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Institute of Social Studies

THE IMPACT OF USER-FEE POLICY ON MATERNAL UTILIZATION OF HEALTH SERVICES: CASE STUDIES IN ZIMBABWE

A Research Paper presented by

Flora Sukoluhle Dlodlo

(Zimbabwe)

In Partial Fulfilment of the Requirements for Obtaining the Degree of

MASTER OF ARTS IN DEVELOPMENT STUDIES

Members of the Examining Committee

Professor J. Björkman
Dr. L.C. Hanmer

The Hague, December 1995

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MEMBERS OF THE EXAMINING COMMITTEE
Professor dr. J. W. Björkman
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The Hague, September 1995

DEDICATION

This work is dedicated to the memory of my beloved and favourite brother Mbalekelwa Joel Ngwenya (MJ) who passed away peacefully on the 3rd October, 1992. Your death left a gap in my life that nobody can ever feel. Although you have been gone three years now, I still cannot come to terms with your sudden death. If you were alive, I know you would have come to the Netherlands to share this achievement with me. You would have said as you always did: "Well done sisinyana". I miss you greatly. May Your Precious Soul Rest in Peace.

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CHAPTER 1: INTRODUCTION

Health is politics, and politics is health on a large scale.

Virchow

Policy related to health in many countries is rarely ever logical because in the majority of cases the steps that are known to be necessary for its improvement are seldom promoted or followed (Kouda 1995). Health is an open-ended and highly political concept whose boundaries and priorities vary from society to society.

The relative roles of the state and the individual vis-à-vis the promotion and financing of health care are influenced by policy-makers' views on health. Green (1992) sees different perspectives on how "health" should be viewed by policy-makers: either as a *consumption good,* an *investment* or a *right.* If health is viewed as a consumption good, then it is up to the individual to choose whether or not to get access to that good. The market forces play a major role and the government's role is marginal; it has only a regulatory function, mainly to maintain standards and protect against unfair competition.

Health as an investment recognizes the need of a healthy nation as instrumental in the overall development of a country. Governments will tend to intervene to ensure that the workforce, the backbone of the nation, has access to health services to ensure continued productive services. Health is seen as a means to an end and not as an end in itself. This would be in line with what Kelman (1975) sees as the capitalist definition of health. Health in a capitalist society is viewed as that organismic condition of the population most consistent with, or least disruptive of the process of capital accumulation, the capacity to effectively do productive work. Policies in this

society will aim at ensuring that resources allocated to social and government services are redirected towards private investment to get the economy back on its feet.

Then, there is the view of health as a right; the Constitution of the World Health Organization (WHO, 1948) states that: "... the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Zwi and Mills 1995). Since health service is a public good, it is therefore a government requirement to ensure that there is increased supply of this good, as the market will only provide it to the extent that there is a profit in providing such a service[1]. Most governments subscribe to this philosophy which provides a basis for government intervention in promoting its achievement. Policies are then formulated which try to overcome the obstacles of health gain such as poverty and health damaging development activities, thus promoting equitable access to health care and assuring the quality of available services.

There are policy implications of government intervention in financing and provision of health services. Firstly, whatever view the policy-makers have on health, a decision has to be made about the role that the government and the individual will play in financing the health services. While a few individuals can afford to pay, the problem arises in that if safety nets are not provided for the poor, they can be excluded from gaining access

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[1] Public goods are goods for which one person's consumption does not diminish another's and from which it is impossible to exclude non-paying members. They are socially defined and constructed: the outcome of complex political processes which evolve around the definition of public need in response to poverty and deprivation in society. Public goods, therefore, are a result of public action prompted by these perceived needs (Wuyts 1992 quoted in Gilson et al).

to the service. Secondly, considering the competing needs of the country and the scarcity of public resources, the decision to allocate resources to the health sector is in itself a difficult decision. It requires political bargaining both at intergovernmental and intragovernmental levels. Governments of the developing countries are under pressure from donors to withdraw from provision of health services and leave them to the invisible hand of market forces, and concentrate their efforts in the productive sectors of the economy.

1.1 Background to the problem

Zimbabwe's health policy was formulated to ensure equitable distribution of health services to the rural areas neglected during the colonial era. The available literature on Zimbabwe hails the country as having made impressive gains in providing health care to its people, especially in redressing the marked inequalities that existed before independence (World Bank Country Study 1992). Many problems, however, still remain because remote rural areas are still under-served and, due to unfavorable conditions of service, there is shortage of qualified staff.

As health services expand, so does government expenditure on both health services and salaries. Despite the expansion of health infrastructure and an increase in the health personnel trained, however, the goal of providing health care to its people and especially in redressing the marked inequalities that existed before independence, has not been reached. Due to fiscal constraints, the government now faces a mounting crisis in trying to finance the service.

The government has sought to relieve the funding constraints by seeking additional sources of revenue. User-fees have been introduced as a form of cost-sharing and revenue generation. The poor and those earning less than Z$150 (which was adjusted to Z$400 in 1990 because of inflation) are exempted from paying hospital fees. The problem is that the process they have to follow to get exemption certificates is very cumbersome such that they end up paying for the service which is meant to be free to them. The criteria used to qualify are difficult for the poor to understand and the information is not readily available until somebody goes to the hospital for treatment.

The current system is based on the assumption that those who should be exempted can be easily verified by requiring that they produce their pay-slips. However, most rural people are self-employed or work where no pay-slips are provided and, rather than face the embarrassment, some opt to pay for the service even though they cannot afford it. This negatively affects the poor people's access to health services.

1.1.1 Health Services during the Colonial Experience

"During the colonial period, the rulers used their political power to allocate to themselves the best services, amenities and income" (de Gaay Fortman and Mihyo 1993:152). Health services were primarily in the urban areas to serve the white community. Rudimentary health services were started not because of concern with the health status of the black population, but to protect the white community for two reasons (Loewenson & Sanders 1988):

- danger of epidemic diseases from blacks spreading to the white community.
- need to maintain a healthy labor force for use in mines and farming areas.[2]

Mine hospitals and infectious disease hospitals were established for the above reasons. Rural dispensaries and hospitals established in 1909-1915 by missionaries and government soon closed due to insufficient staff. Not until 1927 did government give missions grants to employ doctors and train nursing assistants. Rural health care began in earnest in 1928 when the colonial government started five dispensaries and hospitals in Mtoko and Ndanga districts. In 1931, the country was divided into large areas, each with a rural hospital surrounded by dispensaries within a 50 mile radius and supervised by urban general hospitals.

In 1948, the government embarked on preventive services with the appointment of four Provincial Medical Officers of Health. However, the bulk of the resources was channeled toward treating preventable diseases rather than actual prevention of those diseases. The gap between the white and black, urban and rural services widened with the rise of medical aid societies which aimed at serving the white community. Medical education's orientation was toward hospital-based curative care and limited the entry of black students into the medical field.

Herbst (1990:66) provides the following statistics (in Table 1):

---

[2] The British administrators used the same system in Sri Lanka to protect its expatriate population from epidemic diseases. This colonial outlook ensured that government intervention was limited only to matters directly connected with commercial interests (Björkman 1993:10).

Table 1. **A Comparison of Access to Health Care for the White and Black Population.**

	WHITE POPULATION (230 000)	**BLACK POPULATION (7 million)**
doctor/patient ratio	1 : 830	1 : 50 000 to 1 : 100 000
hospital beds per patient population	1 per 219	1 per 525
annual health expenditure per patient	$144	$31 urban; $41 rural
infant mortality rate per 1000 live births	17	120 - 220
disease pattern	degenerative diseases, stress, cancer	malnutrition, air, water and vector-borne diseases

Facilities and personnel were concentrated in urban areas with 75 percent of the rural area residents receiving treatment from mission hospitals. It is estimated that 60 percent of the rural health service was provided by mission hospitals, while 40 percent was provided by government district hospitals and rural council clinics.

1.1.2 Post-Independence Health Policy

Articles 13 and 16 of the African Charter on Human and People's Rights states that "*each person has a right to health and to medical care when sick.*" "*Each citizen must have equal use of the country's public service and property.*" Zimbabwe, as a

signatory to this charter, set out to redress inequalities in the health care system by transforming it into an integrated National Health Service. It identified the problem as **inequitable distribution of health services.** The solution to the problem was seen as the adoption of the World Health Organization's Alma Ata Declaration of **"Health for All by the Year 2000". Primary Health Care** was adopted as the policy guideline. Primary Health Care is defined by WHO as:

> "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community by means acceptable to them, through their own participation, and at a cost that the country and community can afford to maintain, at every stage of their development, in the spirit of self-reliance and self-determination" (WHO 1979:2).

The Health for All concept created demand for health services; encouraged people to go to the health center even for minor ailments. The rationale in most cases was that the service was available, accessible (health center within eight kilometers of each village) and affordable (it was free). Furthermore, the politicians had preached that health care was a right and had made converts of even those who were not comfortable with visiting a hospital. The policy focused on preventive measures with emphasis on:

1. Development of health services for maternal and child health in order to reduce the mortality rate among infants and to improve nutrition in this group.
2. Building more health centers in rural areas with the objective of establishing a health care facility within eight kilometers of each home, thus removing rural, urban, racial and class biases in health care.
3. Provision of free health service to people earning less than Z$150 per month.

4. Increasing **community participation** in the planning and control of services, by teaching village health workers who are the community-based personnel, thus helping people to participate from the village level upwards.

1.1.3 Structure of the Health Services

The health structure in Zimbabwe is hierarchical. There are:

- four Central hospitals distributed equally between Harare (the capital city) and Bulawayo (the second largest city);
- eight provincial hospitals;
- 28 government district hospitals in the country's 55 districts, two of them being mission hospitals;
- local government clinics in most of the major cities which act as the first line of treatment for the local residents. Some clinics have maternity services for people who do not need specialist treatment, thus reducing the numbers of people who go to the central hospitals;
- rural health centers with mobile outreach teams that serve surrounding areas, especially commercial farming areas and isolated clinics whose population might require specialized care from health center staff not available at those localities; and
- village health workers who provide the link between the health center and the community.

These latter cadres receive minimal training on hygiene, identification of people at risk who might need treatment at the health center and treatment of minor ailments from the staff at the health center. Village health workers are taught basic record-keeping are expected to attend all mobile health clinics, and they also help to mobilize the people in their community in order to involve them in matters related to their health. In

some cases, the village health workers, in conjunction with the village development committees, encourage communities to participate in competitions on a health issue of concern to the community. The community that most vividly communicates the message wins a prize which can be used in the development of that area. Primary health care is linked with the referral system through the district medical officer or, if not available, the clinical officer.

1.1.4 Role of Other Service Providers

Nongovernmental Organizations

Nongovernmental church-related organizations in Zimbabwe started as relief organizations whose main interest was the alleviation of poverty and the spread of the gospel. The shift to social services came as a realization that people needed to be self reliant and that hand-outs were not the answer to poverty alleviation. Hospitals and clinics were built in most of the remote rural areas that did not have any government services.

In 1973, a Medical Missions National Workshop identified the need for a national organization to represent the interest of church related personnel and institutions. This organization, the Association of Rhodesian Christian Hospitals (ARCH), was inaugurated in 1974. The name changed at independence in 1980 to the Zimbabwe Association of Church Related Hospitals (ZACH). Article 11 of the Constitution states the following as the aims of ZACH:

1. To encourage and promote the highest standards of Christian medical care among its members for the benefit and welfare of the people of Zimbabwe.
2. To facilitate and coordinate the relationship of the members with the Ministry of Health. Although the association shall in

no way interfere with the autonomy of member institutions, all official relationships with the ministry shall be carried out as far as possible by, and in conjunction with, or with information to the authorized representative of the association.

3. To encourage the meeting together of member institutions at provincial level.
4. To assist the members of the association with respect to the procurement of staff for, and provision of supplies to the hospitals or other medical institutions maintained or controlled or supervised by any member of the association.
5. To assist in planning and coordinating the programmes and other medical work or services of the members of the association.
6. To do such other things in cooperation with members of the associations are conducive to the attainment of the above objects, or any of them generally to act for the benefit of the and the welfare of the people of Zimbabwe.

ZACH is not a legislative or policy-making body and does not infringes on the authority of the governing boards of member institutions or the organizations represented. It can however, offer advice to the person in charge of the institution on matters concerning policy making. The elected management board of nine members meets every two months. ZACH, through the management board, appoints an executive secretary who is responsible for the day-to-day administration of the association's affairs. The membership of ZACH in 1994 stood at 110 hospitals and clinics with a large majority in the rural areas. It is estimated that the association accounts for 68 percent of all the beds in the rural areas. The health facilities vary in size from small clinics with less than 20 beds to district hospitals with more than 200 beds. Through its Missions Section, the Ministry of Health pays all the salaries

of staff employed at the Mission Hospitals plus almost all approved recurrent expenditures.

