

Small Applied Research
Paper No. 2

**User Fees in
Government Health
Units in Uganda:
Implementation,
Impact, and Scope**

June 1998

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Partnerships
for Health
Reform

PHR



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The Partnerships for Health Reform Project (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- > *better informed and more participatory policy processes in health sector reform;*
- > *more equitable and sustainable health financing systems;*
- > *improved incentives within health systems to encourage agents to use and deliver efficient and quality health service; and*
- > *enhanced organization and management of health care systems and institutions to support specific health sector reforms.*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and promotes the exchange of information on critical health reform issues.

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Abstract

The objective of this cross-sectional study, which was conducted both at the Ministry of Health headquarters and in three districts of Uganda namely Mukono, Mpigi and Jinja, was to investigate and outline the implementation and impact of user fees on government health services in Uganda and to explore their scope in the future. The study includes qualitative and quantitative data, which were obtained through questionnaires administered to administrators, patients and health workers and focus groups conducted in the community.

We found that despite an unclear government position on cost sharing, user fees are levied at all government health units in the study districts. Among health workers, there is widespread acceptance of user fees. Health workers report that their morale is better because of the user fees. Other outcomes of the user fees include money available to rehabilitate buildings, improve supplies of drugs and other consumables, expand the presence of health workers at health units and provide better quality medical care at government health units. The public is beginning to reluctantly accept user fees. The patients who were interviewed generally dislike the fee. While some of them acknowledge the positive outcomes of user fees, the proportion of the public acknowledging the benefits is significantly lower than that of health workers. Many patients also complain about rude staff and corruption in the health units. The patients and the community in general had little knowledge about the operational details of cost sharing or the roles of the health unit management committees. The communities are uninformed about both the selection process for committee members and committee members' roles and responsibilities. Many of the complaints from community members related to cost sharing may be attributed to ignorance of the system. The health workers aggravate this by withholding information, which they fear could lead to less money being collected, such as exemption criteria for people who cannot afford to pay user fees.

The implementation of cost sharing has been problematic largely because of unclear policies and corruption in the health units. Our assessment of the scheme is that user fees have had some positive impact on the quality of health care in many government health units in Uganda. Drugs and supplies are now more easily available, and health workers spend more time working at the health units. A low level of community awareness about the management committees has created negative feelings about their roles. The public needs to participate more in decisions related to user fees. With increased transparency and decreased corruption, user fees are likely to play a larger and more positive role in the future.

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Acronyms

DMO	District Medical Officer
HUMC	Health Unit Management Committee
MOH	Ministry of Health
PHR	Partnerships for Health Reform
SAR	Small Applied Research
USAID	U.S. Agency for International Development

Foreword

Part of the mission of the Partnerships for Health Reform Project (PHR) is to advance knowledge and methodologies to develop, implement, and monitor health reforms and their impact. This goal is addressed not only through PHR's technical assistance work but also through its Applied Research program, designed to complement and support technical assistance activities. The main objective of the Applied Research program is to prepare and implement an agenda of research that will advance the knowledge about health sector reform at the global and individual country levels.

An important component of PHR's applied research is the Small Applied Research (SAR) program. Small Applied Research grants are awarded, on a competitive basis, to developing country research institutions, individuals and non-profit organizations to study policy-relevant issues in the realm of health sector reform. The SAR program has twin objectives: to provide data and analyses relevant to policy concerns in the researcher's own country, and to help strengthen the health policy research capacity of developing country organizations.

A total of 16 small research grants have been awarded to researchers throughout the developing world. Topics studied included health financing strategies, the role of the private sector in health care delivery and the efficiency of public health facilities.

SAR grant recipients are encouraged to disseminate the findings of their work locally. In addition final reports of the SAR research studies are available from the PHR Resource Center and via the PHR website. A summary of the findings of each study are also disseminated through the PHR In-brief series.

