sector?
- |        |     |
|--------|-----|
| 1. Yes | [ ] |
| 2. No  | [ ] |
18. If Yes, why do you approve of the policy?
- |                                 |     |
|---------------------------------|-----|
| 1. Payment improves services    | [ ] |
| 2. It is affordable by everyone | [ ] |
| 3. Other reasons specify        | [ ] |
19. If No, why do you disapprove of the policy?
- |  |     |
|--|-----|
| 1. Payment does not improve services       | [ ] |
| 2. Not everyone can afford to pay the fees | [ ] |
| 3. Other reasons specify                   | [ ] |

20. How do you pay for public health services at Senegal District Hospital?

- 1. Pay cash [ ]
- 2. Through hospital medical scheme [ ]
- 3. Pay in kind [ ]
- 4. Don't pay [ ]

(i) If you don't pay give reasons

- 1. Exempted [ ]
- 2. I can't afford [ ]
- 3. I don't want to pay [ ]

(ii) If you don't want to pay what are your reasons?

.....  
.....

21. Is the mode of payment convenient to you?

- 1. Yes [ ]
- 2. No [ ]

22. How would you describe the quality of public health services being offered at Senanga District Hospital since the introduction of cost-sharing?

- 1. Improved significantly [ ]
- 2. Improve slightly [ ]
- 3. Same as before [ ]
- 4. Deteriorated [ ]
- 5. Don't know [ ]

23. After the introduction of Cost-sharing, how often do you receive treatment at Senanga District Hospital without paying fees?

- 1. Always [ ]
- 2. Sometime [ ]
- 3. Never [ ]

24. Are you at times unable to go to Senanga District Hospital for treatment?
1. Yes [ ]
  2. No [ ]
25. If yes, why are you unable to go for treatment?
1. The distance to the hospital is long [ ]
  2. Can not afford the fees [ ]
  3. Can not afford transport cost [ ]
  4. Others specify [ ]
26. When you can't afford to pay user fees what happens?
1. I get family assistance [ ]
  2. I just stay at home [ ]
  3. I get government Social Welfare Assistance [ ]
  4. Get assistance from the church [ ]
  5. Go to traditional healers [ ]
27. How often have you been asked to buy your own medicine by the hospital staff?
1. Always [ ]
  2. Sometimes [ ]
  3. Rarely [ ]
  4. Never [ ]
28. When you are asked to buy your own medicine where do you normally buy medicine?
1. Private pharmacies [ ]
  2. Hospital pharmacies [ ]
  3. Hospital staff [ ]
  4. Others specify [ ]

29. When required to buy the medicine have you ever failed to buy the prescribed medicine?

- 1. Yes [ ]
- 2. No [ ]

(i) If yes. Why

- 1. Medicine was expensive [ ]
- 2. Medicine was not available [ ]
- 3. Others specify [ ]

30. What do you think government and Senanga District Hospital Management should do to help patients meet the requirement of cost-sharing?

.....  
.....  
.....