Most of the doctors' posts are occupied by expatriates with very few Zimbabwean nationals working in the rural areas. Doctors' posts at few hospitals are vacant because their location is said to be too far from the city. Also, there is no incentive for people to work in the rural areas where the staff feel isolated. This produces a strong temptation to work in the urban areas because one can enter private practice which pays more. This problem is not peculiar to Zimbabwe alone; in his research on the health system in India and Pakistan, Björkman (1993:8) reveals that there is under-employment of urban-located physicians who have refused rural postings.

Private Hospitals

The private sector provides health care for its employees through its clinics. This measure ensures that the workers can be serviced at their work-place, thus reducing on time spent traveling to and from government health centers. Some mine and industrial hospitals and clinics are open to non-workers in the surrounding community who can afford to pay.

Private individuals and some churches (notably the Roman Catholic Church) have also started hospitals which cater to a particular clientele, the elite. Located in the big towns, these hospitals are very expensive and therefore inaccessible to the poor and those who are not members of the medical aid societies.

Traditional Healers and Birth Attendants

An important option in the Zimbabwean health care system is traditional medicine, which is usually the first choice for many

or else used in parallel with the so-called modern medicine. The choice between the two types of medicine depends on the perceived origin or cause of the illness. If the people feel that there is some supernatural phenomena causing the disease (witchcraft, ancestral spirits and so forth), they seek the services of traditional healers. However, if it is perceived to be due to natural causes, they seek modern medicine. This does not, however, exclude the possibility of seeking the services of a traditional healer at the same time or later if modern medicine does not give the expected relief.

The colonial government tried to discourage the use of traditional medicine by labeling it as primitive and unscientific and its providers as witch doctors, but these efforts did not deter the people since traditional medicine was deeply rooted in the culture of the people. The post-independence government was aware of the importance of traditional medicine and brought the healers in as partners in health care delivery. The Zimbabwe Traditional Healers Association was formed to coordinate the work of these healers. Seminars were held for exchange of information and also to teach the healers about hygienic methods of work. Emphasis was mainly on avoidance of contamination between patients, and to discourage the use of one razor-blade for all the patients since the AIDS virus is spread by blood.[3] Traditional midwives, who were mainly household-level women, had their skills upgraded in identifying at-risk pregnancies, basic midwifery, elementary hygiene and basic child care (Davies & Sanders 1988). They were each given surgically clean birth-packs to use during delivery. Their supplies could be replenished when they became low.

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[3] Traditional healers used to use a single razor blade or surgical blade on all their patients to cut the skin in order to introduce medicine. There was a danger of contamination with such a procedure.

This recognition by post-independence government improved the relations between the two sectors which no longer needed to regard at each other as adversaries but as partners in health delivery. Traditional healers are now invited to lecture at health training institutes so that the trainees can be aware of their methods of treatment and their theories of disease and disease causation.

1.2 OBJECTIVES OF THE STUDY

The primary research upon which this study draws was carried out in Zimbabwe by Hongoro (1992) and examined the impact of the introduction and enforcement of user-fees in 1991/92 with a major focus on the public health care system. The sample included government hospitals at national, provincial, and district levels and two large mission hospitals. It is important to note that this study also coincided with the worst drought in Zimbabwe since the 1950s. Results obtained, therefore, could also be due to this factor. It can be argued that the procurement of basic food items rather than health concerns became the priority during the drought.

This study concentrate on rural health centers where most of the poor are concentrated, and addresses the following:

- the main issues that affected access to health services before the country got its independence in 1980;
- the progress (if any) in improving the access to health services after independence; and
- the implementation of the user-fee policy as a strategy to inject additional money into the health sector in view of fiscal constraints.

Focus will be on the implementation of the user-fee policy, and its impact on maternal utilization of user-fees. Implementation

will be viewed as a process of ongoing policy execution (Lane 1993). In this analysis, the focus will be on the operation (implementation as a process) of a public policy (user-fee policy) and its consequences (impact). The following issues will be addressed:

- the exemption criterion used and its relevance to the rural population;
- an analysis of the method of dissemination of information to the users;
- the mechanics/methods of collection of fees and, if possible, the administrative costs involved; and
- the impact of the fees on the use of services, as represented by maternal antenatal and postnatal health services.

Data on clinic attendance from two rural hospitals and two clinics in Matebeleland North and South Provinces was used to analyze changing uptake by rural women of these services. When data are available, it is preferable to evaluate the impact of the fee on a particular condition (in this case pregnancy) on attendance for that particular "ailment" (WHO 1994).

This research has chosen pregnancy as opposed to other illnesses because its demand is predictable and it is not a random event. It is assumed that, when people book to deliver in the hospital, they will honor that pledge. If they book and then never utilize the service and if that action coincides with the introduction of user-fees, then it can be assumed that non-utilization was directly related to the introduction of those fees. In other illnesses, however, non-attendance could be due to a variety of reasons which can be difficult to monitor. For instance, people might not attend because they are healthier than the previous year (in times of economic boom) or that they just did not feel ill enough to go to the health center.

The study also seeks to highlight any other aspect peculiar to Zimbabwe which might be missing from available literature on other forms of financing the health services, especially in the rural areas where most of the poor are concentrated.

1.3 RESEARCH QUESTIONS

The following questions will be addressed by this research:

- What is the impact of the introduction of user-fees on utilization of health services by the rural population?
- What is the impact of the enforcement of user-fees on access to health services by the pregnant women?
- What is the method used to collect the fees and what are the administrative costs involved?
- Are there any alternatives to user-fees, including alternative criteria to the present system of exemption in the rural setting?

1.4 HYPOTHESES

Although demand for health care varies from individual to individual, the introduction of user-fees leads to a decline in the utilization of health services by the rural poor. The enforcement of user fees will have a greater impact on the uninsured who have to rely on out-of-pocket payments. This decline in the utilization of services will be evident in maternity patients, leading to a general increase in the use of other services like those of traditional midwives who provide alternative services, sometimes at a lower or non-monetary cost.

There will be very little effect on utilization of the services by government employees and the middle or upper class people who have access to medical aid through health insurance. The only setback for them is that the rural health centers are not equipped administratively to deal with insured people. They are also not registered with the insurance companies nor are they administratively equipped to handle the paper work involved. It is a requirement that only those institutions with a registration number can make claims to the Medical Aid Societies. The insured would, therefore, be required to pay out-of-pocket and not be able to get reimbursement for that payment.

The author is aware that the primary-health-care concept requires that the service should be acceptable, accessible and affordable to the community (WHO 1979:2). One can, therefore, argue that the introduction of user-fees shifts the people's choice to a service that they can afford and that, therefore, it has achieved its goal. This would only apply if people willingly choose that particular service (making an informed choice) rather than doing so out of desperation (forced by circumstances). A change in utilization due to the introduction of fees fits the latter statement.

1.5 METHODOLOGY AND SOURCES OF DATA/INFORMATION

The study is descriptive and analytical. An attempt has been made to utilize available literature on the health services in Zimbabwe both before and after independence. Secondary data, mainly from the library at the Institute of Social Studies, the Tropical Institute in Amsterdam, the African Studies Center in Leiden and also data from lecturers who have worked in Zimbabwe has also been used.

Two questionnaires were sent to the Brethren in Christ Church hospitals to collect data on rural clinic and hospital attendance and uptake of health services by women from 1990 to 1994. I have used (to a limited extent) my personal experience as a nurse in both the urban and rural setting, and as a former Administrator and Coordinator of the Brethren in Christ church hospitals in interpreting some of the data provided by the health centers.

1.6 SCOPE AND LIMITATION OF THE STUDY

Starting at the period before 1980 and using the records available, the study concentrates on the Ministry of Health services in Zimbabwe. The focus is on the rural areas which have been the concern of the government since independence. The study is limited by the availability of primary data due to time and financial constraints which makes it a less than exhaustive study.

1.7 ORGANIZATION OF THE STUDY

Chapter One gives the background to the problem including the history of the health services in Zimbabwe. Objectives of the study including the guiding hypotheses, research questions, limitations of the study, the methodology and sources of data are also discussed and form part of this chapter. Chapter Two discusses the theoretical framework with emphasis on issues related to access and implementation, debates around user-fees and the determinates of demand for health services. An analysis of access to health services in Zimbabwe covering the period before and after independence forms the part of Chapter Three. Chapter Four analyzes the effect of User-Fees on the utilization of health services using information obtained from four rural

health centers in Zimbabwe. Chapter Five provides the summary and recommendations for future policy change.

CHAPTER 2: THEORETICAL FRAMEWORK

INTRODUCTION

This chapter discusses the theoretical framework on which the study of health services in Zimbabwe is based, placing emphasis on the issues related to access and implementation. An overview of the studies that have been done in countries in Sub-Saharan Africa and other developing countries on the impact of the introduction of user-fees and the determinates of demand for health services is made. The experiences that these countries have gone through might assist Zimbabwe in planning for future policy change.

2.1 ACCESS

Smith (1988) states that access refers to the rights created by the state that lead to claims by members of the public to goods and services to which they believe they are entitled. At independence the people were told that access to health services was a right and not a privilege, and that every person could utilize that service whenever they needed it. The problems that arise from the relations between the provider of goods and services and the client are quite different from those of a supplier and a consumer. The difference is that in the former the service is provided in response to a need whereas in the latter it is a demand and supply relationship.

He sees three main obstacles in the access relationship to social services, namely the *gate*, the *queue* and the *counter* that one has to pass through to qualify for the service. The *gate* states who qualifies for exemption and the criteria used. The *queue* is the system that arranges eligibility in order of priority because of the scarcity of resources. The offices where

one encounters the providers of the service is termed the *counter*. This is where one comes face to face with an official who has discretion to decide on the eligibility of the applicant and the level of the entitlement following laid down rules and regulations.

In the health service in Zimbabwe, to qualify for exemption, the client has to prove that he/she is poor and that his/her monthly income is less than Z$400 which must be verified by presentation of a pay slip or an exemption card from the social worker. This is based on the mistaken assumption that everybody has access to one, and for the wives whose husbands work in the city, that they have easy access to the husband's pay slip. In reality, some wives have no idea how much their husbands earn and, even if the pay slip were available, they have no access to it. There is also a lack of clear information for the implementers on other alternative criteria to use, if the income cannot be used as a basis for exemption. The implementers of policy then sometimes have to resort to arbitrariness and can abuse that privilege to the detriment of the poor.

2.2 IMPLEMENTATION

Implementation is a process of translating the policy decisions, programmes and objectives into action programmes, in order to realize a specific goal which can be either tangible or symbolic. It involves day-to-day administration of programmes and continuous follow-up to ensure that programmes are proceeding as planned (Björkman 1986:295, 1993:2).

Webster's dictionary defines implementation as: *carrying out, accomplishing, fulfilling, giving practical effect to and ensuring of actual fulfillment by concrete measures, providing instruments or means of practical expression.* Lane (1993) takes

it further to mean "bringing about by means of outputs, of outcomes that are congruent with the original intention(s). The task of implementation is to establish a link that allows goals of public policies to be realized as outcomes of governmental activity (Grindle 1980).

Policy implementation is not the prerogative of central government only, but involves co-existence of government and nongovernmental agencies at both macro and micro level. Empirical studies have shown that the implementation of social policies, especially health policies, is always difficult. This is due to the fact that local organizations responsible for implementation are relatively independent of central control. These two levels have different sets of problems (Altenstetter and Björkman 1981). Central government has to execute its policy in order for the local organization to implement it in the way desired by government; this is the macro implementation problem. In response to central government actions, local organizations have to operationalize those policies (since they are usually broad); this is the micro implementation problem.

Most of the problems of implementation can be successfully identified and addressed at the design stage. Policy does not operate in a vacuum but within a particular environment which can positively or negatively affect its implementation, it can make or break a policy's success at implementation. The issue of user fees needs to consider the institutional environment under which the policy is being implemented. Are there any incentives to collect the fees? Are the fees collected utilized at the health center, for example for drug purchases or ongoing health center improvement? There is a need to adjust to the task environment. The Contingency Hypothesis states that an organization functions effectively if there is a fit between the contingency factors (environment), and the design parameters

(Mintzberg 1979). The environment includes among other things, public environment (target group), administrative, social, economic, cultural and political environments.