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1. Introduction

The Ugandan economy went through a very difficult period between 1970 and 1986. Inflation eroded the purchasing power so severely that workers' salaries came to be regarded as token payments of little value. This led to extensive corruption in government departments, including medical units. The upturn of the economy in the late 1980s saw the rehabilitation of many government medical units, although due to high inflation government salaries remained inadequate. It is in this context that the concept of cost sharing through user fees in government health units was first floated as a possible solution to widespread corruption, chronic shortages of drugs and supplies, and the low morale of health workers.

In Uganda, where the government traditionally provided free health care, the introduction of cost sharing represented a major shift in government policy. Resistance to such a change was expected, and user fees were not implemented for years because of potential political repercussions. Currently, government policy on user fees remains unclear, and top policy makers have been putting forward conflicting views on the matter.

Studies have shown that the implementation of user fees in Uganda has faced barriers including lack of clear guidelines, consumer unwillingness or inability to pay because of poverty, political opposition to the policy, lack of financial management skills and mismanagement of collected funds (Asiimwe, D., Mwesigye, F., McPake, B., and Streefland, P.; Magyezi R.T. and Namuyomba M.; and McPake, B. I., et al.). However, because the economy, political situation, priorities and attitudes of the population are dynamic, these variables must be monitored. Changes in any one of these areas can occur frequently, and with changes, there may be opportunities to implement new, rational policies.

2. Objectives

The main objective of the study was to investigate the effect of user fees on health services in Uganda and to explore their scope in the future.

Specific objectives:

- ▲ To document current policies on user fees at national and district levels.
- ▲ To identify obstacles which have hindered the successful implementation of user fees.
- ▲ To document any managerial, economic, social, political or other problems associated with user fees.
- ▲ To assess the impact of user fees on the quality of health services and on the utilization of government health facilities.
- ▲ To collect views regarding the sustainability of the user fees program from policy makers, health workers, community leaders, patients and the public.
- ▲ To make recommendations which may assist policy makers at different levels of government and implementors in the field to make better decisions regarding user fees in the future.

3. Methodology

The study was conducted in three districts purposefully selected to include different experiences with user fees and to reflect a wide geographical representation. We studied Mukono, Mpigi and Jinja districts. We selected Mukono district because it is one of the districts that has had long experience with user fees. Some units in this district began cost sharing in 1991, and all of the health unit management committees had adopted cost sharing by 1993. Results from previous studies on user fees in this district indicate that at many units the scheme is operating smoothly (Asimwe, D., et al.). This may be attributed in part to continuity in district leadership. We selected Mpigi district because its experience with user fees has been less smooth. Both Mukono and Mpigi are largely rural districts not far from the capital city of Kampala. We selected Jinja district because it has a fairly large urban population. Jinja is located in the Eastern region, and Mukono and Mpigi are in the Central region. All the three districts are accessible easily from Kampala.

3.1 Data Collection

The study was both qualitative and quantitative. Data were collected through interviews using semi-structured questionnaires with national and district policy makers, health workers and patients. Different questionnaires were designed for different categories of people. Key informant interviews with local community leaders, focus groups with community members and informal discussions were conducted. We conducted 12 key informant interviews with chairmen of local councils in villages where the selected health units are located. Village local councils mobilized people to participate in eight focus groups. We held three discussions in Mukono, three in Mpigi and two in Jinja district. We divided focus group participants by gender and conducted four focus groups for men and four for women.

3.2 Selection of the Health Units for the Study

In each study district, we studied four health units. This included three small health units selected by simple random sampling from among all of the small health units in the district and one hospital. In districts with more than one government hospital, as is the case in Mukono and Mpigi districts, each of which has two, the hospital also was selected randomly. Each of these districts has about 40 small units including health centers, dispensaries and sub-dispensaries.