**END OF QUESTIONNAIRE**

**THANK YOU**

# **THE UNIVERSITY OF ZAMBIA**

## **DEPARTMENT OF POLITICAL AND ADMINISTRATIVE STUDIES**

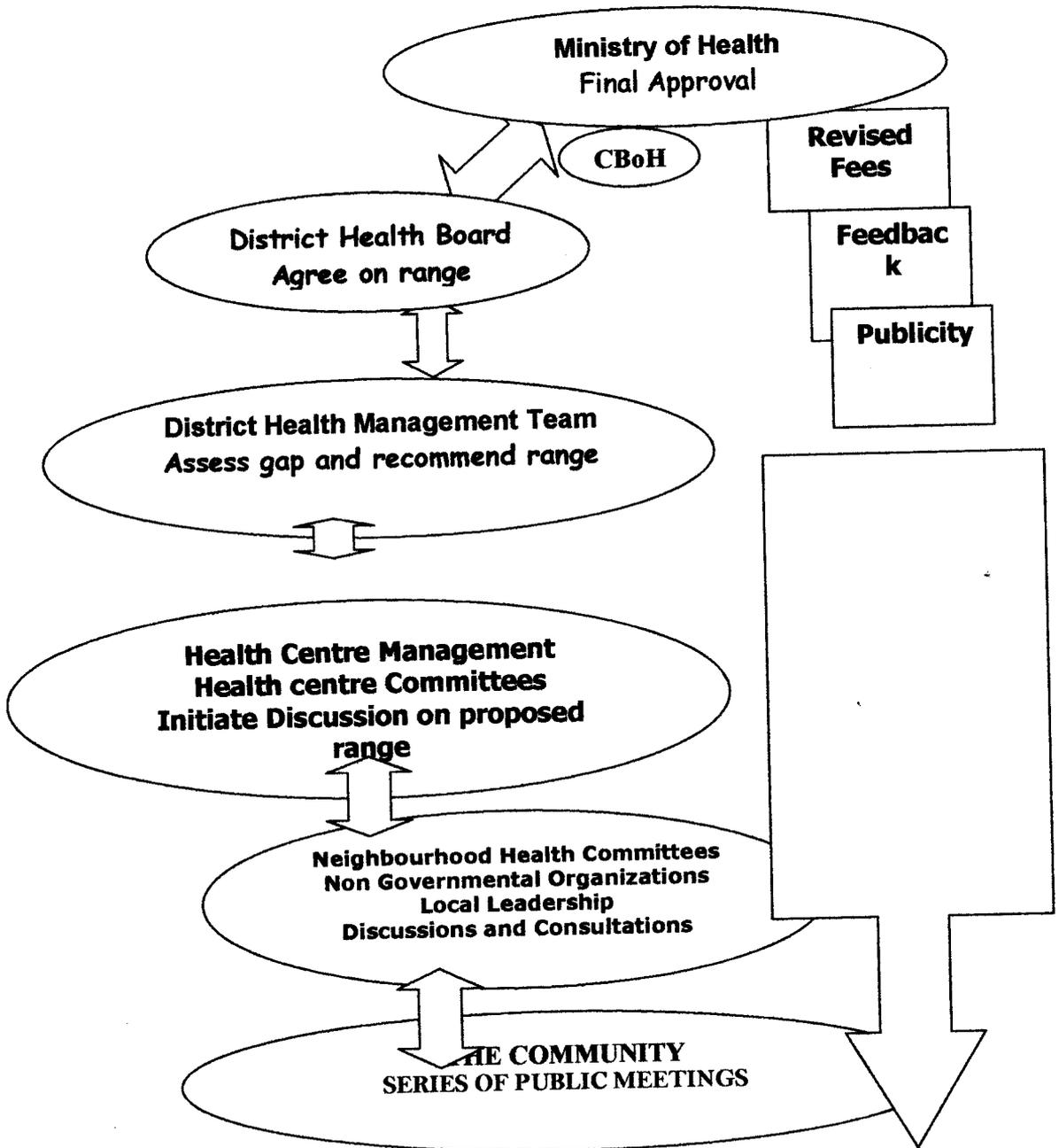
**TOPIC: THE IMPACT OF COST-SHARING ON THE CONSUMERS OF PUBLIC HEALTH SERVICES.**

### **INTERVIEW GUIDE FOR HEALTH PROVIDERS**

1. In your dealing with patients, what problems are you aware of that patient have encountered regarding cost-sharing?
2. If the local communities are willing to the user fees, how would you describe the quality of health services being offered at this hospital since the introduction of cost-sharing?
3. If they are not willing to pay the fees, what happens t o such patients.
4. Do you think the local communities have the ability to pay the fees?
5. What happens to the funds raised through cost-sharing scheme?
6. Do you think that the patients should or should not contribute towards the cost of medical services?
7. Propose ways in which cost-sharing can improve the quality of public health services in your hospital.
8. In your unit/hospitals, what has been the general impact of cost-sharing of public health services?
9. In your view, how has cost-sharing affecting public access to health services at Senanga District Hospital

10. How would you describe the quality of health services being offered at this hospital since the introduction of cost-sharing?
11. Do you think money raised through this scheme is properly utilized?
12. If not propose ways in which funds raised through the scheme of cost-sharing can be utilized.
13. What happens to patients who fail to buy prescribed medicine that is not available in the hospital?
14. What do you suggest government and Senanga District hospital should do to help such people?
15. In your view, has the condition of service improved since the introduction of cost-sharing?

**THE PROCESS AND STEPS TO TAKE WHEN CHANGING USER FEE LEVELS**



The diagram on page 74 shows how the various structures interact in the course of managing cost-sharing activities such as raising of user fees.