The government of Zimbabwe has had problems in ensuring that it provides services to the whole population because of the scarcity of both human and material resources. In an environment where the bulk of the population is relatively poor and rural, financing the health services has tended to fall heavily on the government. As a condition for receiving aid, the donors have advised the government to move away from subsidizing the health sector and concentrate its efforts on the economic sectors that will get the economy back on its feet.

2.3 USER FEES

User charges are one way of raising revenues for the health system and are meant to recover the costs of operating the service (Lewis 1993). Fees for a service can be used to ration service among users or to direct their attention away from it. They can also act as signals indicating the importance of alternatives, creating competition and forcing the consumer to make a choice between two or more alternatives (Björkman 1986).

User fees have been accepted as a reality since the 1980s. The issue is no longer whether or not to introduce them, but how they should be introduced (Gilson et al. 1995). Proponents of user fees base their arguments on the principles of neo-economic theory which have to do with:

> *"...the notion of efficiency in the use of scarce resources. The basic argument is that no one should consume a good or service unless its value to them at least equals the value of the most useful alternative goods and services*

that could be produced with the resources used... health services provided for "free" will be used only by those for whom they are of significant value, but also by those for whom the value of the service is only slightly greater than zero...it is for this reason that fees are suggested as the means to differentiate among those who truly "need" the service and those who do not" (Akin 1986, in ibid:371).

To be effective, they claim that revenue generated should be used at the health center to improve health care offered to the poor, by strengthening the services most relevant to their need, like primary health care. Revenues need not all be retained but a significant portion has to be. This also acts as an incentive for the health center to collect fees. For instance, in Jamaica revenue collected rose from four percent to 28 percent of the hospital operating budget after new regulations allowed the hospital to retain 50 percent of fee revenue (ibid:373).

In Zimbabwe, the collected fees go to the Ministry of Health indirectly because all income collected is reported and the ministry deducts that amount from the vouchers sent in for recurrent expenditure payment. The more fees collected, the less money the institution receives; this leads the administrators to either under-report, or collect less fees intentionally.

Cost recovery measures in Sub-Saharan Africa have produced almost the same impact on the utilization of health services by the poor. The impact has ranged from a boycott of the services in preference of a cheaper alternative where payment is calculated based on results, self medication or letting the disease take its course (Hanmer 1994; Hongoro 1992; David Booth et al. 1994). The same result has been noted even where there is an attempt by government to exempt the poor from payment of the fees if they fulfill certain criteria. The problem in all the

cases is that the target group approach ("the poor") has its own shortcomings, in that the intended beneficiaries are excluded or their benefits actually "leak" to the "non-poor" (Cornia & Stewart 1993, in Hanmer).

The vital step in developing an exemption mechanism is to identify the target group. Direct targeting (used in Zimbabwe) is based on the income level. People with an income below a certain level are exempted from payment of fees. Characteristic targeting is based on the general characteristic of groups of people to identify those who are eligible for protection. These groups can be based on the following characteristics (Gilson et al. 1995):

- geographical - groups within a given area receive subsidized care (for example, low income, at risk);
- demographic - subsidy based on age and sex (for example, under five, elderly);
- health or medical condition (for example, antenatal/postnatal care, immunizations or chronic diseases like mental illness);
- occupation - for example, ministry of health employee, military personnel, civil servants.

There is some disagreement about inclusion of the last group because it is assumed that they can afford to pay for the health service and should therefore be excluded. The argument for including them is that public servants are, in most cases, underpaid and have unfavorable conditions of service. This fringe benefit is meant to address this problem and also to prevent brain drain to the private sector which has more fringe benefits and higher salaries.

While direct targeting contains costs associated with excessive coverage of the non-poor by enabling collection from those who

can pay thus facilitating cross-subsidization by the wealthy of care provided to the poor, it has certain shortcomings (see Table 2). Most countries in Sub-Saharan Africa rely on the size of income as a measure of poverty, but this criterion seems to overlook the problems peculiar to these countries. Data on income and prices needed to get the poverty datum line are scarce, which means that there is no clear proof of income for the economically active people like the informal sector, subsistence farmers and self employed people. It is also expensive for both the government to verify all the required information, and the client in terms of transport and time. This leaves the system open to abuse by those people who have the discretion to issue exemption cards (Hanmer 1994). It is also more stigmatizing than characteristic targeting.

Characteristic targeting is said to be easier, cheaper and requires less information to identify those eligible, and is also less stigmatizing than direct targeting. It offers few incentives to distort behavior in order to gain eligibility since various population-groups, not just the low income are eligible for benefits. Using health condition as a criteria for eligibility makes the job easier for providers and users and administrative simplicity. It has greater potential, in theory, to cover all poor even though some benefits accrue to the non-poor.

Appendix 1 gives selected health care exemption experiences for developing countries and the newly industrialized countries (NICS). It shows some of the problems of targeting and the resultant effect on the poor. Gilson et al. (1995) caution against hasty introduction of user-fee policy as such policies have been proved to have a potentially damaging impact on equity, and current understanding of the processes mediating that impact is limited.

Table 2. **The Potential Targeting Options for Policy-Makers.**

	Direct Targeting	Characteristic Targeting
Ability to cover all eligible	Lower	Greater
Leakage to non-eligible	Lower	Greater
Information requirements	Higher	Lower
Administrative costs	Higher	Lower
Administrative capacity	Higher	Lower
Dangers of stigmatization	Higher	Lower
Behavioral/incentive costs	Higher	Lower
Self-selection possibilities[4]	Lower	Higher

Source: Glewwe and van der Graag (1988); Willis (1993) (adapted)

2.4 DEMAND FOR HEALTH SERVICES

The industrialized world and the Third World face complex dilemmas when it comes to dealing with the health sector. Björkman (1986:281-282) states that despite countless funds being allocated to the health service in the north, there is still insatiable demand for health care that threatens to outstrip supply, making the industrialized countries victims of their own successes. The increasing demand means that:

- those who can afford to pay will demand health care even for minor ailments;

[4] Self-selection mechanism is dependent on public provision being of inferior quality to private provision. People with sufficient money will try to avoid the stigma of being "pooled" with low-income users, and the prestige of using a private institution provide additional disincentives to this group's use of free, public care (Gilson et al. 1995).

- new treatments for previously incurable diseases are now possible but, at greater cost with few lives saved;
- costly routine care for the elderly whose population is increasing, as a result of new advances in science and technology, is on the rise;
- new treatments for curable diseases and expanded coverage for poorer sections of society are now available.

Problems in the developing world tend to be a result of the following factors:

- scarcity in resources allocated to the health sector despite the political rhetoric. It is estimated that the total budget for health is less than two percent of Gross National Product.
- consumption of resources by capital intensive, high technology, low productivity investments.
- health systems which have an urban bias with very little pressure from the masses.

Despite these differences, there are some similarities in these countries, namely that the health service is a greater source of employment and affects the lives of all citizens because it contributes to the quality of life. Scarcity of resources is also common in all countries.

What factors influence demand for health services in any community? The World Health Organization (1994) in a Health Seminar Study proposed that the demand for health services will be affected primarily by the accessibility, the price one has to pay for such service and the mode of payment. The mode of payment affects the utilization of the service, depending on whether the health center charges are per visit or per course of treatment and whether the charges are all inclusive. People will tend to favor payment per course of treatment especially if

drugs and other services (for example, X-Rays) are included in the initial charge. If, however, they have to pay each time they attend, they will be less likely to come back for subsequent treatment, even if they are required to do so. The effect will be more for the poor who have no resources to pay (monetary) even at nominal prices. People will only go to the health center when the disease is life threatening, unless someone else pays for the service needed. It will also be affected by the availability of alternatives, such as self-medication or the services of a traditional healer or other organizations providing a cheaper comparable service.

The opportunity costs in terms of waiting time, transport costs to the health center or the social welfare officer for an exemption certificate, and lost output also play a great role in the rural setting. Screening of patients is time-consuming and leads to delay, especially during the agricultural season when marginal productivity of labor is significantly greater than zero (Hongoro 1991).

Demand also varies overtime in the rural setting. During harvest time, for instance, more people have the means to pay for the services they need. It is thought that to reduce non-attendance there should be prepayment for health services during those periods when people have the means to do so. Premiums or capitation fees could also be used and have an advantage because they are affordable and can be enforced by the community once institutionalized.

Among studies on determinants of demand for health care in developing countries using the criteria of user-fees, time and distance from health center and cultural factors; several concluded that there was a significant drop in the utilization of health services after the introduction of user-fees. It was

also demonstrated that, at low income levels, demand for health care (all things being equal) is more elastic with respect to price among the poor than in high income groups. In his study of the Philippines, however, Akin (1986), found that price, income and quality of service have little influence on demand by low income groups, while Fournier, (1991) discovered that a large increase in fees resulted in a substantial drop in utilization of health services in Zaire. Studies on Kenya by Moses, Manji, Bradley, Nagelkerke, Malisa and Plummer study (1992) revealed a drop of 74 percent in sexually transmitted diseases clinic attendance after the introduction of fees. Waddington, Enyimayew, (1989, 1990) and Yoder (1989) on their studies in Ghana and Swaziland respectively found that user-fees strongly influenced the choice of structure for health care one would utilize including the health sector that was chosen. In both cases, the tendency was to go to a place that charged lesser fees.

Other authors have argued that the utilization of services only drops initially and increases once people are used to the new policy, which is inevitable in any change process. If within the cost-recovery policy package user-fees are complemented by decentralization, and combined with two targeting mechanisms that favor the poor through exemptions and use of collected revenue to improve the services offered to them, it is assumed that equity and efficiency gains can be achieved (Gilson _et_ _al_. 1995).

This study attempts to ascertain which one of the above arguments is applicable in the Zimbabwean situation. The user-fee policy could also possibly have an unstated objective of reducing the utilization of the health service since universal access to health services since independence has cost the country a lot of money. In the western world, charges have been

used to curtail health service use, which is also a way of saving tax-payer's money for other services while at the same time discouraging would be abusers of the health services. This objective, however, is never stated in policy statements because it can potentially be politically damaging.

SUMMARY

In an effort to ensure efficiency in the use of scarce resources policy-makers introduce user-charges as a way to differentiate between those who truly need the service and those who do not. To identify those people eligible for free services, the target approach is frequently used. The direct and characteristic target approaches are problematic and might be an obstacle to access to social services, thus missing the intended beneficiaries. Direct targeting, which is based on income, is not suitable for the rural setting because of scarcity of data, yet this is the approach used in both the urban and rural setting in Zimbabwe.

The demand for health services is also affected by the price one has to pay for such service, the mode of payment and the opportunity costs involved. In the majority of the studies done, the consensus is that user-fees have a negative effect on the utilization of health services by the poor.

CHAPTER 3: AN ANALYSIS OF ACCESS TO HEALTH SERVICES

INTRODUCTION

The priorities of any government can be easily seen in the way it distributes its budget, despite the political rhetoric. In most cases the policies formulated clearly state how the budget will be distributed, but in the majority of cases it is not always the case. The distribution of the budget during the colonial period deliberately benefited the white, colored and Asian community, with the white population getting the best. The blacks only received just enough to keep them free from spreading disease. At independence policies were changed to ensure universal access to health services, and affected the way the budget was distributed. This section makes an analysis of:

- post-independence government budget distribution and health sector allocation;
- access to health services under the colonial government, the changes introduced at independence and the introduction and enforcement of fees in the decade after independence.

3.1 HEALTH BUDGET AND DISTRIBUTION

The allocation of the national budget brings forth a lot of concerns. Certain decisions have to be made concerning the following:

- **Given total resources, how much should be spent on health?**

Table 3 shows the budget allocation for those ministries that have persistently received the top 25 percent of the Zimbabwean government budget for the years under study. The Zimbabwe

Cabinet has 18 ministries. The trend has been the same since independence where the Ministry of Health has always maintained third or fourth place in budget allocation, which shows the importance attached to health. The total budget for health care has, however, decreased in real terms if one considers that inflation has been ranging between 30 and 40 percent since the mid 1980s.

Table 3. **Estimates of Expenditure for the Years 1992-1995 in Z$ '000**

MINISTRY	1992/93	1993/94	1994/95
Education and Culture	Z$2 051 586	Z$2 312 991	Z$2 974 856
Lands and Agriculture	Z$1 393 478		Z$1 043 018
Defense	Z$1 377 415	Z$1 532 180	Z$1 699 200
Health	Z$722 780	Z$873 208	Z$1 066 839
Public Construction		Z$888 793	

Source: Adapted from Estimates of Expenditure Presented to the Parliament of Zimbabwe.