3.3 Sampling of Health Workers

At each health unit, we attempted to interview as many health workers as possible (i.e., every health worker who was on duty). In all instances, we tried and we managed to interview the health worker in-charge and, where available, the cashier in charge of user fees. Each health center and dispensary generally has 5–10 workers in each unit. Each hospital has 30–40 health workers, but we interviewed only 5 managerial level health workers from each hospital. We interviewed a total of 74 health workers in 12 health units, for an average of 6 workers per health unit.

3.4 Sampling of Patients

We selected a target sample size of 384 patients. The sample size was determined as follows: since we are measuring many variables, we used a prevalence of 50 percent, which demands the largest sample size. At a 5 percent level of significance with a precision of +5 percent, the required sample is 384 subjects. We therefore planned to interview at least 32 patients from each unit. We planned to interview patients consecutively until we completed the required number of interviews. At some units, however, attendance was too small to obtain the required numbers. As a result, we interviewed only 348 people. We used a structured questionnaire to interview the patients in private.

We conducted interviews with patients in order to explore their views on user fees and specifically to record whether they regard user fees as a restriction on public access to health services. These interviews provided quantitative data.

3.5 Data Analysis

We compiled qualitative data and analyzed these data qualitatively using a thematic approach. We compared the data collected from different groups and compiled it on the basis of similar themes, and we noted areas of agreement or disagreement. We coded quantitative data and entered it into the computer. We obtained frequencies for different variables.

4. Results

4.1 Existing Policies

Interviews with officials at the Ministry of Health (MOH) headquarters revealed that there is no policy document at the MOH on cost sharing. The national parliament rejected the proposed policy in 1993, and since then, the MOH has kept a low profile on the issue of cost sharing, leaving it in the purview of the districts. Virtually all of the MOH officials who were interviewed expressed their support for cost sharing and indicated that they have continued to encourage the district level health managers and policy makers to adopt and implement cost sharing. Recently introduced decentralization has devolved powers to the district level, and many district councils have enacted by-laws institutionalizing user fees in government units in their districts. In the three districts in the study, the relevant district councils have endorsed cost sharing, and the district medical officers have been assigned to oversee the implementation of user fees. The MOH encourages this trend and is keen to identify uniform guidelines among the districts and possibly adopt those as part of a national policy.

There is a consensus among MOH officials that the MOH should formulate an acceptable national policy, which parliament should then approve for adoption by all districts. Many officials at the district level also share this view. Many policy makers at both the national and district levels feel that although cost sharing was initiated as an emergency measure to generate badly needed financial resources for the health sector, it has come to stay and virtually everyone has come to accept it.

Negative feelings were also reported to be declining. District-level leaders pointed out that any decline in attendance at health units which may have occurred when user fees were first introduced has been reversed, and attendance figures are now higher because of better services.

4.2 Practice in the Study Districts

In the three districts in the study, district managers consider user fees necessary and view them positively. The district councils have “given a green light” to user fees as long as Health Unit Management Committees (HUMCs)—the policy organs at facility level—decide to charge user fees. The district management provides broad guidelines that may be modified by the HUMC. The emerging practice at the district level is that the district administration should only facilitate and provide guidance while the HUMCs or the local political councils at subcounty or parish levels should determine the operational details for each health unit. The district facilitates the work of the health units by providing auditing services to improve accountability and transparency, training opportunities for persons handling cash at the units and regular supervision by the District Medical Officer (DMO).

In the three study districts, as in most other parts of the country, user fees have been in place for about 5–7 years. Money is paid either for a disease episode or for every visit, as determined by the local HUMCs. The commonest amount of money paid is 500 Ugandan shillings, which is currently equivalent to US\$0.50. After paying this amount, a patient should be entitled to full treatment. Extra charges may be levied for laboratory investigations or if the patient is admitted. These guidelines are generally uniform in small units and district hospitals.