- **Given health sector allocation, what will be the best use of the money for services, materials and personnel?** (see Table 4 and Table 5)

Table 4 shows where the money is being spent. Medical care services comprising mainly of government obligations to maintain existing services, consumes the most followed by preventive services. The government commitment to those services that benefit the poor is illustrated by ensuring that preventive services receive a larger share of the budget. Research

surprisingly receives the lowest budget allocation although it is the pillar of health and development.

Table 4. **Budget Distribution within the Ministry of Health**

Allocation by Service	**1992/93**	**1993/94**	**1994/95**
Administration and General	Z$20 055 000	Z$21 170 000	Z$25 720 000
Medical Care Services	Z$573 300 000	Z$733 020 000	Z$905 559 000
Preventive Services	Z$110 290 000	Z$114 113 000	Z$129 565 000
Research	Z$3 135 000	Z$4 905 000	Z$5 995 000

Source: Adapted from Estimates and Expenditure 1992-1995

The rapid and continued expansion of the health services since independence has led to an increase in personnel with an accompanying increase in salaries and allowances (Table 5). Salaries have also been raised partly in response to strikes by health personnel demanding better conditions of service, and to prevent the brain drain to neighboring countries like Botswana and South Africa. Salaries and allowances have therefore continued to take the bulk of the allocation since independence.

- **What will be the best use of allocated resources in a given area or district?**

In any country, development needs differ from area to area with some areas having more resources than others. This means that allocated resources should be channeled to those areas that are still in need. Even within the same district, one area might be more developed than another. In Zimbabwe, regions closer to the bigger cities had better access to health services than those

areas in the remote parts of the country. Resources were then used to either expand the existing infrastructure or in building new health centers and training of personnel to staff these facilities.

Table 5. **Budget Allocation within the Ministry of Health**

Allocation by Use	**1992/93**	**1993/94**	**1994/95**
Salaries and Allowances	Z$325 528 000	Z$401 765 000	Z$446 175 000
Grants	Z$268 953 000	Z$287 465 000	Z$217 055 000
Supplies and Services	Z$113 400 000	Z$201 400 000	Z$240 100 000
Other	Z$66 797 000	Z$67 830 000	Z$76 359 000

Source: Adapted from Estimates and Expenditure 1992-1995

The above concerns entail the use of power in the selection of policy options (Björkman 1988:285). In most countries in the developing world, budget in health services is incremental and often does not take into account the rampant inflation. Although this is intentional, in the majority of cases, data on which to make policy decisions is often unavailable or insufficient. Intuition then becomes the guide to future policy. There is absence of a coherent framework of policy analysis in the health sector and health service research, and a lack of understanding of linkages between health and development, despite its often being preached on the political platform.

Evidence from Zimbabwe shows that despite a massive increase in the health centers, accompanied by aggressive training of personnel to staff these centers, the budget is still incremental and tends to be based on the last allocation, with minimal adjustment for inflation. The other service providers are being encouraged to contribute more funds to the health

service. The government has hinted at future plans to withdraw its contribution to the mission hospitals' recurrent expenditure budget to encourage them to be self-reliant. This withdrawal of funds might force these institutions to pass on the costs to the consumers (patients), if they are to still provide the same standard of care. Those patients who are unable to pay will find it difficult to gain access to these centers in future.

3.2 FINANCING THE HEALTH SERVICES AND ITS EFFECT ON ACCESS

3.2.1 Under colonialism

Health services under colonialism were segregated according to the race of the individual as were all the other services. Most of the patients of other races other than the blacks were on medical aid (health insurance). The colonial government provided tax exemptions for medical aid payments including reimbursement for drugs above a certain limit. Those who could not afford health insurance received assistance from Social Welfare. Blacks were, however, not covered by medical aid societies and Social Welfare.

The health service for blacks in government hospitals was heavily subsidized by the revenue received from the white, colored and Asian hospitals[5]. There was one flat rate for all inpatients, which included all services provided by the hospital irrespective of length of stay. The hospitals were not as well-equipped as the hospitals for the other races, they just provided the minimum services required. The rural community

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[5] In Zimbabwe people of mixed ancestry (white & black or any other colour and black) are referred to as coloured. They received the same allocation of resources as the people of Asian origin which was better than that allocated to blacks, although not equal to what the whites were receiving. This separation created tension between the blacks and coloureds, which has continued up to this day.

received their health care from a few mission hospitals that were available, but could not adequately provide the care for all the people who needed it. Since these institutions relied on donations from well-wishers both internally and internationally, they charged minimal fees to cover the costs of operation. A few mission hospitals received a partial grant from the colonial government.

3.2.2 The Decade After Independence (1980-1990)

The advent of independence ushered in high expectations from the people, coupled with the outpouring of donor funding. Drastic changes were introduced (and expected). The government policy was to rapidly expand health services to be accessible to every Zimbabwean with a plan to construct health centers within eight kilometers of every village, and this came at great cost. The health system of the colonial era was only concerned with a small settler community with a few coloreds and Asians. Expanding it to cater for seven million people was going to require a lot of funds.

The government also introduced free health care for those whose income was less than Z$150 with the stress that health services were a right not to be denied to anyone. There were more people receiving free care than those who were paying for it, and enforcement of payment was not possible. People were keen to enjoy the fruits of independence which meant that even those who could pay for the service got away with it. The hospitals that were previously subsidizing the African hospitals suddenly became big consumers of the resources. The policy of tax exemptions for people on medical aid, however, was not scrapped. This has caused a lot of debate because those opposed to this policy state that the people receiving tax exemptions do not need to, since they can afford to pay for the health care. It is

argued that if these people are taxed rather than subsidized, the revenue collected could then be channeled to the health services that benefit the poor in the rural areas. It is very unlikely that this policy will change in the near future since its beneficiaries are among the middle class and the elite, the stakeholders that can negatively or positively affect the continued popularity of the government. Most of these people are also in government and will therefore not scrap policies that are beneficial to them.

By 1986 the "well of resources was running dry" and reality struck that the government had limitations and could no longer sustain its spending spree. The donors who had previously supported its efforts called on it to cut down its subsidy to social sectors, and introduce user-charges and shift government expenditure to sectors that were more productive.

3.2.3 Cost-Sharing In the 90s: The Introduction and Enforcement of User-Fees in Health Services

In 1991, the government of Zimbabwe, forced by mounting fiscal deficit and the worst drought since 1950, started looking seriously at the service sectors and, with the help of International Monetary Fund and the World Bank who were the major donors to the country, re-introduced and enforced user-fees in education and health. The enforcement was to strictly follow the rules laid down in the Ministry of Health Circular, Number 29 of 1985, "Rules for and Charges at Government Hospitals". The parties involved viewed this strategy as a means to:

1. *Increase government revenue in view of fiscal constraints and donor requirements to meet the target of reducing government*

deficit from 10 percent of Gross National Product in 1990/91 to 5 percent in 1995.

The idea of progressive taxation was ruled out because of the pressure of stakeholders. User-fees in health and education were accepted although this was regressive and was bound to hurt the poor more, not to mention the effect on access to those services.

2. *Streamline the referral system in health by a deliberate graduated increase in fees from the primary to the tertiary level.*

The current pricing policy is that health fees increase as one moves up the referral system. This was introduced to discourage people from by-passing the primary clinics in favor of hospitals, thus undermining the referral system. The plan ensured that patients were channeled to appropriate point of entry into the health care service.

3. *Improve efficiency and equity by generation of resources within the health sector.*

There was a claim by the World Bank, also supported by the government, that out-of-pocket payment by the patients would be a strong indicator of willingness to pay. The argument was that people paid traditional healers out-of-pocket, so if they valued the health service, they would pay for it. However, both parties did not consider the mode of payment the traditional healer uses. The payment tends to be by result (when the patient has been treated) and the said payment is not necessarily monetary, most clients pay in kind.

User-fees were also seen as only a small percentage of people's annual income. In this plan, the government made provision for free treatment for the poor earning less than Z$400 per month if they could prove their eligibility by presentation of a pay slip

or exemption certificate from the Ministry of the Public Service, Labor and Social Welfare.

The information about exemption criteria is not readily available to the rural community and most people are shocked when confronted with the requirement at the health center. There is no organized plan by the Ministry of Health of ensuring that the people who are affected by the policy receive correct information about the changes that have been introduced. This makes it difficult for them to take the required documents when they visit the health center thus, causing delay and inconvenience for the health centers who are usually understaffed. The burden is then on the health institutions to disseminate the information. Some people are still having the mistaken notion that there is free health care, while others have received distorted information to the effect that everyone has to pay, and in response, have boycotted the service or are only brought to hospital when their health has deteriorated, because they cannot afford it. It is the duty of the government to see to it that information is readily available before any policy is enforced.

3.3 PROBLEMS RELATED TO ACCESS TO THE EXEMPTION CERTIFICATES

3.3.1 Informational Constraints

Direct targeting (used by the Ministry of Health) assumes that there is abundant information which makes it easy to identify the "poor"; in reality this is not the case. Most people in the rural areas are outside the formal market economy where data on earnings is often scanty, making it difficult to accurately locate a household above or below an arbitrary poverty line. In cases where targeting is possible, certain problems have been

identified (Atkinson and Hills 1991; Dreze 1990; Benstein et al 1992, in Gilson 1995):

- households transfer income to each other;
- household data indicates little difference in income and access to health care within the household, for example, women within a non-poor household may not have access to money;
- there is often considerable heterogeneity in living conditions among households below a poverty line;
- lack of information may lead to reliance on dubious self-reported income data;
- relatively high levels of illiteracy among claimants and diverse sources of household income may reduce accuracy of information on forms;
- households may be classified as wealthy because they have assets (for example, cattle) even though they do not have access to cash, yet the main determinant of ability to pay for health care may be cash availability rather than assets.

In Zimbabwe some families have also complained that they have been denied exemption letters by councilors because they have wealthy children, and it is wrongly assumed that they have access to that wealth. While this was the case in the olden days, times have now changed and that claim is no longer valid. The economic realities now require that people fend for themselves.

3.3.2 Administrative Constraints

Rural Health centers are not equipped administratively to effectively manage the work related to assessment of people to determine eligibility for exemption. There is also no special training given to these cadres. Although the responsibility of issuing exemption certificates lies with the Ministry of Social

Welfare, people rarely go to get them due to the costs involved. The onus is then on the health center staff to determine who to exempt and who not to. The frequent mobility of personnel means that people are continuously going through the same interview as staff change. There is no staff assigned specifically for dealing with patients requiring exemption, the nursing staff take turns in registering patients and have very little time to conduct such interviews. Because of difficulties involved, a majority of patients are charged except where it is easy to verify. The motto seems to be, "if in doubt, charge".

The effectiveness of exemptions and revenue use to benefit the poor relies heavily on good administration. Administrative failure leads to eligibility rules that are not clearly specified and thus waivers are discretionary at health center level. Sometimes overzealous staff can turn away people without money.
The practice of remitting revenue to central government does not offer encouragement to collect fees, as a result, sometimes free care is given to selected individuals with or without exemption certificates. Decentralized screening procedures in Zimbabwe in which health center staff decide whom to exempt have been criticized because the broader context of revenue collection and revenue use decisions are centralized. The staff merely exercise considerable power but not accountability (ibid,:234). Administrative failure in user-fee management indicates that institutional and administrative contexts of a country and its health sector should be considered in policy development so that administrative procedures do not become a source of targeting error.

3.3.3 Socio-Cultural Constraints

Will the poor take advantage of exemption? In most cases they do not, for a variety of reasons. Targeting is in itself stigmatizing and some poor people would rather pay or postpone care than obtain exemptions. Others equate exemption certificates with receipt of lower quality service. The scarcity of information about exemption criteria coupled with costs of travel, registration and attendance at interviews to qualify for the benefit and the bureaucratic procedures involved, act as a deterrent to the poor to take advantage of the service. They could also be deterred by attitudes and actions of those responsible for granting exemptions.

Pressure on health facility staff might increase opportunities for corruption and inappropriate targeting. Even in cases where the social worker is involved, sometimes the decision to grant or not to grant exemption is not based on formal criteria, but on the ability to bargain. In the final analysis, it is better to identify the poor by living conditions rather than income. This points to the importance of flexibility, depending on the context one is in. A combination of direct and characteristic targeting could provide better coverage of the poor and this would ensure access to health services without fear of stigmatization.

The Ministry of Public Service, Labor and Social Welfare which was enlarged to include the public service, is tasked with issuing exemption certificates among its multiple tasks. It is badly understaffed, following the trimming of the public service. There are no cadres in the community who can quickly make an assessment of villagers and issue exemption certificates to those deserving them. The nearest office is usually in the district. The patient also has to convince the local councilor

that she/he is eligible for an exemption certificate since the social worker cannot assess her/him during that one day visit. There is need for a referral letter.

Councilors have in the past abused this privilege and only given referral letters to their favorites in the village, especially those who voted for them. The deserving cases who are not popular with the councilor become the victims. If a patient becomes ill, he/she has to board a bus, usually past the health center, to the district many kilometers away to get a certificate. Very few, if any, rural people ever consider keeping an exemption certificate handy in case they get ill, it is considered a bad omen which might become a self-fulfilling prophecy. The situation is also compounded by the fact that the rural bus service is unreliable because it relies on an old fleet with no communication equipment, where frequent breakdowns are the norm. The bus trip to the district to get an exemption certificate costs more than the fees at the hospital, so most poor people opt to pay or stay away.

The success of the 1980s in ensuring equitable distribution of social services in Zimbabwe may actually be overshadowed by the enforcement of fees, which have made the health services inaccessible, especially for the poor. The institutions are available to the people, but there is now a barrier for the poor who now have to prove their poverty before they can get the service, although in certain cases the health staff can use their discretion to exempt some from payment.

SUMMARY

The government's power in the selection of policy options is manifested in the allocation of the national budget. Although the health budget has tended to be relatively higher than other

sectors, it tends to be incremental, and in most cases does not give adequate allowance for inflation. The post-independence government's decision to expand the health services to redress the imbalances of colonialism led to fiscal constraints forcing it to introduce user-charges. These charges are aimed at increasing government revenue, streamlining the referral system and increasing efficiency and equity within the health sector.
To ensure equitable access, the targeting approach is used to ensure that the poor are not disadvantaged. This approach has, however, been difficult to implement due to informational, administrative and socio-cultural constraints and a tendency for the benefits to leak to the non-poor. These constraints have affected the utilization of health services as Chapter Four will illustrate.

CHAPTER 4: EFFECT OF USER-FEES ON ACCESS TO HEALTH SERVICES

INTRODUCTION

This chapter makes an analysis of the data received from the Brethren In Christ Church Hospitals on the utilization of health services by pregnant women since the introduction and enforcement of user fees. The data is based on antenatal attendance, hospital and home deliveries and infant deaths at the four health centers.

4.1 Sample Description

The Brethren in Christ Church hospitals are members of the Zimbabwe Association of Church-Related Hospitals (ZACH), and are situated in Matabeleland North and South Provinces, in the south western part of Zimbabwe, (see Appendix 4 and 5). They consist of Phumula hospital in Matabeleland North Province and Mtshabezi hospital, Matopo and Wanezi clinics in Matabeleland South Province. These health centers make up approximately 20 percent of all the rural church-related hospital beds in the two provinces. The area covered by these health centers is semi-arid, and since 1980, has been ravaged by periodic droughts, the worst since the 1950s. As a result of this, the area is frequently declared a disaster area requiring the government to distribute drought relief to the inhabitants of these areas. In most of the drought years, Matabeleland South province has been hardest hit.

Phumula Hospital

Phumula hospital has 50 beds, half of them for maternity patients, and serves a population of 30 000 people. This is the

poorest part of the province with minimal basic facilities like schools and health centers. These few facilities are chronically understaffed and there is rapid turnover of staff due the fact that the area is in the remote part of the country, and is plagued by transport and water problems. Boreholes provide the only source of water, but they frequently dry up and the pipes have a tendency to break down. Manufacturers have so far failed to make borehole pipes that are suitable for the area's soil chemistry, resulting in their premature destruction and frequent replacement. This poor area cannot afford this expense and as a result many of the boreholes are not repaired for long periods of time. The rural women have to walk long distances to collect water for their daily use.

Although this hospital has a doctor's post, it has been vacant since 1987 when the expatriate's contract expired. This hospital has never been staffed by Zimbabwean doctors since it was built, despite pleas from the Provincial Medical Director and the government. Expatriates who unknowingly volunteer to work in this area only work for the duration of their contract and never renew it. The majority of the people qualify for public assistance and free health care. Phumula hospital is two hours away from the Tsholotsho district hospital. The roads between these two centers are sandy and develop potholes during the rainy season, and are also impassable except with a four-wheel drive vehicle. The District Development Fund (DDF) spends most of its budget on road maintenance.

Matopo Clinic

Matopo has 12 beds, with eight beds for maternity patients and serves a community of 5 888 people. The clinic is 48 kilometers from Bulawayo and about 15 kilometers from Kezi/Matobo district hospital. The community served consists mainly of subsistence

farmers and female headed households. Most men in the area work in the city. These women usually have problems when it comes to exemption from payment of fees since it is always difficult, due to lack of documentary evidence to decide whether or not they should be exempted. Most of the time they do not have proof of the husband's salary.

The farmers have access to income only when they sell their produce in the city. Since the income is not predictable, and dependent on the supply and demand of the goods, it is never clear how much the farmer gets in a month and whether this makes him/her qualify for exemption. To remedy this situation an arrangement has been made with the councilors to give exemption letters to those people who qualify for free health care.

The clinic also serves the students and teachers at the primary and high schools. Most teachers contribute to the medical aid society, but as already stated, mission hospitals and clinics require them to pay out-of-pocket. In most cases they never pay their bills because they cannot claim for reimbursement by the medical aid society, since the health center is not registered with the society. This creates problems for the health center staff, who cannot enforce payment or deny treatment to the respectable members of the community.

Wanezi Clinic

Wanezi has 35 beds, with ten reserved for maternity patients. The population served is 3 090. The community served is similar to that of Matopo, but in addition there are also semi-commercial farmers who own larger tracts of land. Subsistence farmers on the other hand, live on communal land. Similar problems are encountered related to payment of fees by those who

are not exempted like teachers and the elite in the community. Councilors and Village Development Committee (VIDCO) chairpersons assist the clinic by giving letters of exemption as means of verification for those who qualify for free treatment thus making the work of the health center staff easier.

Mtshabezi Hospital

Mtshabezi hospital has a bed occupancy of 110 (14 reserved for maternity patients) and a catchment area of 14 616 people. It has more well-to-do people than the other three health centers and has a well-equipped hospital with a post for two doctors. The facilities available almost rival those of Gwanda district hospital which is less than an hour away. Because of its good facilities and the fact that its hospital charges are lower than the district hospital, it attracts patients from outside its catchment area, some coming from as far afield as Bulawayo which is more than two hours away. Maternity patients make the bulk of these latter patients.

4.2 DATA COLLECTION TECHNIQUE

A questionnaire was sent to these health centers to collect data on the utilization of health services by pregnant women in order to find out the impact of the enforcement of user-fees. The questionnaire requested data from 1990 before the enforcement of fees to 1994. Data Collecting instruments were of two types, each designed to collect specific data from the health centers. The following questionnaires were prepared to collect specific data for the study:
Questionnaire 1 was prepared for collecting information on staff establishment, budget allocation, hospital/clinic attendance statistics and hospital charges. (Appendix 2.)

Questionnaire 2 was specifically designed for collecting information on the mode of charging fees at the respective health centers. This questionnaire was also meant to clarify some of the information received in the first questionnaire. (Appendix 3).

4.3 GENERAL COMMENTS

The staff at all the institutions tried their level best to give data that was available, and in record time. Most of the information was however, not available at the health centers or was not being collected. Only one health center, Phumula hospital, was able to give a breakdown of the budget for the health center over the past four years. The other health centers claimed that they could not locate the documents. The information in some of the questionnaires related to attendance statistics is still unclear even after receiving the second questionnaire.

This paper seeks to test the hypothesis that the enforcement of user fees will affect health service utilization, and will also focus on what some authors see as other variables that affect demand for health services. These variables, as discussed more fully in Chapter 2, include, accessibility, drug availability, mode of payment and opportunity costs among others.

4.4 HOSPITAL FEES

Phumula Hospital, Wanezi Clinic and Matopo Clinic

Out patient charges increased from Z$1 per adult per visit in 1990/92 to Z$6,50 in 1993. Children's fees also increased from

Z$0,50 to Z$3 during the same period. Maternity delivery fees shot up from Z$1 to Z$10 in 1994. Phumula hospital fees have been reduced to the level of clinic fees because of socio-economic consideration of the population served by the health center. In reality, hospital fees are higher than clinic fees in order to discourage patients from by-passing the clinic to seek services at the hospital. Fees at all the health centers include the cost of drugs and charges are per course of treatment. Data on inpatient fees was not supplied.

Mtshabezi Hospital

As already stated, the fee structure for a hospital is different from that of a clinic. Adult outpatient charges increased from Z$6,50 to Z$17 per visit, while children's fees rose from Z$2,50 to Z$8,50. Inpatients fees have increased from Z$3 per day to Z$50 a day since 1994. Children's charges are up from a daily rate of Z$1 to Z$25. Maternity fees were increased from Z$3 for delivery, and Z$3 per day after three days, to a flat fee of Z$60 for the duration of the stay in hospital since 1994. The ambulance costs Z$112,50 per call. Minor surgery and major surgery cost Z$5 and Z$35 respectively. The previous charges for surgery were not supplied.

Figures 1 to 3 and Table 6 attempt to depict data related to antenatal visits, hospital deliveries, home deliveries and infant deaths. Antenatal visits and hospital deliveries are given as a percentage of the 1990 figures. Home deliveries are expressed as a percentage of hospital deliveries and infant deaths as a fraction of live hospital deliveries. The results are compared for the four centers to see whether there are any trends per center bearing in mind the differences in the

populations served. For field data on which the following analysis rests, the reader is referred to **Appendix 6**.

4.5 HEALTH CENTRE UTILIZATION

4.5.1 Health Centers' Response

There was general agreement between the three health centers (Mtshabezi Hospital, Phumula Hospital and Wanezi Clinic) that the enforcement of user-fees has led to under-utilization of the health services by the poor. This would be in line with the studies done by several authors in the developing countries as illustrated in Chapter 2. Wanezi states that the requirement to produce a letter of exemption from the local councilor or VIDCO chairperson has led to a decrease in patient attendance at the health center. In any community where there are class differences, people of a higher social class tend to hold all important positions in the community. Posts of councilor and VIDCO chairpersons are, therefore, likely to be held by the elite in the community who are more conservative and probably out of touch with the needs of the poor. This could then deter the poor from approaching them for exemption letters, which would explain why Wanezi is having problems with reduced utilization, while Matopo clinic with a similar arrangement is not having problems. Patients are reported to be now consulting traditional healers where charges are lower or non-monetary. Employed people earning more than Z$400 stay away when asked to pay, resulting in a drop in patient attendance.

In Phumula hospital, although approximately 98 percent of maternity patients qualify for free treatment, the health center reports that there has been a decrease in patient attendance since the introduction of user-fees. Mtshabezi also reports a general decline in attendance.

Matopo clinic on the contrary, stated that user-fee introduction has not affected service utilization because the councilor gives exemption letters to all those eligible for free health care. This makes the work easier for the health center staff who are not burdened with the work of screening those eligible for exemption.

4.5.2 Analysis of the Results

Antenatal Attendance

Antenatal attendance at Mtshabezi hospital showed a progressive decline from seven percent in 1991 to 41 percent in 1994. The charges at this health center are higher than the other three health centers under discussion and it serves a larger area with

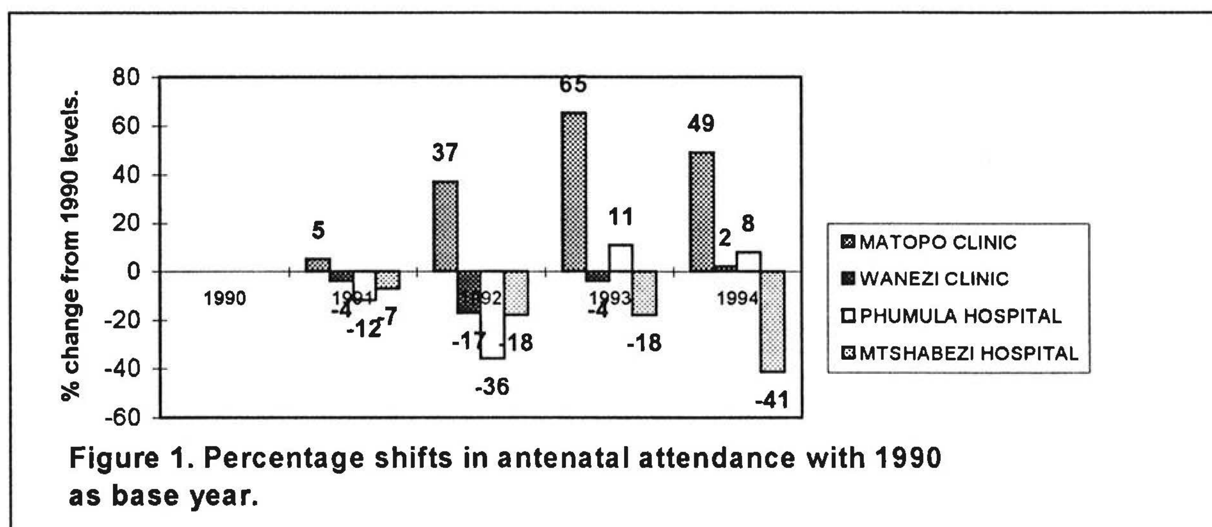

Figure 1. Percentage shifts in antenatal attendance with 1990 as base year.

people of different social standing. The institutional set-up and administration is also quite different and fees are likely to be demanded at the first contact with the hospital. The high turnover of staff means that new staff who do not know the community that well are likely to stick to rules and regulations related to charges.