We found no major differences in practice among the three study districts. The amounts charged are fairly similar, and the problems faced by the different groups affected by user fees—district policy makers, health workers in health units and patients—were generally similar. As a result, we decided to combine the findings from the three districts into one data set. Salaries for health workers are still generally low, and in recognition of this fact, guidelines in all three districts advise that staff receive a fraction of user fees, as much as 50 percent, as an incentive to provide good services. The HUMCs determined the fraction paid to the health workers.

4.3 Acceptability of User Fees to the Public

We investigated public acceptability of user fees by administering questionnaires to patients and health workers and by conducting focus groups discussions in the community. We found no systematic differences between responses of patients in hospitals and patients in smaller health units. All patient responses are therefore combined and presented together.

We interviewed 348 patients from the health units in the three districts. In response to the question of whether the policy was generally accepted by the public 43 percent of the respondents said that the user fees were acceptable to the public; 13 percent (44/348) thought that the user fees were not acceptable to the public; and 44 percent responded that they did not know what other people thought about the fees.

Focus group discussions revealed that virtually everyone in the community was initially opposed to the idea of cost sharing at government health units. Indeed, many people still are, but attitudes are gradually changing. In many of the focus groups, discussants blamed the negative feelings about user fees on the way the scheme was introduced. People were not consulted, and no one provided any explanation concerning the need for cost sharing. The following statements from one group demonstrate the general lack of understanding about the purpose of user fees: “The cost sharing policy was introduced as though it were a short-term measure intended to raise funds for construction of administrative buildings, but even after the achievement of this aim, the money continues to be charged without any explanation from the authorities.”

When we asked whether people should pay for treatment in government health units, 49 percent of the respondents thought that it was alright for people to pay for treatment at government health units, and 51 percent were opposed to cost sharing. There was no significant difference by gender. The people who supported payment said that the expense of medical services made user fees necessary in order to improve the quality of health care and to assist government. Those who opposed payment thought that the government should pay for health services with existing tax revenue. Ten percent of the respondents stated that people were too poor to pay.

In the focus groups many people viewed user fees as an additional burden to taxes that people already must pay. One person in Mukono district said: “I have a vehicle and a shop, and I pay

taxes for them. Why, then, should I pay for treatment?” During further discussions, many people blamed the negative views about user fees on the general lack of communication between the community and the health units.

4.4 Views of Health Workers on the Acceptability of Cost Sharing by the Patients

We asked health workers whether user fees were acceptable to their patients, and 81 percent (60/74) of the respondents said they were acceptable. The others gave answers indicating that it was not popular: 5 percent (4/74) said that the policy was not acceptable or that they did not know, and 14 percent (10/74) said that the policy was being accepted grudgingly. These figures contrast sharply with responses from patients: only 43 percent said the user fees were acceptable (table 1).

Table 1 “Is Cost Sharing Acceptable to the People?”			
RESPONDENTS	ACCEPTABLE	NOT POPULAR	TOTALS
PATIENTS	43% (150)	57% (198)	100% (348)
HEALTH WORKERS	81% (60)	19% (14)	100% (74)

The fraction of health workers who believe that cost sharing is acceptable (81 percent) is much higher than the fraction of patients who think so (43 percent). This difference is significant ($p < 0.001$).

4.4 Implementation of the User Fees Scheme

Information on how the user fees scheme is being implemented was obtained from patients, health workers and the community. The following are the responses on this matter.

4.4.1 Amount Paid per Visit

When patients were asked to state the amount of money paid per visit, figures ranging from 300 shillings to 15,000 shillings were mentioned, with 75 percent (260/348) saying that they paid 500 shillings. In some health units this amount is paid per visit while in other health units it is reportedly paid once for the entire period of treatment for an illness. The next common amount paid was 1,000 shillings which 14 percent (47/348) of the study group said they paid. Payments ranging from 2,000 shillings to 15,000 shillings were made by admitted patients (inpatients) especially for deliveries and for severe illnesses. The pattern was similar in hospitals and smaller health units.