Phumula hospital attendance showed an average decrease of about 24 percent in 1991/92, and an average increase of nine percent in 1993/1994. The decrease in attendance at this center could probably be attributed to problems related to access to exemption certificates since the majority of the patients are eligible

for free treatment. Wanezi also recorded a decline in antenatal attendance with the lowest attendance of 17 percent in 1992. There was a negligible two percent increase in 1994. This clinic has stated that attendance have decreased since fees were introduced. Attendance at Matopo clinic increased steadily throughout this period. This verifies the claim by the clinic that the introduction of fees has not affected attendance at the hospital.

Hospital Deliveries

Hospital deliveries showed a decline for Mtshabezi, Phumula and Matopo. It is not clear why hospital deliveries have decreased in Matopo which has an arrangement with the councilor to give exemption letters, and at Phumula hospital where the majority of patients are eligible to receive free health care. Wanezi clinic is the only health center that recorded an increase in hospital deliveries from 1992.

A decrease in hospital deliveries, however, does not necessarily mean that user-fees are having a negative impact. There are other variables which could play a part like transport costs, use of family planning (which would mean that less people are having babies) including those people who are late in going to the hospital and deliver before they get to the hospital. This research was unable to

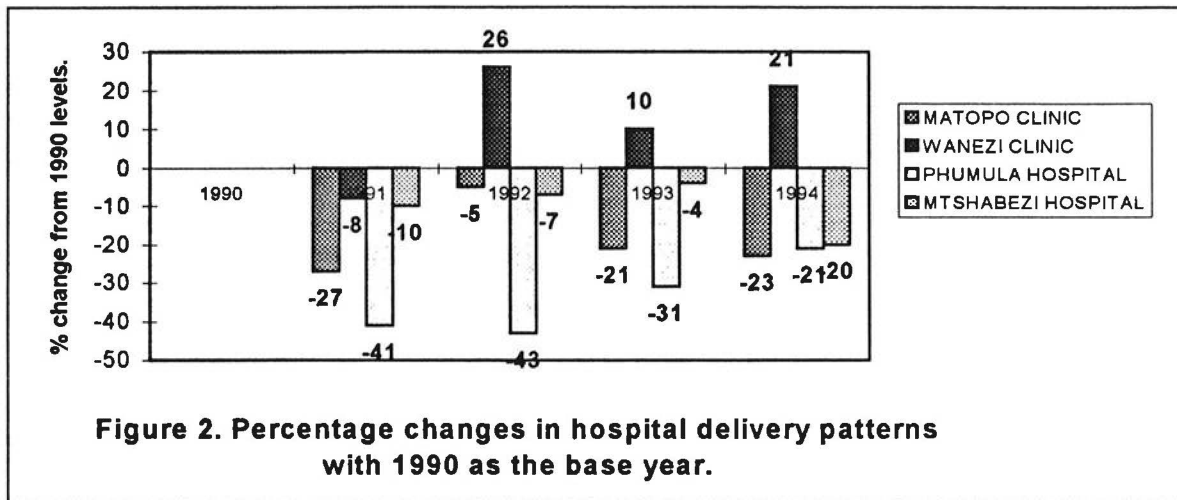

Figure 2. Percentage changes in hospital delivery patterns with 1990 as the base year.

verify impact of these other variables due to time constraints.

Home Deliveries

All the health centers, except Mtshabezi, recorded an increase in the number of home deliveries since the introduction of user fees. Phumula hospital showed a marked increase from 15 percent in 1990 to 52 percent in 1994, despite the fact that approximately 98 percent of maternity patients are eligible for free health care. It is not clear whether there is an arrangement with the local councilors to give exemption letters as is the case with the clinics. Home deliveries at Wanezi clinic increased significantly from zero in 1990/91 to 27 in 1994. This has perhaps, to do with the differences in the social status of the poor and those who have the discretion to give exemption letters who are in most cases conservative. Wanezi has stated that there is an increase in the number of people using the services of traditional healers since fees were introduced. Statistics on home deliveries seem to verify this assertion.

Matopo clinic was not keeping a record of home deliveries until 1994 when 28 home deliveries were recorded against a figure of 34 hospital deliveries, which is 82 percent of all the recorded deliveries in that year. One would therefore, conclude that user

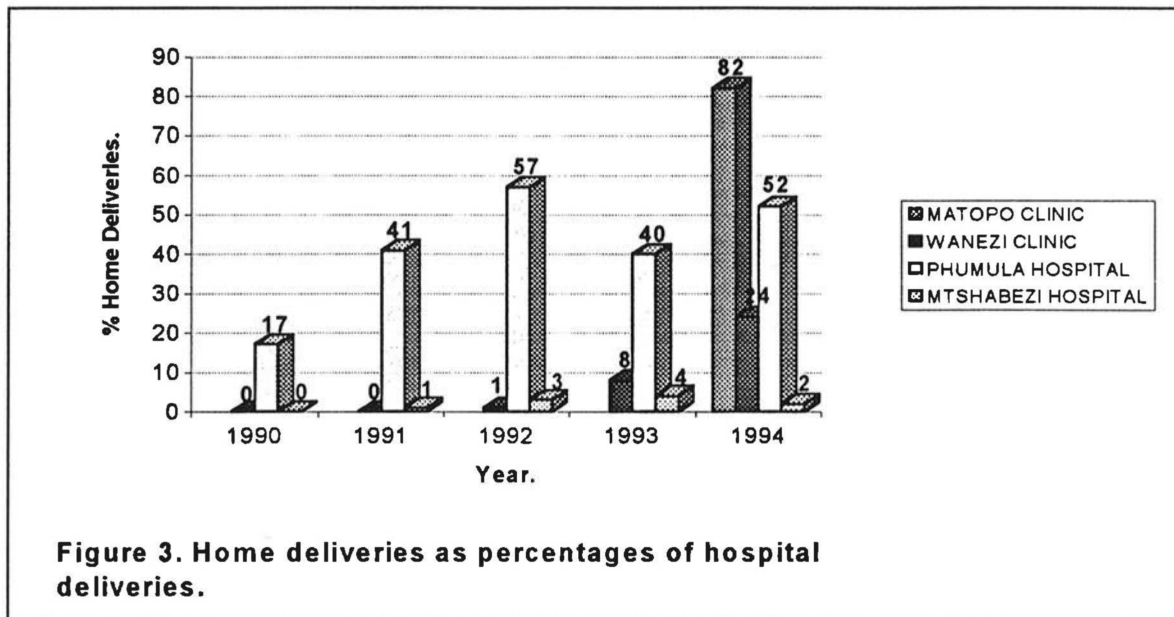

Figure 3. Home deliveries as percentages of hospital deliveries.

fees have had an effect on the utilization of service, judging by the number of reported home deliveries. It is assumed that, this high number indicates a shift in the choice of alternative services by the rural population, unless if these patients deliberately decided to deliver their babies at home, which is very unlikely. Rural women, in general, prefer to deliver at the hospital because it frees them from the multiple tasks that they have to do, thus giving them time to rest and regain their strength after delivery.

All the health centers have shelters for waiting mothers and some women have been known to come prematurely and wait for weeks before they deliver their babies. It is important to note though, that some women fail to take advantage of this facility because they have other younger children at home that they cannot leave unattended. These results seem to verify studies done by Hongoro (1991) and Iliff (1990) on the effect of user-

fees in public health centers, which showed an increase in the number of babies born before arrival (bba) at the health center.

It is not clear whether all the home deliveries were reported to Mtshabezi hospital. One would assume that the marked decrease in hospital deliveries means that some people delivered their babies elsewhere, either at home or at clinics close to Mtshabezi, which charge lower fees.

Infant Deaths

There was a decrease in infant deaths in all the health centers under study. Mtshabezi hospital shown a downward trend from 31 in 1990 to 12 in 1994. If all the infant deaths were reported to the health centers then one can assume that people are much healthier and therefore giving birth to healthier babies.

4.6 DRUG AVAILABILITY

Drugs used in the health centers are obtainable only at the government medical stores. Wanezi Clinic and Mtshabezi hospital state that on the average they have to wait for a period of three to four weeks before they receive the consignment. Phumula hospital and Matopo clinic get their order after two to three months. It is not clear why it takes such a long time for Matopo to get its order when it is only forty-eight kilometers from the medical stores.

The Ministry of Health does not reimburse the health center for drugs purchased from private companies without authority. In those circumstances where the required medication is not available at the medical stores, the doctor has to convince the Provincial Medical Director (PMD) that the medication is

required, that there is no other substitute drug that can be used and that if the patient does not get it, his/her health will be affected. If the PMD is convinced, then the doctor has to get invoices from three different companies which will be sent with the application and a supporting letter from the PMD to the Ministry. To prevent this delay, the health centers use their own resources to buy drugs directly from the companies involved. Health centers are discouraged from purchasing expensive drugs from the private sector. This is perhaps good economic sense but can be a disadvantage for those patients who genuinely need that particular drug and those health centers without the resources to buy directly from the private companies.

The health centers also complain that some major drugs like antibiotics are perpetually out of stock at the medical stores, making the health centers work inefficiently. District hospitals are authorized to supply health centers with drugs on loan from their own stocks until their consignment from the medical stores is received. Sometimes the district also fails to supply the drugs if they are out of stock at the medical stores.

4.7 *ADMINISTRATIVE CAPACITY*

None of the health centers have clerical staff who deal specifically with screening of patients to determine who is eligible for exemption. Part of this work is done by nurse aids as they take histories and vital signs. They are not trained to assess people and because of pressure of work, they charge all those who are unable to produce letters of exemption. In this way those who were not aware of the requirement (since not everybody has access to information) but deserve exemption, get charged.

The trained nurses are very few and their work pressures prevent them from participating fully in this exercise. Those hospitals with administrators sometimes receive complaints from patients who feel that they have been charged unfairly. On the average, poor rural people, do not like to agitate health personnel; they would rather suffer in silence. They are not likely to force their way into the administrator's office demanding exemption (Iliff 1990).

4.8 FEE UTILIZATION AT THE HEALTH CENTRE

All the income received by the health centers has to be reported to the Ministry of Health every month when vouchers are sent in for payment. The reported income is then deducted from the total amount claimed by the health center. This system discourages the staff from collecting fees since there is no tangible evidence of the benefit of collecting them. The staff see the collection of fees as a way of denying the health centers the receipt of funds from the head office, and yet they are required to do so. Those who pay for the service cannot see the benefit of the scheme. Studies on user-fees state that if a substantial amount of the revenue collected is retained at the health center and used to improve the quality of service, patients will willingly pay for the service. Fee retention at the health center also encourages the health center to collect more fees.

Table 6. **Infant Deaths Over Live Births**

HEALTH CENTRE	1990	1991	1992	1993	1994
MTSHABEZI HOSPITAL	31/751	22/675	30/697	1/40	1/50
PHUMULA HOSPITAL	1/145	3/85	1/166	1/200	3/230
WANEZI CLINIC	2/95	1/87	1/120	0	0
MATOPO CLINIC	0	0	0	0	1/34

SUMMARY

The analysis of data from the Brethren in Christ Church Hospitals has shown that enforcement of fees has had an effect on service utilization which can be verified by a decrease in hospital deliveries accompanied by an increases in home deliveries. The figures have been higher even where exemption is reportedly working very well (Phumula, Wanezi and Matopo). This could be an indication of the people's preference for alternative services, like those provided by traditional midwives which are cheaper. The picture at Mtshabezi hospital is however, different mainly because of the presence of clinics close to it which charge lower fees and the clientele from outside the catchment area who utilize the services of this hospital. As a result, although there is a decrease in hospital deliveries, home deliveries are relatively very low compared to the former.

CHAPTER 5 : SUMMARY AND CONCLUSIONS

Studies by Gilson (1995) reveal that user-fees have been accepted as a reality since the 1980s. The issue is no longer whether or not to introduce them, but how they should be introduced. The aim of every government is to ensure that in the introduction of charges, the poor can still gain access to the services. This research has attempted to analyze the impact of the enforcement of the user-fee policy on maternal utilization of health services in a rural setting in Zimbabwe, based on the hypothesis that the enforcement of user-fees will lead to a decline in the utilization of health services. Current debates on the user-fees based on studies done in Sub-Saharan Africa and other developing countries formed the theoretical framework of this study. The roles of government and the individual in the financing of health services from the post-independence period, the decade post-independence and the 1990s after the introduction of cost recovery policies have been analyzed.

As detailed in Chapter 4, the sample of institutions selected is sufficient to enable one to draw some general conclusions for Zimbabwe's rural areas. The analysis of data from the Brethren in Christ Church Hospitals has revealed that enforcement of fees has had an effect on service utilization which can be verified by a decrease in hospital deliveries accompanied by an increase in home deliveries. The figures have been higher even where exemption is reportedly working well. This could be an indication of the people's preference for alternative services, like those provided by traditional midwives which are cheaper. While non-utilization of services is not necessarily a bad thing, it only becomes so if people need the service but cannot afford to pay for it. In the Zimbabwean context, women tend to prefer to deliver their babies in the hospital where they are

assured of rest, which they cannot afford if they deliver at home due to the demands on their time.

Screening of patients by health personnel at the health center to determine exemption for those people who do not bring exemption certificates is time consuming. It requires some people to do that kind of work full-time. While the big central, provincial and district hospitals have clerical staff specifically for this work and resident social workers to interview and issue exemption certificates for those who qualify, the rural health centers, whose clients are generally poor, do not have these posts in their establishment.

The problem of access to health services and the criteria used for exempting those people who are entitled to free care have been discussed. It is evident from this study that the system of targeting that requires the poor to produce proof of exemption in the form of an exemption certificate, has its own shortcomings and affects service utilization. In view of the negative effect of user-fees on maternal utilization of services, Iliff (1990) proposes that policy-makers should consider exempting all maternity patients from payment of fees.

Other factors that affect demand for health services like accessibility, the mode of payment and the opportunity costs do not appear to have affected these health centers. Most rural health centers are situated within eight kilometers of most villages. Mobile teams also visit those areas which are either not close to the health centers or where the work situation makes it difficult for the people to visit health center (like commercial farming areas). Although the drought of 1991/92 also had some effect on attendance, which led to decreased utilization of health services, this trend continued after the drought.

RECOMMENDATIONS FOR FUTURE POLICY CHANGE

Since health care is fundamental to both the economic and social well-being of all Zimbabweans, it should be adequately financed. Although user-fees have some regressive effects on the public health care delivery system, they should be maintained as a form of payment. It is important, however, to consider an alternative to user-fees that could be relevant to the rural community (Hongoro 1992).

Community financing schemes have been used in other counties like India and have worked well. The community in Zimbabwe is already well-organized and training in community financing directed at the Village Development Committee members could have good results. Small contributions by the community into the fund (especially during the harvest season when people have disposable income) could be the starting point since the rural folk do not have stable incomes compared to the urban people.

It is also possible for some people to pay in kind instead of relying on monetary payments which the rural people have very little of. The rural community can volunteer their labor for certain tasks at the hospital as payment. This would ensure that health care remains part of a system of rewards linked to personal effort, rather than as charity, thus preventing the dependency syndrome and restoring personal pride (Donabedian 1971). Rural people have used this system to compensate traditional healers and midwives after treatment.

Studies in other developing countries have demonstrated that if the health centers are allowed to retain all or a significant part of the revenue collected, they are motivated to collect the fees. The retained revenue can then be used to improve services

for the people served by the health center, thereby ensuring that quality of care also increases with an increase in fees. At the moment, all revenue collected is classified as general revenue and is forwarded to central treasury; it has no bearing on future budget allocation for the Ministry of Health. This policy is a disincentive for both the Ministry of Health and the health center to collect fees, leading to lost revenue which the government can ill-afford. Current government policy which ensures that the magnitude of the monthly recurrent expenditure grants is negatively affected by revenue collected needs to be reviewed.

Another critical issue is the level of communication between the service users and the providers. There is currently no effective communication between the service users and health personnel, especially on changes in government policies and procedures. Information about the introduction of user-fees in health services, the people eligible for exemption, the criteria used and means of verification should be readily available. The government has to be aware and sensitive to the differences in the communities it serves and therefore not apply the same criteria to both urban and rural settings. The needs and realities present in a rural community were not taken into account when the exemption criteria was formulated. Policy after independence though, pushing for community participation, seems to have continued to plan <u>for</u> the people rather than <u>with</u> the people.

Communication problems also abound at the inter-ministerial level. There should be better liaison between the Ministry of Health and Social Welfare so that the poor can obtain exemption certificates in the village without having to travel all the way to the district for the same. Most ministries have decentralized to the local level but the Ministry of Social Welfare has not.

As a ministry which is concerned with the poor, it should be where the poor are, and not expect them to have the means to go to the district offices to get the service. The village-level social worker can assess the whole community and give exemption certificates to all those who need them. This would then free staff at a health center to concentrate on their medical work. Alternatively, a shift in the responsibility of issuing exemption certificates from the Ministry of Public Service, Labor and Social Welfare to the Ministry of Health would reduce the delay that is evident in this process.

To ensure adequate protection of the poor, the nominal income cut-off for non-payment of fees needs to be reviewed periodically to keep up with inflation. Failure to monitor and adjust exemption criterion overtime to accommodate inflation in Zimbabwe meant that people who qualified a decade ago no longer did. Hecht (1993) states that less than five percent of the domestic and agricultural employees qualified for free health service after the income level of those eligible for exemption was raised from Z$150 to Z$400 in 1990. Given the high inflation rate of 30 to 40 percent, the revision of income after ten years was insignificant. Most people who had qualified for free health care at independence were excluded after the revision, although their financial situation had not improved in real terms.

This discussion indicates regression in the health policy formulated after independence which had the best reviews from many quarters, including the international community in the way it was addressing the inherited imbalance in the distribution of health services. The poor in the rural areas, whom the government had targeted at independence, now have the health facilities at their disposal but these centers still remain inaccessible since the introduction and enforcement of user-fees and the accompanying criteria for exemption.

On the issue of donor impact on policy, one needs to note that this community has its own global goals and priorities, such as, for instance, the promotion of sustainable projects (Bossert 1990). As long as the World Bank and International Monetary Fund hold the purse strings, policies that further reduce the role of government in the social sectors like health and education, which are considered "non-productive" by the donors, will be vigorously pursued in the name of structural adjustment. One can, however, argue that the so-called non-productive sectors are not only instrumental but are the backbone of the so-called productive sectors. An unhealthy and uneducated population will adversely affect national development. The dictum that "he who pays the piper, calls the tune" is not inappropriate.

All in all, this study will have achieved its goal if it cautions the policy-makers to first consider the possible effect of such policies on the intended beneficiaries prior to enactment and operationalization. In light of this observation, one needs to point out that the limitation of this study was the non-availability of information from the patients themselves. This would have given more solid information on the reasons for non-utilization of health services, the community's perception of user-fees system, survival strategies they use, opportunity costs, assessment of willingness to pay, perception of quality of care provided and alternatives to user-charges. The absence of this vital information means that some of the conclusions drawn on patients' motives will prove to be rather speculative. Subsequent studies would be more balanced if they incorporate a detailed study of the rural communities themselves.

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Appendix 1. Selected health care exemption experience.

Country	Target groups	Mechanism of protection	Targeting procedures for poor	Effectiveness: evidence and issues
Belize (La Forgia 1992b)	• Income groups, especially indigent • Emergency care users • Specific diseases' treatment • Low level civil servants	Sliding scale plus full exemption for indigent	Means test carried out by facility clerks, based on patient-declared household income, or occupation; little verification	• Exemptions granted inconsistently • Clerks reluctant to pressure or question patients, often waive fees for relatives and friends • Fee level low as not adjusted for inflation in 25 years
Dominican Republic (La Forgia, 1992a)	• The 'poor'	Sliding scale	Means tests carried out by social workers at the facility without central guidance; a bargaining process	• 10–50% of patients receive reduced fees • Friends, relatives and those with contacts receive waivers • Patients do not know correct fees or exemption eligibility
El Salvador (Fiedler 1993)	• Maternal-child care users • Preventive care users • Communicable diseases' treatment	Informal sliding scale plus full exemption for indigent	In health units/posts, patient's decision; in health centres and hospitals, a social worker interviews patients	• Informal and variable decision-making
Ethiopia (Barnum and Kutzin, 1993)	• Poor households earning less than 50 birr per month • TB and leprosy patients	Full exemption	Local authorities' decision based on patient proving income level	Addis Ababa hospitals: 30–35% of inpatients and 10% of outpatients receive free care; Rural hospitals: 7–40% of inpatients and 20–60% of outpatients receive free care
Ghana (Waddington and Enyimayew, 1989; 1990)	• Ministry of Health (MoH) staff and families (up to 4 children) • Specific service users e.g. vaccinations, leprosy care • School children • 'Persons unable to pay'	Lower rates for children; full or partial exemptions for MOH staff and indigent	At discretion of facility management or health workers	• MoH staff and families benefit • Staff reluctant to grant exemptions to poor due to extra work, and loss of revenue
Indonesia (Griffin, 1992a)	• The indigent	Sliding scale; poor subject to minimal fees or exempted	Local village chief or other authorised official issues an affidavit of indigence	• Certificates quite easy to obtain
Jamaica (Abel-Smith and Creese, 1989; Barnum and Kutzin, 1993)	• The poor • High-risk pregnancies • Patients with chronic conditions	Full exemption for poor; partial exemption for chronic conditions	MoH uses a pre-existing means test administered by local government authorities in allocating food stamps; involves review by social service committee of local council	• 17–30% of population are exempt
Kenya 1989–90 (Huber, 1993)	• Children under five • Basic service users e.g. ante-natal care, tuberculosis care • Those 'unable to pay'	Full exemption; lower fees at lower levels of system	Facility in-charge grants one month exemption; year-long exemption based on endorsement from local chief; number of exempt stamps issued by each facility audited	• Low rate of exemption • Mechanisms not fully in place and health personnel not motivated

South Korea: universal social insurance (Griffin, 1992a; Willis 1993)	• Three classes of beneficiary and levels of subsidisation, based on income, place of residence and type of treatment:	Fully or partially subsidized insurance payments: – full subsidisation for the chronically ill and those living in public institutions – full subsidisation of outpatient care for those earning less than 42,000 won per month ($50) in large cities (1986)	Means testing by local government	• Beneficiaries accounted for 11% of the population in 1985–6
Mali (Barnum and Kutzin, 1993)	• Those 'unable to pay' • School children • Tuberculosis, leprosy and psychiatric patients • Military personnel • Civil servants	Full exemptions; civil servants liable for 20% of fees	Not clear	• Criteria applied differently across regions • At Hospital du Pont G in 1986 about 70% of inpatient days qualified for free care (Vogel, 1988)
Niger (Niamey National Hospital) (Weaver *et al.*, 1990, 1994)	• Indigents • Students • Infectious disease patients • Psychiatric patients • Civil servants • Military personnel	Full exemptions for most categories; civil servants and military pay 20% of fee; children under 5 years pay 25% of fee; children aged 6–12 years pay 50% of fee	Hospital social worker determines on basis of occupation and appearance (supposed to present certificate from local authorities)	• Most outpatients with exemptions are civil servants • More inpatients with exemptions are indigents than civil servants • Non-exempt have lower median income than exempt • *Ad hoc* exemptions based on kinship/friendship as well as need
Papua New Guinea (Thomason *et al.*, 1994)	Variable but including: • Indigents • School children • Elderly • Child health clinics • Chronic disease patients • Disabled patients	Variable but usually full exemption	Usually determined informally by revenue clerks	• Not always exemptions for indigents • Under-coverage due to rigidity of revenue clerks
Philippines (Griffin, 1992a)	• Those unable to pay	Sliding scale based on category of patient/level of service: class A patients pay full cost; class B pay 50%+; class C pay what they can; class D receive free care	Medical social workers interview patients	• 72% of patients in 60 district hospitals were classified as indigent in 1985
Thailand (GTZ, 1988; Mills, 1991; MOPH, 1989)	• The poor e.g.: – single people below B1500 per month; – households B2000 per month (recently changed to B2000 and B2800 respectively).	Full exemption	Village committee lists names on an official form, completed every three years; list checked and ratified by the Tambon Council; in practice, village head decides who qualifies	• Different criteria applied in different areas • Under-coverage and leakage problems • Budget allocations for exemptions favoured better-off regions
Zimbabwe (Hecht *et al.*, 1993)	• Households earning less than Z$150 per month (recently revised to Z$400) • Tuberculosis, leprosy patients • Committed psychiatric patients • Civil servants	Exemptions for eligible; also inpatient care in central hospitals has a sliding scale based on three income categories; children pay 60% of full fees; some hospital services have sliding scale based on income	At provincial, district and rural levels patients qualify by unchecked verbal statement; at central hospitals patients must prove indigent status with a pay slip/letter from social service authority; often the administrator decides because patient has no proof	• Few benefit because income eligibility cut-off not revised since 1980 • High exemption rate in rural areas because burden of proof is on the facility and lack of information • Low motivation to collect fees because fee low and not kept locally

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APPENDIX 2.