4.4.2 Other Costs Paid

When we asked the patients whether they incurred other expenses apart from the initial fee, 56 percent said there were various other costs a patient had to pay before receiving treatment, while 44 percent (153/348) said that they did not make any additional payments after the official payment. These “other costs” are in most cases “under the table” payments, which, broadly speaking, reflect the extent of corruption at health units. In a few instances these “other costs” may reflect costs for supplies such as gloves or cotton wool, which the health workers may procure privately and sell to patients at a profit.

The focus group participants frequently complained about corruption related to extra costs. Whereas the people had been assured that the amount paid at the first visit would suffice, many frequently found that they needed to pay more to get adequate treatment. For example, in one unit we found that a woman who comes to deliver a baby and is officially required to pay 3,000 shillings in reality must pay as much as 15,000 shillings. One focus group participant made the following statement on this topic:

“When you go to the maternity ward, you discover that there are many things you have to pay for. These include gloves, a polythene bag for delivery, an injection to stop bleeding and paraffin.”

Normally these extra costs are collected by the midwife on duty who then provides the expectant woman with the above mentioned items without issuing a receipt. If a patient does not have money to meet the extra costs she is likely to get very poor attention even if she has paid the official user fees.

During further interviews with health workers it was established that many extra costs, especially those related to maternity services and other admitted patients, are required for supplies such as gloves which the health unit may not provide. The health workers buy the items from drug shops or pharmacies and sell them to patients at a profit. However, it is unclear whether these supplies are always bought privately by the health workers or whether, at times, government-provided supplies are sold to the patients. Many patients think that the latter is actually commonly the case and that charges for supplies are an example of corruption. Although this issue deserves further investigation, it is quite likely that measures to strengthen both the provision of supplies and the accounting procedures for all materials may reduce the level of corruption significantly.

4.4.3 Affordability of the User Fees

On the question of whether the money paid for treatment was affordable, 70 percent (242/348) of the respondents said that the amount was affordable. Only 26 percent (90/348) thought that too much was charged. The remaining 4 percent reserved their comments, or in some instances were dependents, who were not in position to give their opinions about affordability.

4.4.4 Exemption

When patients were asked whether they knew about the exemption policy, only 11 percent (38/348) stated that there were people who were exempt from user fees; 53 percent (185/348) said that there was no exemption policy; while 36 percent said that they did not know. There were no significant differences by gender.

By contrast, when health workers were asked whether their health units had an exemption policy from cost-sharing. Virtually all respondents (99 percent) stated that the policy existed. In fact, only one health worker answered that there were no exemptions (table 2).

Table 2			
Level of Awareness about Exemption: Health Workers and Patients			
RESPONDENTS	KNOWS ABOUT EXEMPTION	DOES NOT KNOW	TOTAL
PATIENTS	11% (38)	(89%) 310	100% (348)
HEALTH WORKERS	99% (73)	(1%) 1	100% (74)

Knowledge of exemption was almost universal among health workers (99 percent), while only 11 percent of the patients knew about the possibility of exemption from paying user fees. This is a significant difference in level of awareness about the user fee policy’s operational details. It appears that information about exemption is withheld from patients in order to collect as much money as possible. During informal discussions with health workers many acknowledged that the information is withheld from patients, which they justified by arguing that many people would falsely claim to be too poor to pay if they knew of the exemption policy.

4.4.5 Opinions about People Being Exempted

When the patients were asked for their opinions about people being exempt from user fees, most of the respondents agreed that some categories of people deserve to be exempt. Supporters of the exemption policy argued that some people who need treatment are, for some reason or other, unable to pay for treatment. Examples of such categories include those with chronic diseases, those who are incapacitated, accident victims and destitutes. Sixty-seven percent (233/348) supported exemption compared to 21 percent who were against any form of exemption and 12 percent who expressed no opinion on the matter.

4.5 Problems Experienced Since the Introduction of the User Fee System

When the patients were asked what problems they had encountered since the introduction of user fees, 63 percent (218/348) said that they had experienced some problems while 37 percent (130/348) said that they had not. Among the problems cited were overcharging, rude health workers, shortages of drugs and supplies and poor knowledge about how the system works.

Participants in most focus groups complained about the rude behavior of health workers, a problem which persists despite the fact that people now pay user fees. People in all the focus groups complained bitterly about the rudeness of medical staff. A frequent comment was: “A person pays money, but the health workers remain abusive or indifferent.”

Drug shortages, which are still a problem, become a sensitive issue once user fees are instituted. People expect full treatment after paying user fees (part of which are earmarked for drugs), but sometimes the drugs prescribed are unavailable. No refund is made in such cases.

Interviews with health workers confirmed that payment is normally made upon arrival, and that if any person is not satisfied with the treatment they cannot get a refund.

Most of the focus group participants had experienced the problem of shortages related to essential drugs like anti-malarials. The female groups even expressed fear that they were deliberately under-treated. One female participant said: “We are given injections diluted by water,” a statement which indicates that there may not be enough medicine available. The male focus groups tended to link these frequent shortages to the corruption among the health workers. This, in turn, was linked to the private clinics, which in some cases are operated by members of staff. “Perhaps the drugs that can be found in private clinics belong to the government clinics.” Participants in several groups made similar statements. This demonstrates the community belief that health workers steal drugs from government health units.

4.6 Low Salaries for Health Workers

Focus group participants said that health workers’ salaries were extremely low, too low to raise workers’ morale. Participants thought low salaries led to corruption. In Jinja, male participants thought that government has ignored the health sector for too long.

4.7 Exemption from Paying User Fees

We asked health workers the guidelines for exemption. The exemption criteria mentioned by most health workers included staff members and their relatives; people with chronic illnesses such as AIDS, tuberculosis and sickle cell anaemia; people in extreme poverty; HUMCs members and local council officials. The district provides broad guidelines for user fees and the HUMCs work within this framework to make specific guidelines for each unit.

4.8 Problems Caused by Exemption

With an exemption policy in place, income will be reduced. This is especially true for the big hospitals like Kawolo and Jinja hospitals, which have a large number of staff members many of whom were capable of paying but due to exemption guidelines get free treatment. Some health workers also abuse the system by granting exemptions to people who were not supposed to be exempt. This creates problems in the smooth running of the scheme and causes tension among staff members.

Another problem is the difficulty of judging whom to exempt. Many health workers argue that the definition of a poor person is relative and if every one were given a chance, nearly all people living in rural areas would claim the right to an exemption because of being poor.

4.9 Handling Money from User Fees

We investigated the management of the user fees and found that in most units there is a cashier or accounts clerk who receives and records all of the money that is collected. In two units out of 12 the in-charge receives money during the day and the staff on duty receive money at night. Receipts are normally given, and the money is deposited into a bank account for the health unit. Most hospital-based cashier/account clerks have had formal training in accounting, but those in the smaller units have simply learned on the job.

4.10 Knowledge of Management Committee Roles

The focus groups discussed the composition and functions of the HUMCs. In all of the discussions it was clear that most participants were unfamiliar with the operations, composition, roles and responsibilities of the HUMCs. One common statement was: “We do not know the members of the committee or what they do. They never invite us to their meetings.” One theme that emerged from the focus groups was that the members of the public have a very limited understanding of the selection process for and role of the HUMCs members. This gap in knowledge may be in part responsible for the friction between HUMCs and the community and the endless complaints.

4.11 Impact of User Fees

When asked to assess the impact of the user fees on health services, 63 percent of the patients said that services had improved considerably since the introduction of the user fees; 21 percent said that services were unchanged and the rest were unsure. The people who said that services had improved pointed out that medicines are now more easily available and that health workers now spend more time working at the health units.