Questionnaire No. 1

BRETHREN IN CHRIST CHURCH HOSPITALS

NAME OF HEALTH CENTRE: : ------------------------------------

NUMBER OF TOTAL BEDS : -----------------------------------

NUMBER OF MATERNITY BEDS : ------------------------------------

POPULATION SERVED : ------------------------------------

STAFF ESTABLISHMENT	POSTS FILLED	POSTS VACANT
Doctors		
State Registered Nurses		
State Certified Nurses		
Maternity Assistants		
Administrators		
Secretaries/Clerks		
Drivers		
Laboratory Assistants		
X - Ray technicians		
Maintenance Personnel		
Cooks		
Laundry Staff		
Nurse Aids		

Others (please specify)

For the following question please give the total budget for each whole year.

BUDGET ALLOCATION:

1990	1991	1992	1993	1994

	1990	1991	1992	1993	1994

INPATIENT FEES:					

Maternity Fees:					

Other fees:					

In your opinion has the introduction of user fees affected patient attendance at your hospital? Yes/No

If "YES" how has it been affected?

HOSPITAL/CLINIC STATISTICS

	1990	1991	1992	1993	1994
Antenatal Visits					
Hospital Deliveries					
No. of booked deliveries					
No.of unbooked deliveries					
No. of low birth weight babies					
No. of maternal deaths					
No. of live births					
No. of infant deaths					
No. of home deliveries					
No. of paying Maternity patients					
No. of nonpaying maternity patients					
No. of paying outpatients					
No.of nonpaying out patients					
No. of paying patients completing treatment course					

HOSPITAL CHARGES

OUT PATIENT FEES: (PLEASE SPECIFY FOR THE 5 YEARS)

APPENDIX 3.

Questionnaire No. 2

BRETHREN IN CHRIST CHURCH HOSPITALS

Please Answer ALL Questions

1. Do you charge consultation fees? yes/no
   If yes how much?
2. Does the consultation fee also include the cost of drugs?
   If not, what is the cost for drugs?
3. Do you charge inpatient fees per day or is there a flat fee regardless of the length of stay?
4. What are the fees for different operations?
5. Out patient fees:
   (a) Adults
   (b) Children
6. Maternity fees:
   (a) Consultation fees
   (b) Antenatal charges
   (c) Drugs
   (d) operations e.g. Caesarian Section
   (e) any other charges
8. How do you screen patients who need to be exempted from paying?
9. How are fees collected? What are the costs of collecting fees in terms of time and money? Do you have the personnel to do this type of work?
10. How do you deal with paying patients who do not pay their hospital that is don't honour their debts?
11. Do you have patients who come to the hospital from outside the catchment area?
12. Do the fees collected help in developing the hospital?
13. In the last questionnaire you did not have any figures for unbooked maternity patients, is that the case?
14. Drug supply:
    (a) are the drugs easily available from medical stores?
    (b) on the average, how long does it take to receive your

drugs after ordering?

(c) can you freely purchase drugs from private companies e.g. Geddes, without authority from the Ministry of Health?

(d) How much on the average is spent on drugs from private companies?

15. Please state the following:

    (a) Recurrent monthly expenditure

    (b) Amount of fees collected monthly

16. Has there been any changes in fees since 1990? If so please itemize the charges for each year.

Appendix 6

Table 7. **Antenatal Attendance (compared to 1990 figures)**

HEALTH CENTRE	1990	1991	1992	1993	1994
MTSHABEZI HOSPITAL	4042	3743	3311	3314	2372
PHUMULA HOSPITAL	1400	1230	900	1560	1520
WANEZI CLINIC	709	682	591	681	724
MATOPO CLINIC	332	349	454	549	493

Table 8. **Hospital Deliveries (compared to 1990 figures)**

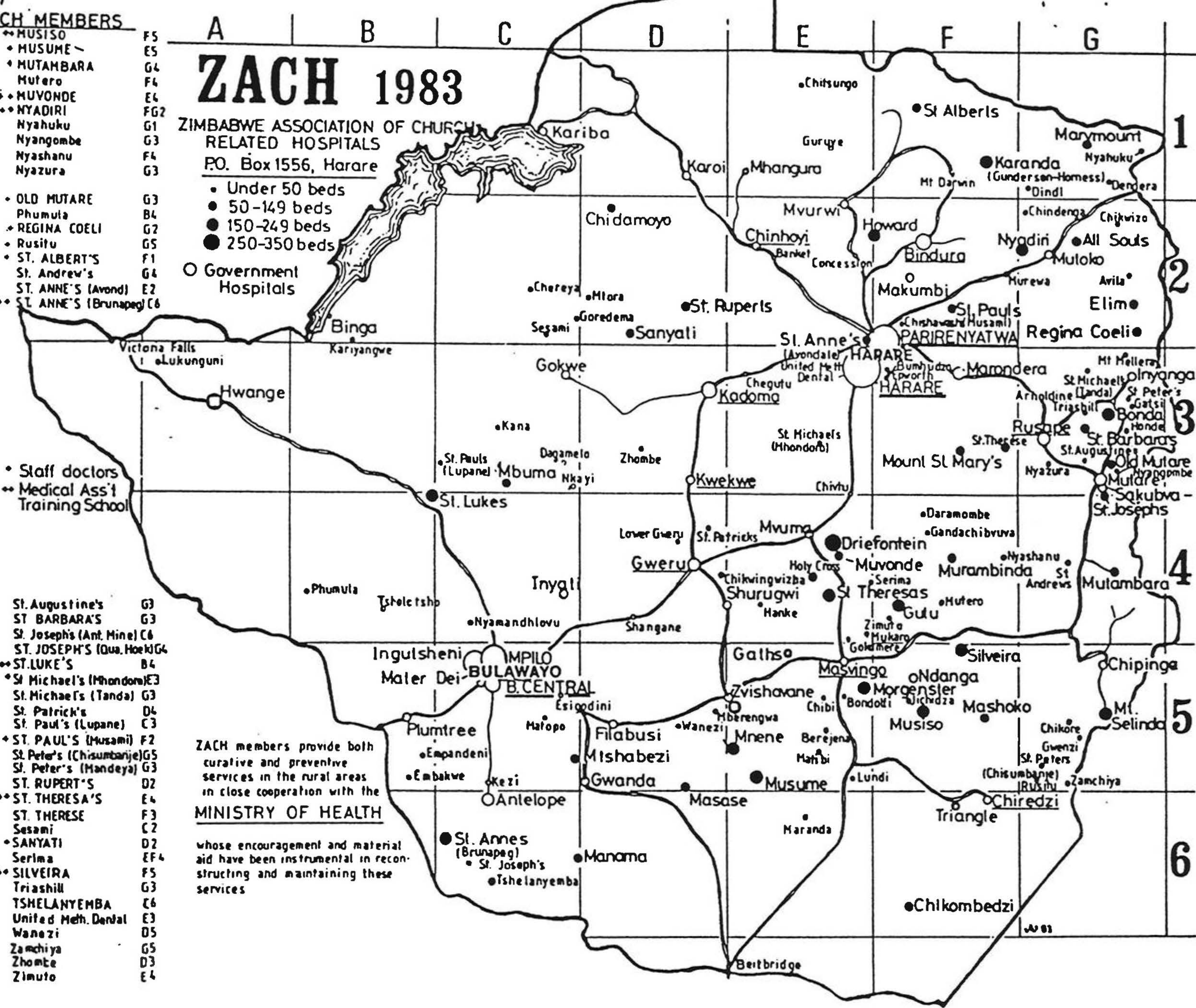
HEALTH CENTRE	1990	1991	1992	1993	1994
MTSHABEZI HOSPITAL	751	675	697	720	600
PHUMULA HOSPITAL	290	170	166	200	230
WANEZI CLINIC	95	87	120	104	115
MATOPO CLINIC	44	32	40	35	34

Table 9. **Home Deliveries (compared to Hospital Deliveries)**

HEALTH CENTRE	1990	1991	1992	1993	1994
MTSHABEZI HOSPITAL	0	4	20	25	13
PHUMULA HOSPITAL	50	70	95	80	120
WANEZI CLINIC	0	0	1	8	27
MATOPO CLINIC	Data	not	on	record	28

INDEX TO ZACH MEMBERS

Member	Grid
• ALL SOULS	G2
Arnoldine	G3
AVILA	G2
BEREJENA	E5
•• BONDA	G3
Bondolfi	E5
BUMHUDZO	F2
Chibi	E5
• CHIDAMOYO	D2
• CHIKOMBEDZI	F6
Chikore	G5
Chikwingwizha	D4
Chikwizo	G2
Chindenga	G2
Chireya	C2
Chishawasha	F2
Chitsungo	E1
Daramombe	F4
Dendera	G1
Dindi	G1
• DRIEFONTEIN	E4
• ELIM	G2
Embakwe	B5
Empandeni	B5
Epworth	F3
Gandachibvuva	F4
Gatsi	G3
Gokomere	E4
Gorodema	C2
• GUNDERSEN-HORNESS	F1
• GUTU	F4
Gwenzi	G5
Hanke	E4
HOLY CROSS	E4
Honde	G3
•• HOWARD	EF2
•• HWANGE COLLIERY	A3
Jichidza	F5
KANA	C3
•• KARANDA	F1
Kariyangwe	B2
Lower Gweru	D4
Lukunguni	A3
Lundi	E5
• MANAMA	CD6
Maranda	E6
• MARYMOUNT	G1
• MASASE	D56
•• MASHOKO	F5
MATER DEI	C5
• Matibi	E5
• Matopo	C5
• MBUMA	C3
•• MNENE	E5
•• MORGENSTER	E5
MOUNT MELLERAY	G3
•• MOUNT ST. MARY'S	F3
•• MOUNT SELINDA	G5
Mtora	D2
• MTSHABEZI	CD5
Mukaro	E4
• MURAMBINDA	F4
•• MUSISO	F5
• MUSUME	E5
• MUTAMBARA	G4
Mutero	F4
•• MUVONDE	E4
•• NYADIRI	FG2
Nyahuku	G1
Nyangombe	G3
Nyashanu	F4
Nyazura	G3
• OLD MUTARE	G3
Phumula	B4
• REGINA COELI	G2
• Rusitu	G5
• ST. ALBERT'S	F1
St. Andrew's	G4
ST. ANNE'S (Avond)	E2
•• ST. ANNE'S (Brunapeg)	C6
St. Augustine's	G3
ST BARBARA'S	G3
St. Joseph's (Ant. Mine)	C6
ST. JOSEPH'S (Qua. Hoek)	G4
•• ST. LUKE'S	B4
• St Michael's (Mhondoro)	E3
St. Michael's (Tanda)	G3
St. Patrick's	D4
St. Paul's (Lupane)	C3
• ST. PAUL'S (Musami)	F2
St. Peter's (Chisumbanje)	G5
St. Peter's (Mandeya)	G3
ST. RUPERT'S	D2
•• ST. THERESA'S	E4
ST. THERESE	F3
Sesami	C2
• SANYATI	D2
Serima	EF4
•• SILVEIRA	F5
Triashill	G3
TSHELANYEMBA	C6
United Meth. Dental	E3
Wanezi	D5
Zamchiya	G5
Zhombe	D3
Zimuto	E4



APPENDIX 5

ZIMBABWE - PROVINCES

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