Focus groups also discussed the benefits of user fees and singled out renovation and construction of buildings. In most health units the focus groups participants attributed the face-lifts that were taking place in the health units to the user fees. One female at Seeta-Nazigo said: “A new maternity wing that was set up solved the problem of having to travel long distances for delivery—thanks to cost sharing.” Another benefit cited was longer working hours of health workers. This was reflected in the following statement, with which many participants agreed, “These days whenever you come to a health unit you will find a health worker.”

When health workers were asked about the overall impact of user fees on the quality of care 89 percent (66/74) said that the user fees had brought about many improvements. However, most health workers were not in a position to discuss what fraction of the total health unit expenditures is met from user fees because they lack budgetary control. The Ministry of Health controls budgets for hospitals and the DMO manages budgets for small units. The fees contribute very significantly to the funds which are directly controlled by the health units. In the small health units user fees are the only source of money controlled at the unit level.

4.12 Views on the Future of User Fees

We investigated the views of the patients, the community and health workers to find out what each group thought about the future of user fees, and we obtained the following ideas. Only 22 percent of the patients suggested that the policy should continue in its present form. These were happy about the existing user fee system, and they did not see any need for making any changes.

A bigger group, comprising 43 percent (150/348) of the patients, argued that the user fees should produce tangible results in rural health units by helping to improve services, specifically by buying more supplies. Only 21 percent (72/348) of the patients suggested that user fees should be reduced, and 17 percent wanted the user fees to be abolished. The dominant view from both the patient survey and the focus groups is that if user fees bring about tangible improvements in services and infrastructure, the policy should continue.

4.13 Health Workers' Views about User Fees

Most health workers wanted the policy to remain in place, and many of their recommendations centered on better sensitization of the public and making cost sharing official government policy. Some 18 percent (13/74) felt that the amount charged was too low and wanted it to be raised to a more realistic amount. Only 4 percent (3/74) of health workers felt that fees should be reduced because people are too poor to pay current fees.

5. Discussion

Historically, government provided health care was free in Uganda. Over the years, however, official policy was overtaken by events. The extremely low salaries of health workers resulted in the widespread practice of informal charging. In 1987, the Health Policy Review commission proposed the introduction of user fees in order to boost income for the health sector arguing that patients attending government facilities were already paying anyway. The intense political pressure mounted against any moves to introduce user fees in public facilities has led the government to shift its position many times and to leave the policy unclear. In 1993, the government of Uganda adopted the local government bill, which effectively decentralized authority to the district level. Because of this, many districts began to review their own health financing schemes. Subsequently, virtually all of the districts have adopted the user fees policy and have begun implementing versions of it over the last five years or so.

The major findings from this study include:

- ▲ The absence of a national policy on cost sharing has created a leadership vacuum.
- ▲ Policies are emerging at the district level
- ▲ Negative feelings are developing in the community towards the government health system, especially regarding the implementation of cost sharing.
- ▲ There is a low level of awareness among the public about the operational details of cost sharing.

While the districts have embraced the user fees scheme partly as a mechanism to help them mobilize revenue to sustain services, the program faces several obstacles. First, lack of a central guiding role for the MOH in the operation of the policy is a major shortcoming. While decentralization allows the districts to take initiatives and to adopt policy decisions, the districts generally have weak capacity and skills to effectively formulate policies.

Secondly, there is a general lack of financial management capacity in the health units where the fees are generated. A sound financial management and procedural framework is required to facilitate collection and proper use of and accountability for funds generated. This study has revealed that corruption is apparently still widespread in government health units. Although it appears that some health workers engage in corruption in order to “make ends meet,” the situation may not be as bad as some of the interviewed patients and community focus groups suggest. For example, patients attribute all of the shortages of drugs and supplies to corruption, but it is widely acknowledged that the drugs supplied to most health units are sometimes inadequate. Another recently concluded study by Asiimwe and others (Asiimwe, D., et al.) shows that corruption is common in Ugandan government health units. It found that the commonest types of corruption include informal charging, “leakage” of drugs and funds from user fees and failure of health workers to work their assigned hours (with the mean facility time being less than 30 percent of the expected working time).

Lack of community mobilization prior to the introduction of the user fees scheme has created some resistance to the scheme. At the moment the official fees collected remain too low to have a major impact. In addition, the prospects for improving revenue collection is limited. Patients are

only willing to continue paying if the money is used to improve services in the health units. Contrary to consumer expectations, services in the health units have not yet significantly improved, and health workers are still corrupt and rude. The community is opposed to the implementation of user fees without improvements in the quality of care provided.

Another major obstacle to the user fees scheme relates to the general level of poverty in the community. In Uganda, mainly the poor go to government health units, while the better off members of the community mainly use private medical facilities (Okello, D.O., et al.). While patients attending private health services frequently pay for the full costs of treatment, those attending government units are still making only a token payment. This may have to be the case for some time if the most needy persons are to be provided health care.

This study provides several insights into the sustainability of the user fees strategy in Uganda. First and foremost, there is a need for community sensitization. The HUMCs should be acceptable and accountable to the communities they serve. The public is unhappy because major decisions affecting their well being are imposed on them.

Second, if all of the money collected at the health units were used to improve services, there would be better community acceptance of the scheme. In addition, the community would be convinced to continue paying.

Third, one of the reasons there is rampant corruption is poor remuneration of health workers. The apparent correlation between low pay and corruption has a major implication on the sustainability of the user fees program.

Finally, after broadly accepting and providing the guidelines for the fees, the districts have opted to transfer the responsibility for making the key decisions on user fees to the health unit management committees and to the lower level local councils. This means that many sensitive decisions are made at the lowest level possible and by the people most directly affected. This is good for sustainability of the scheme.

6. Conclusions and Recommendations

The implementation of cost sharing in Uganda has been problematic and has been characterized by public resistance and shifting government positions. Public resistance may largely be attributed to the government's failure to consult the public, public ignorance about the scheme and corruption in the system. Still, the scheme is gradually gaining acceptance and operating fairly smoothly at most health units even though the public continues to complain that it is riddled with corruption. Districts have started to institutionalize user fees into their health systems.

The positive impacts of user fees are evident in reports from most health units of repaired buildings, improved morale among health workers and improved availability of drugs and other supplies. Furthermore, the utilization of health units apparently recovered very quickly from an initial shock when attendance figures fell sharply after the introduction of user fees. What appears to determine attendance now is not the presence or absence of user fees, but rather the quality of care provided. Quality appears to have improved as a result of user fees.

The negative impacts of user fees to date include persistent corruption among health workers, public resentment of the scheme, and the possibility of the very poor being deprived of health care if they are unable to pay. In addition, at their current levels, the impact of user fees can only be small. In order for major improvements to occur in the health sector either user fees or government expenditure will have to be increased significantly.

Overall, if the positive impacts of the user fees can be sustained their scope in the future can only become larger and brighter.

On the basis of our findings, we proposed the following recommendations and submitted them to the Ministry of Health and the administrations of the study districts.

1. The Ministry of Health should formulate an acceptable policy on cost sharing in government health units in Uganda. This should be done after consultations with the districts that are implementing the scheme fairly successfully. A national policy is needed as a reference point and to give credibility to the districts.
2. District administrations should improve the capacity of the health units to handle cash. The DMO's office should supervise implementation of the user fees scheme by providing training in accounting for persons handling user fees, providing audit services for user fees and promoting transparency in order to eliminate corruption from the scheme at all health units.
3. The low level of community awareness about the HUMCs has created a negative feeling about their roles. There is need to sensitize the public about the HUMCs' roles. The HUMCs should hold more consultations with the communities that they serve. Public awareness on matters concerning the government health units needs to be promoted in the community. The community needs to get involved and to participate in all decisions related to user fees.

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